Audit and Assurance Meeting - 6 April 2021

Tue 06 April 2021, 09:00 - 12:30

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 9th February 2021

John Union

4 Draft Public Audit Mins - February 2021 - V4 - Final.pdf (14 pages)

5. Action log following meeting held on 9th February 2021

John Union

5 Public Audit Action Log - February 2021.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 Report

Ian Virgill

7.1a - Internal Audit Progress Report cover April 2021.pdf (2 pages)
7.1b - Internal Audit Progress Report April 21.pdf (21 pages)

7.2. Audit Wales Update

Wales Audit

7.2 - AC Update (April 2021).pdf (12 pages)

7.3. Report of the Auditor General on Test, Trace, and Protect in Wales

Wales Audit

7.3 - TTP Report (March 2021).pdf (36 pages)

7.4. Assessment of progress against previous ICT recommendations

Wales Audit

7.4a Audit Wales Response AuditMar21.pdf (5 pages)
7.4b - Progress Review ICT Follow Up (final).pdf (20 pages)

7.5. 2021-22 Fee Letter

Wales Audit

7.5 - CVUHB outturn and fee letter 050321.pdf (3 pages)

7.6. Review the system of assurance

Nicola Foreman

7.6 Assurance FrameworkV2.pdf (4 pages)

7.7. Draft Accountability Report 2020-2021

Nicola Foreman

7.7a Draft Report - Accountability Report 2020-21 Audit Committee 6 April 2021 1.NF.pdf (4 pages)
7.7b Appendix 1 - Draft Accountability Report 2020-2021 CVUHB v7 30 March 2021.NF.pdf (74 pages)

8. Items for Approval / Ratification

8.1. Declarations of Interest and Gifts and Hospitality Tracking Report

Nicola Foreman

8.1a Declarations of Interest and Gifts and Hospitality Tracking Report.pdf (3 pages)
8.1b - Declarations of Interest Register 2020 - 21.pdf (3 pages)

8.2. Regulatory Compliance Tracking Report

Nicola Foreman

8.2a Regulatory Compliance Covering Report.NF.pdf (4 pages)
8.2b Regulatory Heat Map - Apr 21 (1).pdf (6 pages)

8.3. Internal Audit Tracking Report

Nicola Foreman

8.3a Internal Audit Tracker Covering Report April 2021.pdf (3 pages)
8.3b Internal Audit Tracker - Apr 21 DRAFT v1.pdf (5 pages)
8.3c Internal Audit Tracker - 2017-18 (2).pdf (1 pages)
8.3d Internal Audit Summary Tables - Appendix 1 April 2021.pdf (4 pages)

8.4. Outstanding Audit Recommendations Update – 2017/18

Nicola Foreman

8.4 Outstanding Audity Recommendations 2017-18.NF.pdf (3 pages)

8.5. Audit Wales Tracking Report

Nicola Foreman

- 8.5a External Audit Recommendation Tracking report covering report.NF.pdf (2 pages)
- 8.5b WAO Apr 21 DRAFT v1 (Autosaved) (1).pdf (2 pages)
- 8.5c External Audit Summary Table - Appendix 1 (1).pdf (1 pages)

8.6. Review and approve annual counter fraud plan

Nigel Price

- 8.6a Committee Report Cover Sheet CF Annual Plan 2021-2022.pdf (2 pages)
- 8.6b - Counter Fraud GOV 013 Workplan 2021-2022 CV.pdf (11 pages)

8.7. Self-assessment of effectiveness - Verbal

Nicola Foreman

8.8. Induction Support for Committee Members - Verbal

Nicola Foreman

8.9. Effectiveness of Clinical Audit Report – Present at 11AM

Stuart Walker

- 8.9 - Clinical Audit Plan Paper - Audit Committee - with Apendix V2 - march 2021.pdf (13 pages)

8.10. Review & Approve Internal Audit Plan 21/22

Ian Virgill

- 8.10a - CV UHB A&A Internal Audit Plan 21-22 Cover.pdf (2 pages)
- 8.10b - CV UHB A&A Internal Audit Plan 21-22.pdf (35 pages)

9. Items for Information and Noting

9.1. Internal Audit reports for information:

Ian Virgill

Assignment **Assurance Rating**

1. UHW Surge Hospital - Lakeside Wing
2. Compliance with the Nurse Staffing Levels Act (Wales) 2016
3. Claims Reimbursement
4. Charitable Funds
5. Tentacle IT System Follow-up
6. Integrated Health Pathways
7. UHB Core Financial Systems
8. Risk Management

- 9.1.1 - Lakeside Wing Final Report - CVUHB 2021.pdf (27 pages)
- 9.1.2 - Nurse Staffing Levels Final Report.pdf (18 pages)
- 9.1.3 - Claims Reimbursement Final Internal Audit Report_.pdf (13 pages)
- 9.1.4 - Charitable Funds Final Report_.pdf (13 pages)
- 9.1.5 - tentacle Follow-Up final report.pdf (18 pages)
- 9.1.6 - Integrated Health Pathways Final Report.pdf (19 pages)
- 9.1.7 - Core Financials final report.pdf (18 pages)
- 9.1.8 - Risk Managment Final Audit Report.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:

John Union

Thursday 13th May 2021 at 9am - Audit Workshop

Unconfirmed Minutes of the Public Audit and Assurance Committee
Held on Tuesday 9th February 2021 09:00am – 12:30am
Via MS Teams

Chair		
John Union	JU	Independent Member – Finance
Present:		
Eileen Brandreth	EB	Independent Member – ICT
In Attendance:		
Anthony Veale	AV	Audit Wales
Charles Janczewski	CJ	UHB Chair
Chris Lewis	CL	Interim Director of Finance
Darren Griffith	DG	Audit Wales
Ian Virgil	IV	Head of Internal Audit
Mark Jones	MJ	Audit Wales
Michael Imperato	MI	UHB Vice Chair & Independent Member - Legal
Nicola Foreman	NF	Director of Corporate Governance
Nigel Price	NP	Local Counter Fraud Specialist
Steve Curry	SC	Chief Operating Officer
Wendy Wright	WW	Deputy Head of Internal Audit
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		
Rachel Gidman	RG	Interim Executive Director of Workforce & OD

AAC 21/02/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting.	**ACTION**
AAC 21/02/002	**Apologies for Absence** Apologies for absence were noted. Nigel Price Local Counter Fraud Specialist (LCS) mentioned he would be attending in place of Craig Greenstock, Counter Fraud Manager, for the foreseeable future as he was away from work on sick leave.	
AAC 21/02/003	**Declarations of Interest** There were no declarations of interest.	
AAC 21/02/004	**Items for Information and Noting - Internal Audit reports for information** **1. Mental Health Outpatient Clinic Cancellations** The CC informed the committee that a slight adjustment would be made to the agenda order so the committee could discuss the Mental Health Outpatient Clinic Cancellations with the Chief Operating Officer (COO) present at the meeting.	

	The Head of Internal Audit (HIA) stated that the report was their final report from an audit looking at the management of outpatient clinic cancellations within the Mental Health clinical board. The audit looked at, amongst other things, whether there was a consistent documented procedure in place for managing cancellations, whether there were appropriate justifications for cancelled outpatient appointments, the processes for booking and replacing of appointments and the wider reporting and monitoring of those cancellations within the clinical board. The HIA confirmed that the report provided limited assurance of the operational controls in place. The key reasons for this were: • The lack of monthly reporting of cancellations within the clinical board • The absence of a system for monitoring incidents where outpatients clinics were being cancelled • In regards to PARIS, a lack of detailed recordings within the system highlighting the justifications for cancellations was noted • Processes in place across the clinical board were inconsistent. In the two directorates they had focused on there were different systems in operation that resulted in a lack of any consistent or written procedures being in place. The HIA stated that the bulk of report reflected on findings and areas of good practices and the action plan at appendix A provided the full detail of each of the issues that had been highlighted with management responses to address those issues. The CC noted the two high & three medium management responses that were included and highlight that the bulk of the responses were scheduled to be completed by 21st April 2021. The COO thanked the CC for the opportunity to contribute his views in the meeting and the HIA for his report. He said that the report sets out management response to five areas of concern two high & three medium rated. In regards to the two high rated areas and the written guidance, the COO met with the clinical board twice and the information & reporting teams to discuss this as there were a few nuances in the background which the COO would discuss further. He stated essentially there was no real reason why the Health Boards overall rules for cancellations could not apply in Mental Health with some nuances. It was agreed that the Mental Health Clinical Board would be adopting Health Board guidance immediately but due to the nature of some of the appointments and the models of care in Mental Health, (a mix of community, primary and secondary care services) there maybe changes in how cancellations are systematically recorded those going forward. Nevertheless the general principles would apply. The COO then spoke about recommendation number five in regards to performance reporting and how this was expected to be in place by April. There was some work to be done around PARIS and he highlighted that some of the information in Mental Health was coming through Biz and some through PARIS which reflected the transformation work in that area	

to move to a more community based model through the 8 CMHT's., He added that they had committed to ensuring performance would be reported through that model.

The COO then discussed the three medium recommendations:

1) Finding 2 – Lack of Evidence to support Cancellations – this was being worked on. In regards to the PARIS system the individual managing the system had been on sick leave but a replacement had been sourced to continue that work and it was expected that the management response plans would be achieved..
2) Finding 3 – Authorisation of clinic cancellations - the Clinical Director and Deputy Clinical Board Director had made contact with all clinical teams to ensure that cancellation of clinics are signed off by the respective Clinical Director. The COO mentioned that he noted from the report rebooking of patients was happening in a timely manner but commented that it was important to record those events systematically.
3) Finding 4 - PARIS is used inconsistently between Mental Health
4) Directorates - In regards to Mental Health services for older people it was noted that staff were not consistently using the systems available to them. The COO confirmed that on a locality basis, the southern localities had moved from manual to system recording from the 21st January, Northern localities would move across in February.

The COO spoke about how things would operate moving forward. Work was underway with partners across the Health Board, including Lightfoot whom they have partnered with to join up information streams to understand whole system pathways for service users. Lightfoot's ability to use the existing information systems, pull out information and present it in a pathway specific form has afforded the opportunity to deal with the Biz vs PARIS information. The COO added that the mental health clinical board were working with Lightfoot on opportunities like this going forward so that the issues identified in the report were apparent sooner rather than later. The COO mentioned that his last conversation with the clinical board was on the 08/02/2021 and he felt assured that they had accepted the report and recognised the urgency of the required actions.

Independent Member – ICT (IM-ICT) was pleased to see the prompt action taken to the report but was concerned about the impact on patients of cancellations. She noted the reasons for patient cancellations were recorded but that the reasons for clinical cancellations were not. She queried whether clinical reasons for cancellations could also be included.. She also noted that the audit excluded CAMHS outpatients and suggested that the application of process improvements should be applied to CAHMS patients as well.

The COO confirmed that the drop down box method of recording cancellations did not allow for a lot of detail but he agreed this could be dealt with more appropriately and was hoping to receive some feedback

	on this.. In response to the second query the COO answered that the remit agreed was around Adult and older persons services to which the HIA reinforced. The meeting was then resumed in its original order.	
AAC 21/02/005	**Minutes of the Committee meeting held on 17th November 2020** The CC reviewed the minutes from the 17th November 2020 **Resolved that:** (a) The Committee approved the minutes of the meeting held on 17th November 2020 as a true and accurate record.	
AAC 21/02/006	**Action Log following the Meeting held on 17th November 2020** The Committee reviewed the action log and the following updates were provided: • Completed actions were noted • **AAC 20/09/008** – update to be brought to the April meeting • **AAC 20/04/005 and AAC 20/11/023** – The HIA confirmed that he had met with the Executive Medical Director and that there was an expectation that the Follow up report would be brought to the committee by April / May • **AAC 19/12/012** – The item was deferred from this meeting and would be brought to a future meeting • **AAC 20/11/021** – The Director of Corporate Governance (DCG) stated that the item had come to the previous committee meeting and went to the January Board for approval. The Action was now complete. • **AAC 20/11/010 + AAC 20/11/013** – IM-ICT confirmed that these reports would go to DHIC for noting and information. • **AAC 20/11/011** – DCG stated that this will be taken to the March S+D meeting **Resolved that:** (a) The Committee reviewed and noted the action log and the updates provided.	
AAC 21/02/007	**Any Other Urgent Business** There were no items raised.	
AAC 21/02/008	**Internal Audit Progress and Tracking Reports** The HIA stated that this was the usual report that came to the committee detailing progress made against the internal audit plan for the year. He highlighted section 2 that detailed the audits planned to be delivered in February of which 9 weren't finalised in time due to difficulties in progressing work in the prevailing climate. Section **2.1** of the report provided reasons for each delay.	

Section 3 of the report detailed the 3 reports that have been finalised since the last committee meeting. The mental Health report was discussed earlier in meeting and the other 2 reports summaries were provided at section 6.Full copies of the reports were available as part of the meeting agenda at item 9.1.

The HIA confirmed that the:

- Specialist CB report – Patient Assessment and Provision of Equipment by ALAS – this received a substantial assurance rating and there was nothing that he wanted to bring to the attention to the committee regarding this.
- The Asbestos Management report received a reasonable assurance rating with positive outcomes and a few medium priority recommendations around compliance with contractors signing in and out of UHW premises.

Section 4 of the report addressed delivery of the Audit Plan. He stated that over the last few meetings updates were given of the adjustments that had been made to the plan due to the ongoing pandemic. He had therefore provided an update on the 2021 plan and his proposed timings for the production of an annual report and opinion.

Section 5 of the report provided an update on work undertaken to validate completion of recommendations within the Health Boards Internal Audit recommendations tracker. The purposed of the exercise was to provide assurance to the committee that the management responses detailed within the tracker were accurate and that actions listed as completed and been undertaken.. Since the previous meeting he had taken a sample of responses from the 2018/19 recommendations and the outcomes confirmed that the information recorded in the tracker was accurate and backed up by evidence. The HIA stated that this provided the committee with assurance that the information within the tracker was accurate.

The CC commented that this provides good assurance to the committee and thanked the HIA for his work.

The DCG commented that the work undertaken by the HIA gave good reassurance to the committee and to members of her team that the information being provided was accurate.

Section 6 of the report confirmed that he had begun planning for the 2021/22 internal audit plan, a draft of which would be shared at a management executive meeting in March for approval and subsequently come to the Audit committee in April for formal sign off.

The HIA commented that the Appendix area provided detail of all audits within the plan and their present status. He stated that and appendices B and C provide information on current responses to the audit reports they had finalised. Of the 10 finalised to date, 8 had been responded to by management within the agreed timescales.

Resolved that:

	a) The Committee considered the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports. b) The Committee approved the proposed amendments to the Internal Audit Plan for 2020/21	
AAC 21/02/009	**Internal Audit Plan to Complete 2020/2021** The HIA stated that the report was for information rather than approval and to provide more detail on the adjustments made to the plan for the year and the potential impact on the HIA's opinion for the year. He highlighted that due to the fact he anticipated delivering fewer audits than in 2019/20 it had been agreed with the Board Secretaries Group to remove the formal use of the domain approach to arrive at the Head of Internal Audit Annual Opinion for Health Boards in 2020/21. The HIA then highlighted the key areas that Internal Audit would look to gain assurance over as part of the work throughout the year. • Governance And Risk Management – in the audit plan they have a detailed piece of work looking at this process. The HIA is happy they have sufficient coverage over the governance and risk management side of things in this area to form an opinion for the year. The HIA added that the piece of work done around Covid governance arrangements within the Health Board had provided additional assurance on the governance processes and changes that were made during the pandemic and he felt that this gave invaluable resource to feed into the HIA opinion for the year. • Controlled Activity within Health Board – The HIA stated that the key assurance they get in this area comes from the actual internal audit work and advisory work that they had undertaken in the various departments and clinical boards. He added that it is in this area that they had seen impact on the level of number audits they were planning to undertake. The HIA informed the committee that at the time of producing the report in December there were 17 complete on going audits and a further 14 reviews that they were still planning to start and complete before the end of the year. The HIA advised that he had discussed those further 14 reports with each of the lead executives to confirm that they were happy for the work to go forward and engage in and he provided assurance that the work should be able to start and completed for inclusion in the opinion for the year. • The HIA added that there were 4 further reviews identified that could not be completed (the reasons for this were detailed within the report).He added that in the majority of cases where reports could not proceed this was because the reviews would be in areas of Health Board that were significantly impacted by the pandemic and staff were not available engage in the proposed Audits.	

	The HIA informed the committee that his team planned to deliver 31 audits as part of the year's plan, which compared to 39 from previous year. He stated that although there was a reduction it still demonstrated that they were getting good coverage across the Health Board. The HIA concluded that given all the considerations into account and where they were within the plan, he still intended to deliver a full HIA Opinion for the year which was very positive for the Health Board and would be the ideal outcome. The CC commented that the paper was welcomed by the committee and that he felt it was very timely as it set out clearly where the Health Board was and provided assurance that Internal Audit would complete the work outlined and provide an end of year opinion. The Interim Director of Finance (IDF) queried entries on page 8 of the report in relation to Financial Governance & Management and 2 reports expected from shared services. He asked if they would form part of the HIA's opinion of controls in place for the Health Board. The HIA confirmed that they undertake audit work on services provided by NWSSP around payroll and accounts payable. He said every year they do work on these areas and they do feed into the HIA Opinion to give assurance on those processes that are being undertaken for the Health Board. He added in normal years' work done on those systems is an overall piece of work covering the services provided for all the trusts and Health Boards in Wales, for this year they have increased testing in those pieces of work and undertaken more specific tests on transactions for individual Health Boards to be able to give a more detailed assurance and report for the individual Health Board. The IDF asked if the HIA would bring back the report to the Audit committee from those areas. The HIA stated that he would need to confirm whether this would be a specific report or an additional item within the annual report with NWSSP colleagues but advised that there will be a level of assurance for the Health Board in that area. He also confirmed that Internal Audit had sufficient resource to carry out the work in the remaining months. **Resolved that:** a) The Committee noted the Internal Audit Plan to Complete 2020/2021	
AAC 21/02/010 Saunders.Nathan 03/31/2021 15:03:39	**Audit Wales Update** Anthony Veale – Audit Wales (AV-AW) firstly discussed the letter sent by the AGW to the Health Board and to other Chief Executives in Wales. He said that it sets the context on how Audit Wales will conduct its work against the backdrop of the pandemic, he feels within the letter are a few important messages that the committee should hear: • Against the backdrop of the pressures that the Health Board is under currently they will adjust focus and timing of their work as	

	Audit Wales recognises that it is a difficult time but will continue to be agile, work in partnership and maintain the audit focus. AV-AW continued to discuss the Audit Wales update and stated that it can be taken as read by the committee and asked Darren Griffiths – Audit Wales (DG-AW) to highlight key areas from the report. DG-AW highlighted the approach undertaken for structured assessment work for that year. He stated that they are planning to take the work in 2 phases: • Phase 1 – Health Board Operational Planning Arrangements • Phase 2 – Corporate Governance And Financial Management Arrangements DG-AW stated that Phase 1 is well underway and that they had to adjust and adapt their approach due to Covid and remote working. He added that they are hoping to provide initial feedback to Health Board the following month verbally and would look to commence Phase 2 soon afterwards being mindful of the circumstances under which the Health Board are operating under. He then provided an update on the GPX programme. They were hosting a Covid learning week from 8th March to 13th March. This would be to showcase positive practice in public sector demonstrating how public bodies reacted to the pandemic and there would be sessions that were relevant to NHS bodies which would be available on their website. The IDF queried the work on the structured assessment looking at the timing and asked if it is mainly an exercise in looking back as opposed looking forward. DG-AW confirmed that the IDF was correct and that they are looking at Q3/Q4 operational plans and looking at the arrangements the Health Board has in place for producing that plan. He said that this would be a retrospective look on how this plan was pulled together to provide feedback before formalising a 2021/22 plan. **Resolved that:** (a) The Committee noted the Audit Wales update.	
AAC 21/02/011 Saunders.Nathan 03/31/2021 15:03:39	**Doing it Differently, Doing it Right? Governance in the NHS During the COVID-19 Crisis** The CC asked AV-AW if any further comments were required for the report. AV-AW was happy for the committee to take the report as read.	

	The CC confirmed with committee members that they had, had the opportunity to read the report and no further queries were raised **Resolved that:** a) The Committee noted the Audit Wales update	
AAC 21/02/012	**Follow-up of Operating Theatres** The CC asked AV-AW if any further comments were required for the report. AV-AW was happy for the committee to take the report as read. The CC confirmed with committee members that they had, had the opportunity to read the report and no further queries were raised **Resolved that:** a) The Committee noted the Audit Wales update	
AAC 21/02/013	**Declarations of Interest and Gifts and Hospitality Tracking Report** The DCG advised that the report was shared for members to review. Since the previous meeting a further 705 declarations had been received in addition another 400 had been received since the report had been written. Of those declarations received and recorded: • 144 declared an interest – identified 3 potential conflicts – 2 relate to other employment and other one was procurement issues • returns • 11 gifts declared up to November 2020 The CC asked of that 1100 what is the total number we could get back or is it only 8a or above? The DCG answered that they chase all staff annually but chase Band 8a and above more robustly to ensure that declarations from decision makers are recorded. She added that if people withhold information we won't know, as long as they chase and receive information there is less chance of breach as people would have been made aware of the policy. **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 21/02/014	**Regulatory Compliance Tracking Report** The DCG confirmed that there had not been a lot of activity in this area due to the external agencies that undertake inspections being unable to attend in the usual way. She made the committee aware that since November 2020 only 3 further inspections had taken place. The DCG highlighted the list of upcoming inspections in the following quarter and advised that it was still uncertain whether these inspections would be undertaken in the prevailing climate. **Resolved that:** a) The Committee Noted the inspections which had taken place since the last meeting of the Audit Committee in November 2020 and their respective outcomes. b) The Committee noted the continuing development of the Legislative and Regulatory Compliance Tracker.	
AAC 21/02/015	**Internal Audit Tracking Report** The DCG stated that this report concerned internal audit recommendations that had been made between 2017/18 and 2018/19 with additional entries for 2021/22 added to the report added for the first time. She highlighted that they have been reduced from 111 to 110 but 19 recommendations were added meaning that 20 had completed since the previous meeting. She mentioned that these were followed up with the executive colleagues between each committee meeting to ensure that recommendations and actions against them are continually monitored. The DCG added that those recommendations which were listed as completed would be taken off for the next meeting but were displayed for reporting purposes similar to an action log. The CC queried whether it was difficult chasing the 2017/18 recommendations because of their age. The DCG responded that she had asked her team to meet the individuals rather than the executive leads for those recommendations so that action could be taken for them to be completed or for confirmation to be given that they had been superseded by another. It was identified that there were a number of actions that could potentially be removed once team members had the opportunity to liaise with operational leads. The HIA mentioned that he would look to meet with the DCG and her teams to agree a process of reducing outstanding areas. IM-ICT queried if any of the outstanding audits were high priority and whether management in the areas couldn't complete these due to lack of resource, or they had made a decision that the action was no longer necessary. She also asked whether a mechanism was available to close the action with those conclusions.	

	The DCG stated that would be her plan and was why she wanted her team to go out and meet the individuals responsible for the recommendations so they have a clear understanding as to why recommendations hadn't been completed. This would allow colleagues to report back with clear commentary on the status of recommendations. The DCG added that for the next meeting she would bring back a clearer and updated position on these recommendations with specific narrative around them to demonstrate that the DCG and her team had spoken with the individuals concerned as well as seeing the reasons why. From this the Committee could sign off or keep them on the tracker depending on the responses received. IM-ICT suggested that the persons responsible are accepting the risk in delaying these actions and that the clinical boards responsible are condoning a different appetite for risk. She felt that there needs to be a firm statement and acknowledged by Audit on any subsequent review. **Resolved that:** a) The Committee Noted the tracking report which was 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 which were completed/closed	**NF**
AAC 21/02/016	**Audit Wales Tracking Report** The DCG advised that the report tracked progress against recommendations made by Audit Wales in the same manner that internal audit recommendations were tracked and discussed in the previous item. Since the previous meeting 3 recommendations had been added • 2 in relation to the effectiveness in Counter Fraud Arrangements • 1 in relation to the Structured Assessment 2020 She highlighted that the tracker demonstrated that 3 recommendations had been completed since November and a further 12 recommendations had been partially completed. 8 had no actions recorded against them however the DCG informed the committee that this didn't mean that nothing had been happening, rather it was the case that her team had received no response to requests for updates. She stated some of this work has been impacted by Covid-19. **Resolved that:** a) The Committee noted the progress which had been made in relation to the completion of WAO recommendations. b) Committee noted the continuing development of the WAO Recommendation Tracker.	
AAC 21/02/017	**Final Accounts Timetable and Plans** The IDF stated that the purpose of the report was to provide members an opportunity to comment on the draft timetable for the production of the	

Health Board's annual report. The IDF reminded the committee that the annual report and accounts came in 3 parts

- Performance report
- Accountability Report
- Financial Statements

The IDF highlighted that the previous year the Health Boards accounts received a 'qualified with limitation of scope' opinion as Audit Wales were unable to sufficiently evidence the inventory balances due to remote work and Covid. He stated that the same was likely to apply for the accounts going forward for 2021 and he informed the committee that they are highly likely to end up with a qualified set of accounts due to limitation of scope.

The CC queried if this would be for all UHB's in Wales or all public bodies.

The IDF responded that there were very few who have a materiality threshold which warrants this and due to the nature of C&V UHB and the type of services the Health Board provides the stock is about 1% of the UHB turnover.

AV-AW commented that this is the cut-off point that if stock balances are greater than materiality which is set relatively consistently across public sector bodies. Once it goes above that threshold auditing standards mandate Audit Wales to attend an audit committee because of the circumstances they can't therefore have a qualification.

The IDF referred to appendix 1 and the draft timetable which set the following key dates:

- 30th April – Draft Accounts
- 7th May - Draft of whole suite of reports need to be submitted for consideration
- 10th June - Special Audit meeting which includes a special Board Meeting on 11th June to submit to Welsh Government for consideration.

The IDF mentioned that the Audit Committee Workshop which goes through the detail of major judgment and estimates which takes a review of accounts and all major supporting documentation needs to be arranged after they submit draft accounts in May (after the 7th).
The IDF added that for 2021 they will be reverting back to a normal timescale as the previous year it was elongated by an extra month. He also commented that the audits and preparation of accounts worked well remotely so lessons would have been learned from that experience. He mentioned that it would still be a pressurised time period for both Audit wales, the DCG teams and his own team to complete the Annual Statement.

Resolved that:

	a) The Committee reviewed and noted the proposed timetable and approach for the Annual Report 2020-21.	
AAC 21/02/018	**Review Committee Terms of Reference** The DCG confirmed that it was an annual requirement that the Committee review it's terms of reference. She added that the TOR's and work plan for all committees would be submitted to the Board at the end of March. She highlighted that very few changes had been made from the previous year's terms of reference. **Resolved that:** a) The Committee approve the changes to the Terms of Reference for the Audit and Assurance Committee and b) The Committee recommended the changes to the Board for approval.	
AAC 21/02/019	**Audit Committee Annual Report** The DCG stated that the report provides a summary of the work undertaken by the committee over the course of the financial year and provides assurance to the committee that it is doing what it should be in line with its TOR. **Resolved that:** a) The Committee reviewed the draft Annual Report 2020/21 of the Audit and Assurance Committee b) The Committee recommended the Annual Report to the Board for approval.	
AAC 21/02/020	**Annual Work Plan** The DCG stated that the work plan is prepared and approved to ensure that the committee gets through the work it is supposed to, in alignment with the Terms Of Reference, during the next financial year. **Resolved that:** a) The Committee reviewed the Work Plan 2021/22 b) The Committee approved the Work Plan 2021/22 c) The Committee recommended approval to the Board	
AAC 21/02/021	**Audit Wales 2021 Audit Plan 139 – 144** AV-AW – reminded members that the plan sets out who they are, what they will do, and how much it will cost. He stated that their work is defined in two strands 1. Audit of the accounts 2. Performance Audit works Mark Jones – Audit Wales (MJ-AW) spoke in regards to the NHS Finance Wales Act 2014 which is about the rolling 3 year revenue	

	resource limit and capital resource limit which is very relevant to the regularity opinion of the annual accounts. He mentioned that HEIW have qualified their accounts for the last 4 years in this area because on a 3 year rolling basis there has always been a deficit, which was likely to continue in the 2021 accounts because in 2018/19 the Health Board had a £9.8 Million deficit which was still within that 3 year period. He provided the example of the Health Board needing to make a surplus of £9.8 Million to not have this 3 year deficit. AV-AW highlighted that one thing that was not included in the plan was the Audit fee which was due to the fact that their fee scheme had not been approved but was expected at the end of the month. He stated that he would confirm to the committee and Health Board what the estimate fee would be once available.	
AAC 21/02/022	**Items for Information and Noting - Internal Audit reports for information** The Committee received the following 3 reports: 1. Pre-Employment Checks – Reasonable assurance 2. Surgery CB – Theatres Directorate Sickness Absence Management – Reasonable assurance 3. Regional Partnership Board – Reasonable assurance **Resolved that:** (a) The Committee noted the Internal Audit reports.	
AAC 21/02/023	**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 21/02/024	**Review of the Meeting** The CC thanked everyone for their attendance and contribution to the meeting.	
AAC 21/02/025	**Date and Time of Next Meeting** To note the date, time and venue of the next Committee meeting: **Tuesday 6th April 2021 at 9.00am**	

Action Log
Following Audit & Assurance Committee Meeting
9th February 2021

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
AAC 20/11/021	Business of other Committees and Review of Inter-relationships	To share with the other Committees for information.	Nicola Foreman	17/11/2020	**Complete**
AAC 20/11/010	Management of Clinical Coding Across Wales	IM-ICT to take to future DHIC meeting.	Eileen Brandreth / Audit Wales	11.02.21	**Complete**
AAC 20/11/013	Welsh Community Care Information System	IM-ICT to take report to future DHIC meeting.	Eileen Brandreth / Audit Wales	11.02.21	**Complete**
Actions in Progress					
AAC 20/09/008	Audit Wales (AW) Update	AW reports on TTP to be brought to the next Committee meeting.	AW	**06.04.21**	Update on TTP to be provided at **April 2021** meeting. **- Item 7.3**
AAC 20/04/005 AAC 20/11/023	Consultant Job Planning Follow-up: Limited Assurance Report	Follow up Internal Audit Report to be carried out at an appropriate time to be agreed with EMD & to be included in the 2021 Internal Audit plan.	Stuart Walker / Ian Virgil	TBC	HIA confirms his meeting with the MD and the progression of this with an expectation of this to be brought to the committee by **April / May. - Item 9.2**
AAC 20/11/023	Job Planning Update	To provide a further update in 6 months' time.	Stuart Walker	**06.04.21**	Update to be brought to the **April 2021** Meeting - **Item 9.2**
AAC 19/12/012	Effectiveness of Clinical Audit Report	To consider arrangements to deliver effective programme of Clinical Audit	Stuart Walker	**06.04.21**	To be brought to **April 2021 meeting**. (deferred) **- Item 8.10**
AAC 21/02/015	Internal Audit Tracking Report	In regards to the outstanding audit actions The DCG added that for the next meeting she would bring back a more clear and updated position on these recommendations with specific narrative around them	Nicola Foreman	**06.04.21**	Update to be brought to the **April 2021** Meeting - **Item 8.4**

Actions referred to Board / Committees					
AAC 20/11/010	Management of Clinical Coding Across Wales	To include in a future Board Development session.	Nicola Foreman	TBC	To be taken to a future Board Development session
AAC 20/11/011	10 Opportunities for Planned Care	To take report to a future Strategy and Delivery Committee to ensure that the 10 opportunities are considered as part of the Health Board's planning arrangements.	Nicola Foreman	12.01.21	To be taken to a future S&D Meeting

Report Title:	**Internal Audit Progress Report**								
Meeting:	Audit & Assurance Committee						**Meeting Date:**	06/04/21	
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 a further proposed amendment 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 and a second round was approved in November.

The audits remaining within the plan still allow sufficient coverage for the provision of a full Head of Internal Audit annual opinion at the end of the year. This will however be dependent on the Health Board being in a position to engage with the remaining audits.

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 amendment 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 April 2021

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

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.

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

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 April Audit Committee but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
IM&T Control & Risk Assessment	Work in Progress		Significant delays in completion of fieldwork due to availability of HB staff and supply of information.
CD&T CB – Ultrasound Governance	Work in Progress		Delay in commencing fieldwork; initially due to availability of Internal Audit resource and then availability of HB Management during Covid
Health & Care Standards	Work in Progress		Delay in commencing fieldwork due to change in Health Board's timetable for completion of Standards.
Engagement Around Service Planning	Work in Progress		Delay in commencing fieldwork due to availability of HB Management during Covid
Recruitment & Retention of Staff	Work in Progress		Delay in commencing fieldwork due to availability of HB Management during Covid
Consultant Job Planning Follow-up	Work in Progress		Start of fieldwork delayed, as agreed with Medical Director.

2.2. Whilst the table above provides a brief reason for the delay to each individual assignment, it should also be noted that there has been a general delay throughout the year in progressing with delivery of the plan. This was 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. Eight 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. 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 (2020/21 Plan)	ASSURANCE RATING	
Compliance with the Nurse Staffing Levels Act (Wales) 2016	Substantial	
Claims Reimbursement		
Charitable Funds		
Tentacle IT System Follow-up		
Integrated Health Pathways	Reasonable	
UHW Surge Hospital - Lakeside Wing		
Risk Management		
UHB Core Financial Systems		

4. DELIVERY OF THE 2020/21 INTERNAL AUDIT PLAN

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

In addition, there are ten other audits that are 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 with a second round then approved at the November meeting.

Due to the ongoing impact of the pandemic a number of additional audits were identified for removal from the plan and these were approved by the Committee in February.

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

The additional adjustment for agreement by the April Audit Committee is summarised below:

Audit to be removed from the 20/21 plan:

- Post Contract Audit of DHH Costs

  The audit will need to be deferred to the 21/22 plan as the DHH contracts will not be completed until after May 21. This was discussed and agreed with the Interim Director of Finance.

The adjustment identified above, combined with those previously agreed, mean that there will be a total of 30 audits scheduled for delivery within the 20/21 plan. This will still allow sufficient coverage for the provision of a full Head of Internal Audit annual opinion at the end of the year. This will however be dependent on the Health Board being able to engage with the remaining audits.

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. The outcome of the validation process undertaken to date means that the Audit Committee has been provided with assurance that the progress information detailed within the tracker for the

2017/18 and 2018/19 recommendations represent an accurate position.

5.3. The Internal Audit team, in conjunction with the Corporate Governance team, are working to refine this process in order to provide on-going assurance around the recommendation tracker. The outcome of the refined process will be reported as a standing item within the Progress Reports submitted to each Audit Committee meeting in the new year.

6. FINAL REPORT SUMMARIES

6.1. Compliance with the Nurse Staffing Levels Act (Wales) 2016

RATING	INDICATOR	DEFINITION
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.

The Health Board's processes for calculating and monitoring nurse staffing levels and ensuring compliance with the requirements of the Act have been significantly impacted by the Covid-19 pandemic.

The CNO issued a letter to all Health Boards/Trusts in March 20 confirming what was required in relation to the Nurse Staffing (Wales) Act during the pandemic. The letter allowed Health Boards/Trusts the flexibility to decide when to undertake the annual calculation of nurse staffing levels on adult acute medical and surgical wards and whether to present their annual report to the Board as planned in May 2020. The Health Board therefore produced the annual report for the September 2020 Board.

It was identified that the Health Board has developed a process during Covid-19 whereby they monitor the Nurse staffing levels through a Summary of Required Establishments on Wards during Covid-19 Pandemic report. This confirms the adjusted establishments during covid-19 and the previous establishments. The report is updated as required and comments are included to ensure that all the information is correct. However, it was evidenced that the establishment levels recorded within Rosterpro and the finance reports do not align with the report.

Nurse staffing levels reports have been taken to the Board meetings in May, July and September and the adjusted establishment levels have been

formally approved. The Nurse Staffing Levels for Adult Acute Medical and Surgical Wards following the Bi-annual Calculation report was taken to the November Board.

The Health Board have a number of processes in place for nurse recruitment including social media such as Linked In, Facebook and Twitter, International recruitment, local adaption programme and Students. The International recruitment process successfully recruited 67 nurses for a number of areas and they are now hoping to recruit a further 75 staff.

The Health Board has established a Nurse Retention Task and Finish Group in place to ensure that both new and existing staff are supported and encouraged to remain within the Health Board. A draft programme has been produced for this but has not been updated due to covid-19 plus meetings have been unable to happen.

The current assurance rating reflects the fact that the Health Board has put in place robust processes to monitor and report nurse staffing levels during the pandemic and has appropriately followed the guidance received from the CNO in relation to adjustments to the requirements of the Nurse Staffing Levels Act.

6.2. Claims Reimbursement

RATING	INDICATOR	DEFINITION
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.

We tested 25 claims that had been paid in 2020/21 up to the date of our fieldwork. The claims covered clinical negligence, personal injury and redress. Our testing confirmed that the required Learning From Events Report (LFER), Case Management Report (CMR), Case Finance Record (Checklist U1/2) and the Losses and Special Payments Register (LASPAR) were in place, and documentation was in place to support the costs incurred.

In 2019 the WRP updated their standards and included the requirement that for cases submitted after 1 October 2019, LFERs had to be submitted within 60-days of the decision to settle the case. As the claims in our sample had been submitted prior to October 2019, the 60-day timeframe requirement was not applicable.

Our testing confirmed that all claims had been appropriately authorised and there is appropriate evidence to support the costs incurred.

However, we identified a small number of issues that require management attention, such as the current process in which forms are completed initially by Claims and finalised by Finance.

6.3. Charitable Funds

RATING	INDICATOR	DEFINITION
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.

Overall, the controls in place for the management of dormant funds and Covid related expenditure were of a high standard.

The majority of fundholders of funds classified as dormant have now provided appropriate plans to utilise their funds. Where responses have not been received, the Trustees have agreed that funds should be transferred to a general reserve, although this action had not been completed at the time of audit. The Charitable Funds Financial Control Procedure has been updated and includes a specific section for the ongoing management of dormant funds.

There was a robust process agreed and put in place for the management of expenditure applications against Covid monies received.

Some minor weaknesses concerning record keeping and incomplete documentation were identified as part of the testing undertaken on the Covid Expenditure element of the audit.

6.4. Tentacle IT System Follow-up

RATING	INDICATOR	DEFINITION
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.

From discussions with key staff we note that actions were undertaken to mitigate issues identified in the report. Subsequently the use of Tentacle has ceased with the functionality now being delivered from a module within PMS which was developed specifically to replace Tentacle.

Data from after January 1st 2020 has been transferred into the PMS module, with older data being retained within Tentacle to enable historical reporting. Discussions are ongoing over the optimal course of action for enabling reporting, with an upload of all data to PMS along with a partition and archiving as a separate data store within the warehouse being the two options.

We do note however that although the use of the system has ceased, the database is still being held in an open Information folder and as such remains accessible to numerous staff.

The progress made against the original recommendations and subsequent replacement of Tentacle means that the level of assurance that can be given to manage the risks associated with the Tentacle system can now be considered **Substantial Assurance**.

6.5. Integrated Health Pathways

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.

The Health Board has introduced an online Integrated Health Pathways system known as Community HealthPathways that went live in February 2019. The HealthPathways database is a New Zealand based website provided and hosted by Streamliners NZ Limited.

The introduction and implementation of the HealthPathways database was not subject to a formal project structure or methodology, but its acquisition was undertaken via a formal Service Level Agreement (SLA) with the software provider in respect of user and software management support.

Additionally, the UHB officer responsible for the day-to-day management of the database has no administrative support or cover in the event of extended absence.

It is noted that work plans are in place to enable the ongoing creation and review of clinical pathways on the basis of liaison and feedback provided by GP and Consultant users. Full training was provided to users prior to and post implementation and user support is readily accessible to facilitate any 'troubleshooting' required. However, no online user guides are available in the event that UHB staff cannot be contacted.

Whilst HealthPathways can provide reports that identify clinical pathways frequency of use, there is no means by which the system can identify who accessed the pathways.

Questionnaires sent to GP users identified overall satisfaction with the database and its functionality, but the limited response could not provide a definitive and complete feedback measure.

It is also noted that no performance metrics or reporting of the effectiveness of the HealthPathways database are produced or reported within the organisation.

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.

6.6. UHW Surge Hospital - Lakeside Wing

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.

In response to the current pandemic situation, the Lakeside Wing was required to be delivered in a significantly shorter timeframe than typical projects of this size/complexity would normally be afforded.

Despite this significant time pressure, robust governance arrangements have been applied at the project with no evidence of reduced controls in key areas such as the establishment of a sound project structure, assignment and operation of responsibilities, reporting or project decision making. Project meetings have taken place on a weekly (or more frequent) basis, with attendance from key parties at all times to enable the project to move forward at the required pace.

The project, managed by an in-house team, achieved handover of Phase 1 on schedule, with Phase 2 delivery on target at the date of this report.
In delivering the project within such a tight timescale, to provide the anticipated Covid-19 surge capacity, there were instances noted where the UHB operated outside of normal control parameters e.g.:

- As agreed with Welsh Government, the project was not progressed in line with the requirements of the Welsh Government Infrastructure Investment Guidance (including the development of a formal business case). Accordingly, formal identification and approval of revenue costs did not take place at the time of project scrutiny and approval; and
- Variation to the standard project governance protocols / guidance.

These items are reported as observations, rather than recommendations, noting the accepted divergence from standard UHB practices and noting that the divergence was deemed to be of limited risk to the UHB.

A small number of recommendations have been raised for management attention.

6.7. Risk 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.

The 2019/20 audit of risk management reported an assurance rating of reasonable, the same assurance is offered in 2020/21. Since the previous audit it is evident that the Health Board is progressing its maturity of risk

management, with a clear sense of direction and additional resource to deliver, resulting in an improvement on last year. Recommendations arising from this review will support the Health Board through their journey of improvement. The Board received the Board Assurance Framework in January 2021, which highlighted the impact of COVID-19 on the pace of delivering some actions.

The Risk Management (RM) and Board Assurance Framework (BAF) Strategy directs the Heath Board's approach to maturing risk management arrangements. Since Board approval of the Strategy in 2019, the Board have been kept informed of progress and approved future direction through updates of the BAF, Corporate Risk Register (CRR), and wider considerations of Board risk appetite.

The RM and BAF Strategy is underpinned by procedure UHB024, Risk Assessment and Risk Register Procedure, which was under review at the time of the audit.

The design of the strategy and procedure ensures alignment to the UHB's strategic objectives, which is illustrated in the BAF and CRR. There is minimal reference to RM standards / best practice guides in the strategy, which if referenced would provide greater assurance to the Board, whilst evidencing and progressing RM maturity *(Recommendation 1 – low priority)*.

The Health Board's risk management framework is designed to support a comprehensive view of the risk profile, aggregated where appropriate but this is an area which requires further development. Risk Registers are currently held in Microsoft Excel spreadsheets, a sample of Clinical Boards and Corporate Departments were made available upon request (in most instances). Visibility of all registers, particularly at a directorate level was limited. The means of capturing and recording risks requires consideration, to facilitate greater aggregation and transparency, also aiding efficiency and effectiveness *(Recommendation2 – medium priority)*.

Whilst the Health Board continues to use Excel spreadsheets to capture risks, consideration should be given to further developments to support users, at the avoidance of added burden *(Recommendation 5 – low priority)*.

There is a clear link between the CRR and the BAF, which has improved since the previous audit of risk management arrangements. Reporting the CRR to the Board is established and consideration should be given to enhancing the current report to facilitate Board focus and discussion, for instance, highlighting corporate risks which are the most extreme or on an upward trend within the summary register *(Recommendation 3 – low priority)*.

The BAF update to the Board in January 2021 detailed a BAF and RM action plan, with reported progress, acknowledging the impact of COVID-19. The results of audit testing aligned with reported progress in the paper, noting

that continuing and ongoing action is required to support RM and BAF maturation *(Recommendation 4 – medium priority)*.

6.8. UHB Core Financial Systems

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.

The asset register and treasury management Financial Control Procedure (FCP) are both currently out of date.

There are generally good processes in place for the management of the Health Board's Fixed Asset Register. Good practices were observed within all the areas covered as documented in section 6 of this report.

Due to COVID, the training session which is usually held in the 3rd quarter of the year with key members of staff responsible for the maintenance of the asset register in the various departments did not take place. However, the capital asset booklet which is usually provided during training is available to all staff on the intranet.

The asset verification exercise has commenced although at the time of the audit confirmation had not been received by Finance from all the areas. A review was done by randomly selecting departments that had responded and performed the verification exercise. On review of the asset register, it was identified that changes flagged by the departments from the verification exercise undertaken were yet to be updated.

Overall, the controls in place to manage the risks associated with the cash management systems and the processes tested within, are of a good standard and in line with the Welsh Government requirements.

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	Final – Issued November 20	Substantial	Feb
Asbestos Management	40	Finance	Q2	Final – Issued November 20	Reasonable	Feb
MH CB – Outpatient Clinic Cancellations	31	COO	Q2	Final – Issued January 21	Limited	Feb
Compliance with the Nurse Staffing Levels Act	17	Nursing	Q3	Final – Issued February 21	Substantial	April
Integrated Health Pathways	20	Transformation & Informatics	Q2	Final – Issued February 21	Reasonable	April

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
UHW Surge Hospital – Lakeside Wing	**44**	**Strategic Planning**	**Q2**	**Final – Issued February 21**	**Reasonable**	**April**
Risk Management	**02**	**Corporate Governance**	**Q4**	**Final – Issued March 2021**	**Reasonable**	**April**
Claims Reimbursement	**04**	**Nursing**	**Q3**	**Final – Issued March 2021**	**Substantial**	**April**
Charitable Funds	**14**	**Finance**	**Q3**	**Final – Issued March 2021**	**Substantial**	**April**
UHB Core Financial Systems	**13**	**Finance**	**Q3**	**Final – Issued March 2021**	**Reasonable**	**April**
Tentacle IT System Follow-up	**26**	**Transformation & Informatics**	**Q4**	**Final – Issued March 2021**	**Substantial**	**April**
IM&T Control & Risk Assessment	01	Transformation & Informatics	Q2	Work in Progress		May
Health and Care Standards	03	Nursing	Q3	Work in Progress		May
Engagement Around Service Planning	06	Strategic Planning	Q3	Work in Progress		May
CD&T CB – US Governance	33	COO	Q3	Work in Progress		May
Recruitment & Retention of Staff	35	Workforce	Q3	Work in progress		May
Annual Planning process 21/22	08	Strategic Planning	Q4	Planning		May
Data Quality Performance Reporting	10	Transformation & Informatics	Q4	Work in Progress		May

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Infrastructure / Network Management	23	Transformation & Informatics	Q4	Work in Progress		May
Cyber Security System Follow-up	27	Transformation & Informatics	Q4	Planning		May
C&W CB – Rostering in Community Children's Nursing	34	COO	Q4	Work in Progress		May
Consultant Job Planning Follow-up	37	COO	Q4	Work in Progress		May
Shaping Future Wellbeing in the Community Scheme	43	Strategic Planning	Q4	Planning		May
Development of Integrated Audit Plans	45	Strategic Planning	Q1-4	Work in progress		May
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		

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
				Raising Concerns process which incorporates whistle blowing - Agreed by Nov AC		
Strategic Performance Reporting	09	Transformation & Informatics	Q3	Postponed to the 21/22 plan. Formal performance reporting requirements have been paused by Welsh Government - 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 – Agreed by the November AC		
ITIL Service Management	21	Transformation & Informatics		Director of Digital requested removal from the plan due to the current pressures on key IT staff - 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 - Agreed by November AC		
PCIC CB – GP Access	32	COO		Deferred to 21/22 as agreed with CB Management. GP Access monitoring paused due to Covid - Agreed by the November AC		
Fire Safety	39	Finance		Director CEF requested deferral to the 21/22 plan due to current pressures on key staff - Agreed by November AC		
Major Capital Scheme – UHW New Academic Avenue	42	Strategic Planning		Removed from the plan as the scheme has not progressed - Agreed by November AC		

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Major Capital Scheme – UHW II	41	Strategic Planning		Removed from the plan as the scheme has not progressed - 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 - agreed by November AC.		
Clinical Board QS&E Governance	19	Nursing		Determined that Clinical Boards would be unable to engage in this audit due to the pressures of dealing with Covid – To be agreed By February AC		
Medicine CB – Bank & Agency Nurses Scrutiny Process	30	COO		The CB Director of Nursing identified that the service would not be able to engage in the audit due to the pressures of dealing with Covid – To be agreed by February AC		
Public Health	12	Public Health		Considered inappropriate to carry out an audit in this area given the current situation – To be agreed by February AC		
Management of Staff Sickness Absence	36	Workforce		The Director of Workforce identified that it would be inappropriate to carry out this audit at the current time due to service pressures – To be agreed by February AC		
Post Contract Audit of DHH Costs	47	Finance	Q4	Proposed for deferral to the 21/22 plan due to timing of completion of the contracts – To be agreed by the April AC. *Had been added to the plan following request from Director of Finance – 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	
Asbestos Management	*Reasonable*	*Final*	*03/11/20*	*25/11/20*	*10/11/20*	*11/11/20*	*G*	
Specialist CB – Patient Assessment & Provision of Equipment in ALAS	Substantial	Final	03/11/20	25/11/20	20/11/20	24/11/20	G	
MH CB – Outpatient Clinic Cancellations	Limited	Final	17/12/20	12/01/21	04/01/21	13/01/21	G	
Compliance with the Nurse Staffing Levels Act (Wales) 2016	Substantial	Final	17/12/20	12/01/21	25/02/21	26/02/21	R	
Integrated Health Pathways	Reasonable	Final	11/01/21	01/02/21	24/02/21	25/02/21	R	
UHW Surge Hospital – Lakeside Wing	*Reasonable*	*Final*	*11/01/21*	*01/02/21*	*17/02/21*	*22/02/21*	*R*	
Charitable Funds	Substantial	Final	09/03/32	31/03/21	11/03/21	11/03/21	G	
Tentacle IT System Follow-up	Substantial	Final	16/03/21	08/04/21	16/03/21	18/03/21	G	
Claims Reimbursement	Substantial	Final	16/03/21	12/04/21	18/03/21	19/03/21	G	
UHB Core Financials Systems	Reasonable	Final	10/03/21	06/04/21	17/03/21	23/03/21	G	
Risk Management	Reasonable	Final	23/03/21	15/04/21	24/03/21	24/03/21	G	

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	74% 17 from 23	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 17 from 17	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	A	71% 12 from 17	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 17 from 17	80%	v>20%	10%<v< 20%	v<10%

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Archwilio Cymru
Audit Wales

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

Date issued: March 2021

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.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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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).

Financial audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2021-22.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2020-21 Performance Report, Accountability Report and Financial Statements	Audit planning and testing is ongoing. In accordance with the Welsh Government's timetable, we are due to receive the draft Financial Statements on 30 April; and the draft Performance Report and Accountability Report on 7 May. The Audit Committee and Board are scheduled to consider the audited documents, and our audit report, on 10 June. The Welsh Government's submission deadline is 11 June.

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
Assessment of progress against previous ICT recommendations	April 2021
Test, Trace, and Protect in Wales	April 2021

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Structured Assessment 2020 - Supplementary Outputs Executive Leads – Director of Governance and Executive Director of Workforce & Organisational Development	To support our annual structured assessment work, we are undertaking further work to pull together two all-Wales outputs. The first output was published in January and focusses on how NHS bodies have governed differently during the COVID-19 crisis. The second output will focus on arrangements to support staff well-being during the pandemic and will be published in April.	All-Wales output on staff well-being being drafted July 2021*
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.	Report being drafted July 2021*

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
	Our findings will be summarised into a single national report with supplementary outputs setting out the local position for each health board.	
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.	Draft report in clearance July 2021*
Quality Governance Executive Lead – Executive Nurse Director and Executive Medical Director	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.	Fieldwork underway September 2021*
Structured Assessment 2021 (Phase 1) – Operational Planning Executive Lead – Director of Governance	Our annual structured assessment is one of the main ways in which the AGW discharges his statutory requirement to examine the arrangements NHS bodies have in place to secure efficiency, effectiveness, and economy in the use of their resources.	Phase 1 report being drafted Phase 1 – July 2021* Phase 2 – September 2021*

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
	Our work in 2021 will be undertaken in two phases, as follows: • Phase 1 will examine the operational planning arrangements of each NHS body. • Phase 2 will look at the governance and financial management arrangements of each NHS body.	
COVID-19 vaccination rollout in Wales Executive Lead – Executive Nurse Director and Executive Director of Public Health	This review will provide a high-level overview on key aspects relating to the administration, planning and approach for the rollout of vaccinations in Wales. The high-level aim being to provide assurance on the efficiency and effectiveness of the rollout approaches and to provide insight and support learning by identifying both success factors and any barriers to implementing national and local rollout plans.	Fieldwork underway September 2021*

***** *These dates are subject to change given the current challenges and pressures associated with the ongoing pandemic*

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
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. 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
Making sense of a crisis: Learning from the COVID-19 pandemic (March 2021)	Between 8th and 12th of March, we held an online week of learning, good practice, and ideas linked to our Covid-19 Learning Project (see paragraph 6). During the course of the week, we held a number of live events and shared a number of useful resources which included pre-recorded video interviews with colleagues across public services, blogs, and podcasts. The themes covered during the week were: • The role of communities during the COVID-19 pandemic • Crisis Governance • Dynamic Strategy • The impact of COVID-19 on the workforce • Communication and engagement All of the resources shared during the week are available here.

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
Test, Trace, Protect in Wales: An Overview of Progress to Date	March 2021

Archwilio Cymru
Audit Wales

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Test, Trace, Protect in Wales: An Overview of Progress to Date

Report of the Auditor General for Wales

March 2021

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

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 his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the umbrella brand of the Auditor General for Wales and the Wales Audit Office, which are each separate legal entities with their own legal functions. Audit Wales is not itself a legal entity. While the Auditor General has the auditing and reporting functions described above, the Wales Audit Office's main functions are to providing staff and other resources for the exercise of the Auditor General's functions, and to monitoring and advise the Auditor General.

For further information, or if you require any of our publications in an alternative format and/or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales. We welcome telephone calls in Welsh and English. You can also write to us in either Welsh or English and we will respond in the language you have used. Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Summary report

Introduction

1 Test, Trace, Protect (TTP) is a crucial part of the Welsh Government's approach to limiting the spread of COVID-19 and reducing the need for restrictions on people's lives. The TTP programme was developed rapidly from scratch through the partnership arrangements put in place when the pandemic first hit in March 2020 and forms part of the wider response to the virus, set out in the Welsh Government's **Coronavirus Control Plan for Wales**.

2 The Welsh Government's **Test, Trace, Protect** strategy sets out the key elements of the programme which comprise:

- identifying and testing people who may have COVID-19;
- tracing people who have been in close contact with someone who has tested positive for COVID-19; and
- providing advice and guidance to protect the public and supporting people to self-isolate where necessary.

3 **Exhibit 1** provides further information on how TTP works in Wales.

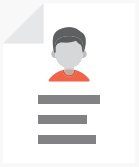
Exhibit 1 – how TTP works in Wales

The Welsh Government sets the priorities and provides funding and oversight of TTP with advice from Public Health Wales NHS Trust (PHW)

Test

- Health boards and local authorities work with partners to provide testing facilities where swabs are taken and then sent for analysis.
- Welsh NHS (PHW) labs analyse some of the tests. Some are analysed by private labs known collectively as the UK Lighthouse Labs. The Lighthouse Labs are managed by a partnership led by the UK Government[1].

Trace



- Where relevant[2], the details of people who tested positive for COVID-19 are sent to local contact tracing teams in the area where they live. Teams are coordinated regionally by health boards and local authorities.
- Contact tracing teams speak to people who tested positive to identify anyone they may have infected.
- Contact tracing teams try to reach anyone who came into contact with the person who tested positive. They advise people who have symptoms to get tested and self-isolate. They send regular text messages to contacts without symptoms to see if they have developed symptoms.

Protect

- Contact tracing teams ask people whether they need help to self-isolate and pass their details onto local authority teams.
- Local authority teams and the third sector support people who need help to self-isolate.

Source: Audit Wales

1 The partnership includes Medicines Discovery Catapult (a UK Government funded organisation), the UK Biocentre, the University of Glasgow, the University of Cambridge, and private companies: AstraZeneca, GSK, and PerkinElmer.

2 There are people whose details do not go to contact tracing teams, for instance people in care homes, prisons, or hospitals.

About this report

4 This report sets out the main findings from the Auditor General's review of how public services are responding to the challenges of delivering TTP services in Wales. It is a high-level overview of what has been, and continues to be, a rapidly evolving programme. The evidence base for our commentary comes from document reviews, interviews with staff in health boards, local authorities, NHS Wales Informatics Service (NWIS), Public Health Wales (PHW) and the Welsh Government between September and December 2020, and analysis of key metrics that show how well the TTP programme has been performing. As well as commenting on the delivery of TTP up to and including December 2020, the report sets out some key challenges and opportunities that will present themselves as part of the ongoing battle to control COVID-19.

Key messages

5 The TTP programme has seen different parts of the Welsh public and third sector work together well, in strong and effective partnerships, to rapidly build a programme of activities that is making an important contribution to the management of COVID-19 in Wales.

6 The configuration of the TTP system in Wales has a number of strengths, blending national oversight and technical expertise with local and regional ownership of the programme, and the ability to use local intelligence and knowledge to shape responses.

7 Arrangements for testing and contact tracing have evolved as the pandemic has progressed. But maintaining the required performance in these areas has proved challenging in the face of increasing demand.

8 TTP is a crucial part of the Welsh Government's approach but has not been the only way it is trying to prevent the virus spreading. Despite increased testing and tracing activity, the virus has continued to spread. In Wales, as in other parts of the UK and internationally, testing and tracing has needed to be supplemented with increasingly stringent local and national lockdown restrictions in an attempt to reduce transmission rates.

9 Lockdowns have only provided temporary solutions to controlling transmission and regardless of progress with vaccines, the TTP programme will remain a key tool in Wales's battle with the virus for some time to come.

10 Testing volumes increased significantly in response to increasing incidence of COVID-19, and results have generally been turned around quickly. The tracing workforce has expanded rapidly. But when demand has risen across regions at the same time, there has been insufficient contact tracing capacity to meet the increased demand.

11 Most importantly of all, the public has a huge role to stop the virus spreading by following guidance and self-isolating when necessary. There is now good information to show the breadth and range of services and support adopted across Wales during the pandemic. But it remains difficult to know how well the 'protect' element of TTP has been working in supporting people to self-isolate. This will become increasingly important as 'lockdown fatigue' sets in with its associated challenges for emotional, physical and economic well-being.

12 These key messages are explored further in the following sections.

> Wales has developed a Test, Trace, Protect service largely from scratch and at unprecedented scale and pace.
>
> It has been particularly encouraging to see how well public sector partners have worked together at a national, regional, and local level to combine specialist expertise with local knowledge, and an ability to rapidly learn and adjust the programme as we've gone through the pandemic. It's important that the positive learning is captured and applied more widely.
>
> There have been times when the Test, Trace, Protect service has been stretched to the limit, but it has responded well to these challenges. The programme needs to continue to evolve, alongside the rollout of vaccines, to ensure it remains focused on reaching positive cases and their contacts, and supporting people to self-isolate to keep the virus in check.

Adrian Crompton
Auditor General for Wales

Main findings

01

How well are various agencies working together to deliver TTP in Wales?

1.1 The various organisations involved in delivering TTP in Wales have worked incredibly hard, in strong and effective partnerships, at a rapid pace and together have established a range of activities that have been making important contributions to the management of COVID-19 in Wales.

1.2 The scale of the challenge has been significant. With the exception of localised arrangements that have been previously enacted to respond to public health outbreaks, TTP arrangements were non-existent prior to the pandemic. The following exhibit provides an indication of the scale of the TTP programme during the second peak in COVID-19 cases.

Exhibit 2 – comparison of TTP activity at the week ending 2 January

40 testing sites in place, carrying out **96,000** tests per week → Equivalent to the average number of outpatients seen by Cardiff & Vale University Health Board every two months

2,400 staff appointed, trained, and onboarded to provide contact tracing → Equivalent to just under half of the total workforce employed by the Welsh Government

8 regional teams in place, tracing, providing advice to, and following up on **14,000** positive (index) cases and **31,200** close contacts per week → Equivalent to the average number of 999 calls made to the Welsh Ambulance service each month

Source: Welsh Government and Public Health Wales

1.3 Whilst roles and responsibilities within the system were not fully understood by all in the early stages of the pandemic, they became clearer as the programme evolved and responded to the challenges of incidents, outbreaks, and rising transmission rates.

1.4 The configuration of the TTP system in Wales has a number of strengths, blending national oversight from Welsh Government, with the technical expertise and experience that sits within PHW, health boards, local authorities, third sector and NWIS. Crucially, the TTP model in Wales has given PHW, health boards and local authorities' ownership of the process, and the ability to use local intelligence and knowledge to shape responses to the pandemic.

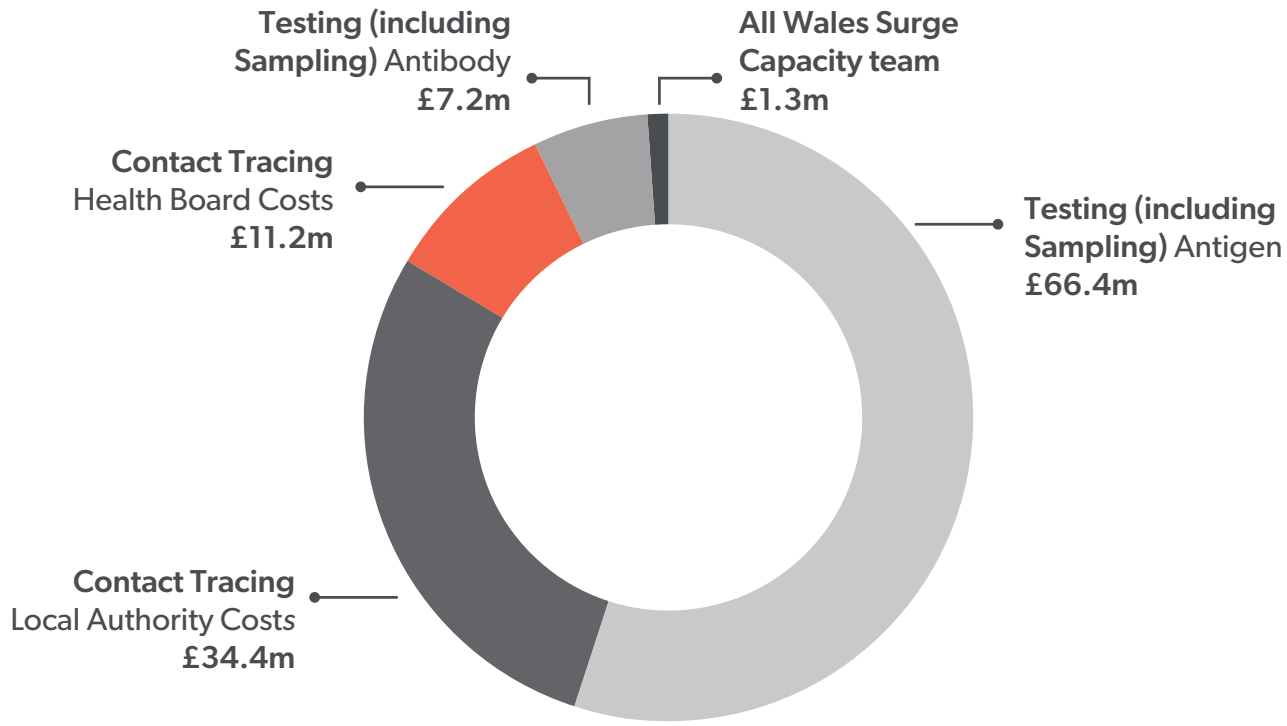
1.5 The programme has demonstrated that it can adapt and evolve quickly, learning lessons from the management of early outbreaks and trying to effectively marry Wales specific and UK-wide arrangements. However, this has, and continues to be, a challenge and officials we spoke to described it as trying to 'design, build and fly an aircraft all at the same time'. The new variants of the virus also present a significant challenge and are increasing the pressure on the TTP programme to remain agile.

1.6 The fact that Wales has not had sole control over all the elements of the TTP programme has caused some operational challenges in respect of access to tests. Wales relies heavily on the UK Lighthouse Laboratories (Lighthouse Labs) and in September, the UK Government unilaterally announced that it was capping daily testing capacity in Lighthouse Labs in response to high demand for tests. Whilst the UK Government quickly released more tests for Wales, the episode highlighted some of the challenges associated with the hybrid testing system. This issue is explored further in **paragraph 1.21**.

How much is TTP costing?

1.7 The Welsh Government element of the TTP programme is expected to cost over £120 million during 2020-21, of which almost three-quarters is on testing (**Exhibit 3**). The actual costs to the taxpayer are considerably higher because Wales does not pay directly for its share of testing sites or laboratory facilities which are commissioned by the UK government (**see section on testing**). Health boards, local authorities, PHW and the Welsh Government have also redeployed staff to deliver TTP which is not included in the all-Wales spending figures. The exact expenditure relating to the 'protect' element of the programme is also not included as associated costs are part of wider service provision costs for local authority and third sector organisations.

Exhibit 3 – all-Wales TTP expenditure for 2020-21 (£ million) based on actual expenditure to month 10 and forecast to year end. This chart does not include all TTP expenditure



Source: TTP Monthly monitoring returns[1] – based on 'Month 10' submission

1 Health boards and trusts submit the monitoring returns to Welsh Government for review.

How well is testing for COVID-19 working in Wales?

1.8 At the start of the pandemic, the level of available lab capacity across Wales was below that required to meet expected demand from its TTP programme. The UK-wide network of Lighthouse Labs has provided significant additional capacity since May which the Welsh public sector would not have been able to secure on its own. Plans to further increase Welsh public sector provided lab capacity were announced in August supported by additional Welsh Government funding of £32 million.

1.9 When compared to other countries, the UK and Wales has had some of the highest population testing rates in the world[2]. The extra investment helped to support an additional 6 'hot labs' to enable rapid test analysis, and to support 24-hour provision of Welsh NHS laboratories. This required the recruitment of additional laboratory staff.

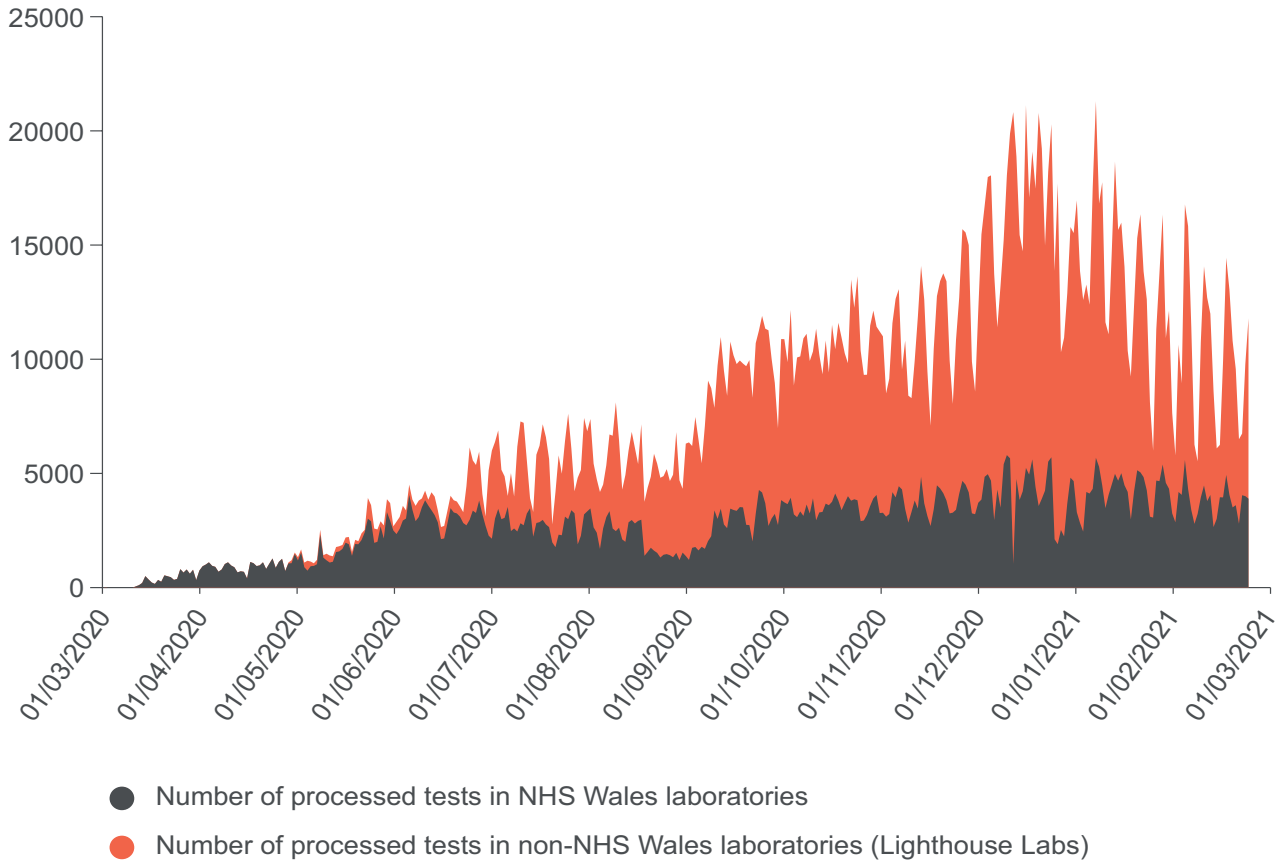
1.10 Significant sampling capacity has also been put in place since May. This continues to expand, including local testing sites and mobile testing units which can be moved to areas of need. A number of sampling facilities are run by private contractors as part of the UK testing programme. But health boards, and the Welsh Ambulance Services NHS Trust have increasingly been providing additional sampling capacity.

1.11 The pathway for sampling and analysis of tests has varied depending on who is having the test and includes a level of complexity (**Appendix 1**). The Lighthouse Labs provide basic positive or negative results but have been able to respond to high demand and analyse large volumes. Welsh NHS laboratories provide tests which provide greater detailed analysis, but they have been unable to respond to high demand. These arrangements have and will continue to change when new swabbing and lab services are introduced, and new tests are developed and introduced.

1.12 **Exhibit 4** shows a significant growth in the level of testing done between mid-March and February 2021. It also shows that a significant proportion of the demand for tests across Wales has been met by the Lighthouse Labs.

2 At the time of our fieldwork we looked at the top 30 countries with the most cases. Since the start of the pandemic, the UK had the second highest rate and Wales had the sixth highest rate of testing (antigen and antibody).

Exhibit 4 – total processed tests for Welsh residents split by NHS Wales and Lighthouse Labs provision up to 25 February 2021

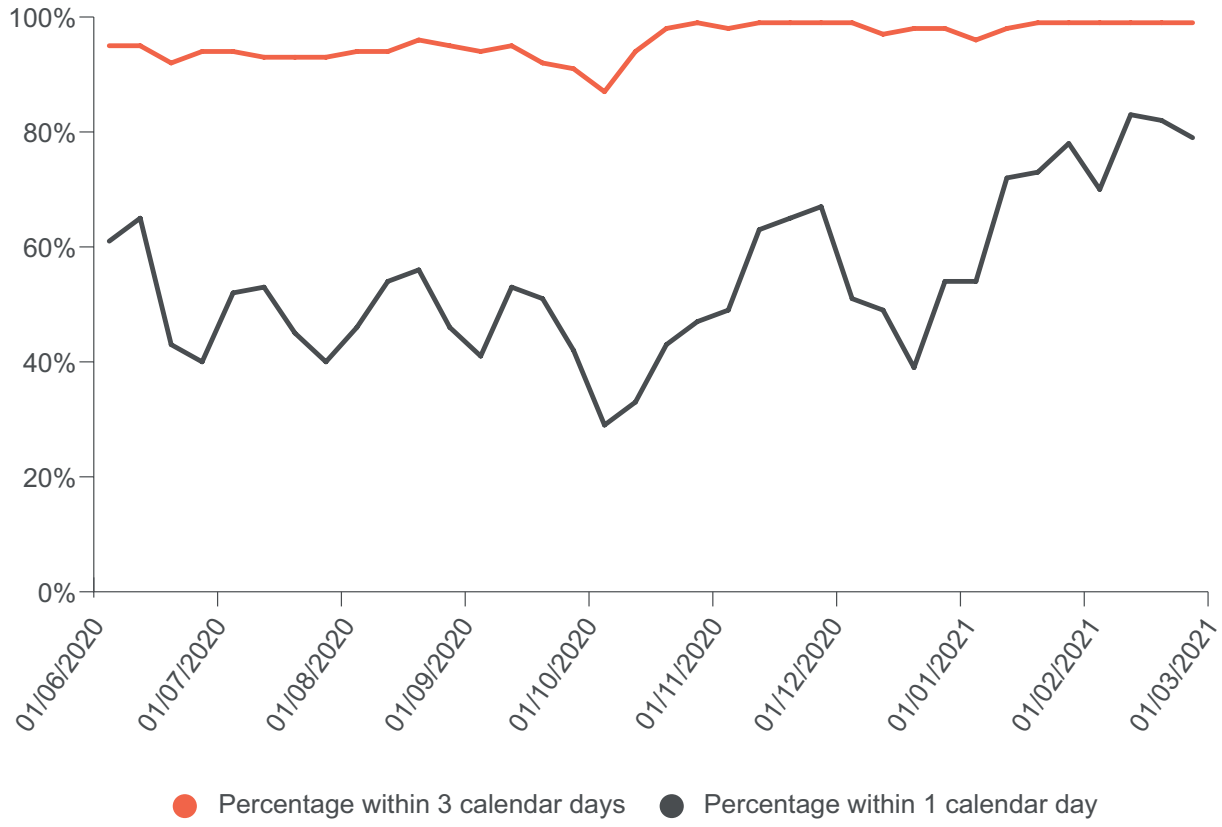


Source: Public Health Wales

1.13 Timeliness is crucial to containing the spread of the virus. A quick turnaround for a positive test result allows contact tracing teams to reach that person's contacts sooner and tell them to self-isolate to prevent further spread. A quick turn-around on a negative result also reduces the impact on individuals and on the wider economy, for example, by allowing them to return to work.

1.14 **Exhibit 4** indicates that by late September, laboratories were processing over 10,000 tests a day for Welsh residents. At that time, there were increasing rates of COVID-19 across a number of county areas, significant increases in demand for tests as a result of schools reopening, and the onset of seasonal illnesses with similar symptoms. The effect of the above factors contributed to a reduction in the proportion of tests that were turned around within the 'gold' standard of one calendar day, although turnaround within three calendar days has largely been maintained. The additional testing capacity across Wales has helped improve the performance over recent months (**Exhibit 5**).

Exhibit 5 – percentage of tests reported within one calendar day and within three calendar days (both Welsh and Lighthouse Labs) up to 1 March 2021



Source: Public Health Wales

1.15 The time between people giving a sample and the results being reported by the lab (turnaround times), however, has varied quite significantly depending on the location of the test and where it has been analysed. We found that:

- Welsh NHS lab turnaround times for hospital tests, and more latterly community and mass tests[3], have generally performed well with over 80% of hospital tests, and over 70% of community tests turned around within one calendar day.
- Welsh NHS lab turnaround times for asymptomatic key workers (including care home staff) and care home residents within one calendar day has been as low as 25%. But more recently increased to around 50%, although it is important to note that the expected turnaround times for this cohort is three calendar days. Although performance dipped during the September period, almost all results have been turned around with three calendar days.

3 This includes regional drive-through, mobile, and local walk-in test centres supported by Welsh NHS labs, as well as community testing sites for outpatients and symptomatic key workers.

- Lighthouse Lab turnaround times for community testing[4] performed well until September. But then timeliness sharply declined when demand increased (as set out in **paragraph 1.14**), with an average of just 30% of tests turned around within one calendar day at the end of October. Performance has since improved and was running at 98%.
- Lighthouse Lab turnaround times for tests kits, either via the organisation portal for care homes, or for home-testing, within one calendar day has been low at around 30% and has been consistently since August albeit a slight improvement for portal tests during November. Note that the expected turnaround time for this cohort is also three calendar days. Although performance was around 50% during the summer period, almost all results are now being turned around within three calendar days.

1.16 When considering the points above, it is worth recognising the logistical challenges associated with transporting swabs from some geographically isolated sampling locations to labs in Wales and in England can contribute to longer turnaround times. The timeliness of home test kits is also reliant on swabs being posted back to the labs in a timely manner. The volume of testing in the UK and in Wales is also high in comparison with other countries with similar case numbers. However, these challenges need to be overcome as success of the TTP programme is critically dependent on timeliness of test results. As a result, a Lighthouse Lab was opened in Newport in October, and a consolidation centre opened in Cardiff in January to enable faster transportation.

1.17 The frequency of in-hospital testing has improved since the start of the pandemic but needs to be strengthened further. Hospital outbreaks of COVID-19 have clearly been a risk which could have been reduced through effective testing regimes, both before and on admission, as well as more frequent testing during a patient's hospital stay.

4 This includes regional drive-through, mobile, and local walk-in test centres supported by Lighthouse Labs.

1.18 PHW figures show that compared to the first wave of the pandemic, hospitals have been testing proportionately more patients on admission[5], increasing from 24% in the first wave to 54% in October, but there remains considerable room for improvement. Data on the **PHW website** provides further detail and indicates that levels of testing has varied significantly across Wales, with Hywel Dda University Health Board testing approximately 24% of patients in October compared to 64% in Betsi Cadwaladr University Health Board. Variation between health boards narrowed during November, with all health boards more recently testing between 50-60% of all admissions, with the exception of Cardiff and Vale which has been at a lower rate of around 40%. Once tested on admission however there has been no regular testing during a patient's hospital stay unless patients have developed symptoms. This has been with the exception of patients discharged to care homes, which has required patients to have had two negative test results before being discharged.

1.19 The levels of risk have varied in different areas of Wales because of different prevalence of disease in the communities, However, it has been clear that once an in-hospital outbreak occurs, spread of COVID-19 as a result of hospital transmission has placed a significant burden on hospital capacity and resulted in very poor outcomes for patients.

1.20 The number of people who have got COVID-19 in hospital has been relatively low across Wales (approximately 8% of all cases during the week commencing 8 February) but there had been an increasing number of outbreaks over recent months. It is important that testing regimes within hospital settings are designed to meet this challenge and reduce the risk of hospital acquired coronavirus infections.

5 PHW figures exclude confirmed positive cases and elective patients who are tested prior to admission.

What factors are affecting testing?

1.21 The Lighthouse Lab arrangements have created some challenges for Wales given that the UK Government make the decisions about the use of lab capacity. Up until October, regions in Wales were not sighted on the Lighthouse Lab capacity available to them in their retrospective areas. During that time, increased demand in other parts of the UK as well as decisions made by the UK Government impacted on the availability of testing across Wales. This included:

- the decision to cap the number of tests available during September to manage demand through the Lighthouse Labs, resulted in reduced slots available and underuse of test centres which meant not everyone who needed a test could get one.
- the decision by the Lighthouse Labs to hold back on analysing swabs from the regular programme of asymptomatic care home testing which resulted in those swabs no longer being valid for analysis.
- the setting up of the UK Government's portal for booking tests which directed residents to the geographically nearest testing site with available capacity. This resulted in English residents travelling into Wales for tests, sometimes into areas that were in local lockdown, reducing the number of tests available for Welsh residents. It also resulted in Welsh residents being offered tests in other parts of the UK.

1.22 All regions now have access to the Lighthouse Lab capacity available to them on a daily basis, and for the week ahead to enable capacity to be deployed to the right areas. Mileage restrictions have also now been placed on tests booked through the UK Government portal to minimise the flow across countries, as well as the flagging-up of local restrictions to stop travel into lockdown areas. Where there have been community outbreaks, regions have also been able to take some control of the booking arrangements to ring-fence privately run sampling capacity to local communities where appropriate, although this has been reliant on health board's having alternative booking systems in place.

1.23 Current service performance management data focuses on the time from which a sample is taken to the time when the result is reported. Information on the testing capacity is also available, as is the extent that the capacity has been utilised. This operational information is useful to manage what are a complex set of services that are provided by distributed test site and lab units. However, there has been no information on the number of people that try to get a test but are unable to get one. This, if available, would give a picture on unmet demand.

1.24 Similarly, no information is reported on the time taken from when people identify the symptoms to the time when they have a test. This would be important to establish delays in accessing tests, particularly at times of high demand, as well as understanding population behaviours and potentially 'soft' barriers that are delaying people going for tests. This could include for example a person showing a symptom of the disease but not going for a test until their symptoms exacerbate. This information is captured as part of the contact tracing process but has not been reported.

1.25 Since the early part of December the Welsh Government, with the regional partners, have been utilising rapid testing. This includes the Lateral Flow Device, which gives results within 30-40 minutes. This was used in the recent pilot in Merthyr Tydfil and Lower Cynon, to understand the rate of infection. Rapid testing is now providing some significant benefits, for example, testing care home visitors, emergency department patients and key workers to enable rapid decisions and action to be taken. It is also providing benefits by reducing the elapsed time for contacts to be traced and told to isolate, as the rapid results enable the positive cases to inform their contacts immediately.

1.26 However, the rapid tests have come with some challenges, as they are not as accurate as the swab tests analysed through the labs. Until recently, people who returned a positive lateral flow test were advised to have an additional swab test to confirm the positive result and for their details to then be added to the contact tracing system. This had the potential to create additional demand on the testing system when applied to asymptomatic populations. The level of 'false positives' to date, however, has been very low and the decision has since been taken to directly record the rapid test result on the contact tracing system to enable tracing. There remains a risk, however, that some people who have the virus get a 'false negative' result and inadvertently infect more people. It should be noted that the risk of 'false negative' results also applies to lab-based tests as well as rapid lateral flow tests.

How good is contact tracing?

1.27 It is internationally recognised that contact tracing is a well-established mechanism to control the spread of infectious disease. It involves contacting and providing advice to people who have tested positive, finding out who their close contacts have been, and reaching those close contacts to advise them on what they need to do. Contact tracers try to build trust to find out who people have been in contact with, especially where they may be reluctant to admit they have broken the rules. Tracers also play a key role in advising people of the importance of self-isolating, and to flag up with wider public and third sector services where additional support may be needed.

1.28 While some small-scale public health control and outbreak tracing arrangements were in place prior to the pandemic, the pace at which new tracing services have been introduced, as well as the scale of them, has been significant. This has included:

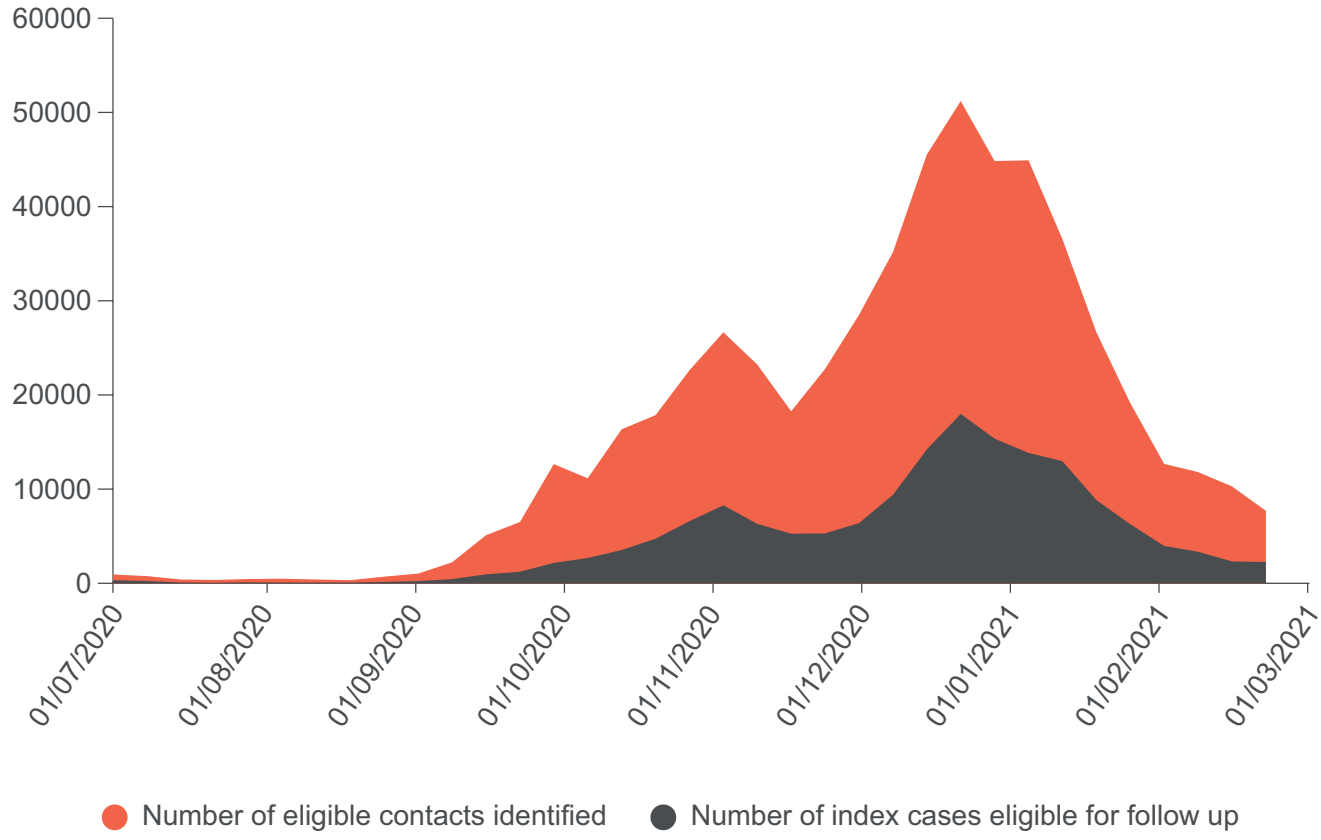
- development of all-Wales processes, guidance and scripts;
- the procurement, development and rollout of an IT system within a six-week period; and
- the local recruitment and training of a workforce which, by December 2020, was 2,400 strong.

1.29 The scale of these contact tracing arrangements has never been seen in Wales before. This was enabled by strong and effective partnership working within and across local authorities and health board regions.

1.30 Irrespective of the scale of the tracing service introduced, the challenge presented by the pandemic has been immense. Contact tracing services in Wales have generally performed well but the timeliness of tracing activity has seen some deterioration at periods of high demand, when services have needed to respond to increasing infection rates during the autumn and winter. **Exhibit 6** shows the significant weekly growth in the numbers of eligible[6] cases and their contacts that need to be traced by the service.

6 An eligible index (positive) case is one that requires contact. There may be instances where the case is not eligible, for example they are an inpatient in a hospital (and therefore all contacts are known and informed through internal processes), or it may be a repeat or duplicated test.

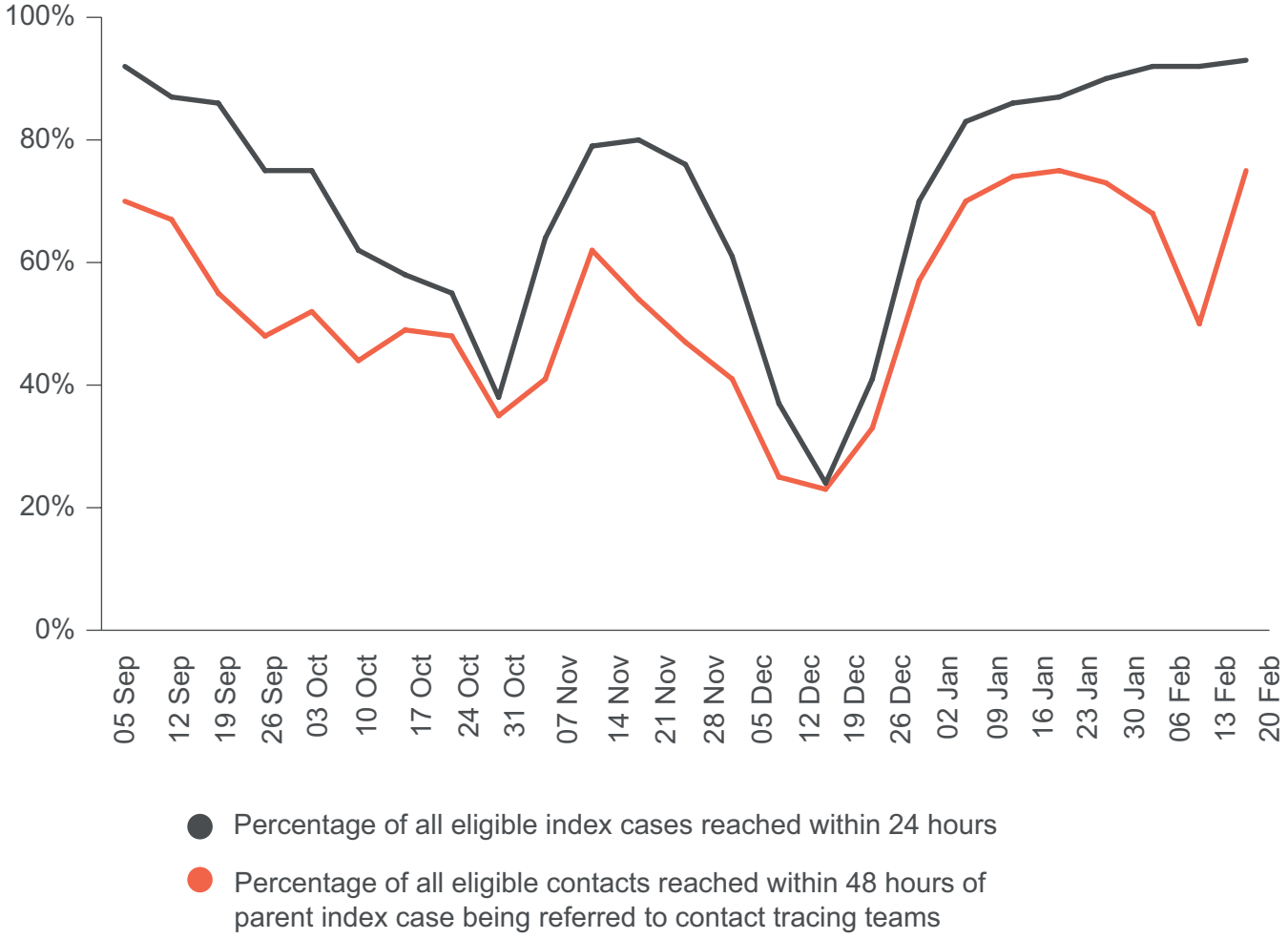
Exhibit 6 – all-Wales number of eligible cases needing to be contacted up to 21 February 2021



Source: Welsh Government

1.31 At the beginning of September tracing teams were reaching most positive 'index' cases in 24 hours. The time taken to reach index cases is measured from when their details are uploaded into the digital tracing system to the time tracers successfully make contact. For close contacts, the clock starts both when a close contact is identified by a positive case, and also from the point when the related index case was referred onto the contact tracing system. The clock stops when successful contact has been made. Whilst index cases know they have tested positive and should self-isolate, their close contacts may have the virus and be unaware of it. Therefore, the longer it takes to reach contacts, the more likely they are to unwittingly spread the virus. **Exhibit 7** shows how the timeliness of tracing activity can deteriorate when demand on contact tracing teams increases. At 19 December, 24% of all eligible index cases were reached within 24 hours, compared with 93% at 20 February. Also, at 19 December, only 23% of all eligible contact cases were reached within 48 hours of the index case being reported to the tracing teams, compared with 75% at 20 February.

Exhibit 7 – all-Wales timeliness of contact tracing (within 24 and 48 hours) up to 21 February 2021



Source: Welsh Government

1.32 Even though the TTP system has been contacting a high proportion of both positive index cases and their close contacts, a small proportion of people have not been reached at all. This has been for a number of reasons which includes incorrect contact details or a reluctance of contacts to respond to the call. At 20 February, 625 index cases (0.4%) and 21,482 close contacts (5%) had not been reached at all. It is important to note that only people going through the TTP system will have been traced, Members of the public who have reported symptoms through other means, such as the **ZOE symptom app** or tested positive by undertaking a private test will not have been traced.

What factors are affecting contact tracing?

1.33 The capacity within tracing teams has been a key determinant of their ability to reach positive cases and their close contacts. At the start of the TTP programme in June, the Welsh Government made £45 million available for health boards and local authorities to set up contact tracing teams across Wales. Plans were developed to manage peaks and troughs in demand for contact tracing with a flexible workforce that included staff redeployed from other services which had closed down because of the pandemic.

1.34 Over the summer, some staff returned to their main job when services started operating again, and health boards and local authorities started recruiting new staff to boost their tracing capacity. In November, the Welsh Government provided an additional £15.7 million to nearly double the tracing workforce in Wales from 1,800 to 3,100. By December 2020, there were 2,400 people[7] working in tracing teams.

1.35 Recruiting new staff, including bilingual staff, into local tracing teams at the same time as redeployed staff were returning to their normal job resulted in a greater degree of churn than expected for some teams and created some gaps in tracing skills and experience. New staff can take longer to process tracing cases. We are also aware that introducing new staff in some regions created problems such as data entry errors by inexperienced staff. There was also a heavy reliance on the existing expertise of public health protection and environmental health specialists who needed to deal with the more complex outbreaks, alongside their wider work supporting the application of social distancing measures in various settings.

1.36 Effective training has therefore been an important part of the work to build the capacity of contact tracing teams. In the Cardiff and Vale region there has been a dedicated tracing trainer whilst in other regions training has been provided by an existing member of the contact tracing team alongside their existing tracing duties.

1.37 It is important to note that whilst training of new contact tracing staff is clearly important, each local and regional team will have been working within an operating framework that was developed by PHW, who also wrote the ‘scripts’ for contact tracing teams.

7 Full time equivalents.

1.38 A positive feature of the way contact tracing has operated in Wales is the concept of ‘mutual aid’ where caseload work has been shared between regions if one region has been experiencing particular pressures due to rapid rises in positive cases. This mutual aid played a part in the management of the early outbreak in Anglesey and more latterly when case numbers rose sharply in the Cwm Taf Morgannwg area. The Welsh Government has also set up a new all-Wales ‘surge’ team which, along with mutual aid arrangements, has been used to manage peaks and troughs in demand for tracing activity. It is also been conducting an efficiency review of tracing across Wales to ensure best performance.

1.39 Within each region there has also been a central contact tracing team which includes specialist staff drawn from NHS and local authority partners to help deal with the more complex issues such as contact tracing within care homes and hospital settings. More detailed contact tracing to understand the exact source of the transmission has also taken place as capacity has allowed. This has required the reshaping of the work of public protection, the wider cohort of environmental health officers and local authority health and safety teams to work with businesses and communities found to be at the source of the outbreak, and apply enforcement notices where relevant.

1.40 The tracing workforce in Wales has increased rapidly, but during December, tracing teams struggled to meet demand from the surge in infection rates. To meet the demand, some teams temporarily prioritised cases to be traced and asked people who had tested positive to speak to close contacts themselves.

1.41 Since 9 June, all tracing teams have used the same digital Customer Relationship Management (CRM) information system. NWIS procured the CRM system and negotiated a software licensing contract where the number of users could be scaled up or down, which helped to control costs. The CRM system links to the Welsh laboratory information system and updates every 30 minutes with new positive cases. The system allocates positive cases to the tracing team where they live. Tracing teams then record information about positive cases and their contacts in the CRM system. Information can be extracted from the CRM system to gauge how well contact tracing is performing and to understand the spread of the virus.

1.42 Contact tracing teams have encountered some practical challenges since the launch of the CRM system. For example, one region reported that system functionality resulted in ‘shadow lists’ on the system where some positive cases were recorded but were not visible in the tracing queue. These types of issues are, however, quickly resolved. Concerns, however, have remained with the unreliability of the telephony system, which supports calls from the CRM system. This is resulting in contact tracers, for example, not being able to make calls when they need to because of connectivity issues.

1.43 Some tracing teams have also reported that the batch processing of lab results and the subsequent upload of positive cases onto the CRM created a peak of cases to follow up. Whilst this was to be expected, the uploads particularly at the end of the day made it difficult for tracing teams to meet timeliness targets, as many cases would not have been followed up until the next working day.

1.44 The quality of the information coming from the system has depended on the accuracy of information entered by contact tracing teams. It has also relied on having skilled data analysts to extract the information and use it in meaningful ways, but at the time of our review some regions lacked data analyst capacity.

1.45 There have been other practical challenges that contact tracing teams have encountered as the pandemic has progressed. There have been outbreaks in commercial work settings where many employees did not speak English. There have also been incidences of contact details being incorrectly recorded either deliberately or because the systems for recording information were rudimentary (ie handwritten details with associated problems with legibility).

1.46 All of these challenges have been worked through with lessons learnt and shared as part of the ongoing evolution of the TTP programme. These challenges have also been worked through quickly, reflecting the ability of the service to respond to issues and where relevant make changes to working processes or policies, at pace.

What is being done to support people who need to self-isolate?

1.47 Despite the positive recent news about vaccine development and roll out, Wales still finds itself in a position where cases of COVID-19 are circulating widely. It is therefore absolutely vital for people to self-isolate if they have tested positive for the virus, or if they are a contact of somebody who has tested positive.

1.48 However, for many people self-isolation has brought numerous practical, financial and well-being challenges. The 'protect' element of TTP has been about providing the necessary support and information to those who need to self-isolate.

1.49 Whilst the initial Prevention and Response Plans[8] at a regional level lacked detail on what would be done to support people to self-isolate, our work has found that numerous initiatives have been in place to provide such support. Typically, these have been collaborative initiatives at a regional and local level involving public sector bodies and various agencies from the voluntary sector, often supported by community volunteers. These services have looked to provide practical help such as food shopping, medicines collection and wider support for those at risk of loneliness and social isolation. Work has also been undertaken to provide support to specific population groups such as university students and tourists travelling into Wales during periods when lockdown restrictions are lifted so they are aware of local measures that are in place and where to go to for support.

1.50 In response to the financial challenge associated with self-isolation, from 1 November, people on low incomes in Wales have been able to apply for a £500 payment if they have tested positive for COVID-19 or told to self-isolate. A similar scheme has been available to social care workers as a top-up payment to their statutory sick pay. Self-isolation payments have recently been extended to some parents and carers on low incomes who have had to look after children who are self-isolating. Local authorities received just under 20,000 applications between November and January 2021 with around 50% of those eligible for payment. The scheme was being reviewed at the end of January, but there was clear recognition that there remained a need to financially support those in most financial need to allow them to comply with self-isolation requirements.

8 The Welsh Government required health boards, local authorities, and their partners to submit the plans setting out how they would limit the spread of the virus in their region.

1.51 The peaks in community virus transmission which have followed periods of lockdown raise questions about the extent to which the public have been willing to observe the necessary social distancing. PHW's weekly '**How are we doing in Wales**' provides a good summary of how people in the community are feeling, their opinion on policy, and the extent they understand and follow COVID-19 guidance and legislation. This survey showed compliance with the Welsh Government's restrictions was falling amongst respondents. It is not clear to what extent a failure to comply with self-isolation requirements associated with contact tracing has contributed to rises in community transmission. So far, limited information exists to understand the scale of any non-compliance with self-isolation requirements or indeed the reasons for it. PHW has been conducting two pieces of research to understand whether people are self-isolating after being contacted by tracers.

1.52 Clearer information on the level of need for 'protect' services and how well existing services have been meeting that need, would help with the identification and targeting of resources at both a regional and national level. Nevertheless, there is now good information on the range of support services that have been introduced across Wales, often through partnership working. On 16 December, Welsh Government published a review of the **support arrangements for non-shielding vulnerable groups**. As well as identifying support activity, the report also identified lessons learnt, including early engagement with local authorities on shielding guidance, mental health support, more support for digital inclusion, and the long-term benefits of maintaining the momentum that has built up around volunteering. Welsh Government is undertaking an additional survey of local authority protect teams and has established a 'Protect Leads' group. These are focused on understanding the nature of protect requests arising, improving the range of support provided and sharing practice and learning.

1.53 As the TTP programme developed in response to the pandemic, national oversight arrangements have tended to focus much more strongly on the testing and tracing components of the programme. There has been less national oversight of what is needed by way of support for people to self-isolate and an absence of information to know whether those services are effectively influencing public behaviour.

1.54 Self-isolation for people who test positive, and their close contacts, will continue to be a key part of the approach to keeping the spread of the virus in check whilst vaccination programmes are rolled out during 2021. Ensuring that the 'protect' element of TTP gets the focus it needs will therefore be crucial if the programme is going to eventually help us get on top of the virus.

1.55 There is good practice to build upon and adopt more widely, such as the self-isolation helpline that was launched in the Cwm Taf Morgannwg region in November 2020. The helpline is a partnership venture between the Health Board, local authorities in the area, PHW, the Regional Partnership Board and the voluntary sector. It provides help and advice for people who are asked to self-isolate and was set up following analysis of intelligence from the regional TTP programme that showed there was considerable confusion about self-isolation and what support was available, leading to non-compliance with measures to control the spread of COVID-19.

1.56 Other important activities are also underway such as work the Welsh Government is undertaking with the Welsh Local Government Association (WLGA) to develop a monitoring framework that maintains a clearer overview of support needs of people who are required to self-isolate. Welsh Government officials have also been working with NWIS to improve the information captured in the CRM system about people who need help to self-isolate.

Looking ahead: key challenges and opportunities

02

Having better information to improve efficiency and evaluate the impact of TTP

2.1 The performance in one part of the TTP system will determine how effective other parts of the system are. For instance, quick turnaround times for testing are necessary for contact tracing to be effective. Similarly, the ability of contact tracing teams to reach the right people quickly will help identify those who need to self-isolate before they spread the virus further. While there is information about how well different parts of the TTP programme have been working, there has been no performance information that looks at the whole programme, from the moment someone requests a test to the point their contacts are traced, to demonstrate how quickly it is identifying and isolating infected people. Such information could be a powerful tool to help know what is needed to enhance the efficiency and effectiveness of the overall programme.

Ensuring testing activities are fit for purpose and meet increasing demand

2.2 Notwithstanding some of the challenges set out earlier in the report, testing and tracing arrangements have responded reasonably well to the challenges posed by the virus. However, testing and tracing capacity will need to continue to respond to demand in 2021. Tests need to be easy to access and results must be returned quickly to help control the spread of the virus. There is also a considerable risk that if people think it is hard to get a test, or fast results, they may not bother to get tested.

2.3 As highlighted in **paragraph 1.25**, at the time of our review, the Welsh Government had started using new testing technologies such as lateral flow devices and the Lumira DX test. The tests provide quick results and can support large scale testing of asymptomatic populations or screening for health and social care staff. As the demand for these rapid tests increase across both the public and private sectors, the Welsh Government will need to think clearly about which sectors have priority as part of the roll-out, taking into account the known limitations with the accuracy of these tests,

2.4 Testing arrangements within hospital settings is also an area that needs some consideration. Although testing in hospitals has improved since the first peak, hospital patients typically only get tested at the point of admission unless they develop symptoms. To minimise the spread of the virus from patients who may have tested negative at the point of admission but then go on to develop symptoms, there are opportunities to expand the frequency of testing within hospitals as well as ensuring that infection control regimes are as effective as they can be.

Creating a skilled, resilient workforce to deliver TTP

2.5 As with other parts of the public sector, many staff involved in overseeing and delivering TTP have been under considerable pressure for several months. We heard that many staff have been working long hours with limited opportunities to take leave. Organisations have put some measures in place to ensure resilience including recruiting or redeploying additional staff, reallocating work, and putting weekend rotas in place. But there is still considerable pressure on many staff, including those in leadership and specialist roles. Public bodies are also managing competing demands on their workforce associated with the wider impact of the pandemic, the COVID-19 vaccination programme, and the ongoing consequences of Brexit[9]. Irrespective of how quickly the general public can be vaccinated against COVID-19 it is a reasonable assumption that TTP services will be needed at least until the middle of this year and most probably longer. Many new staff have only been recruited until 31 March to align with the current funding availability. It is important that a commitment to fund services into 2021-22 is made as soon as possible to enable staff to be retained and the workforce to remain stable.

2.6 Some staff, including officials leading TTP, have been redeployed and adapted quickly and successfully to new roles outside their previous area of expertise. There may be opportunities to move more staff from other areas to support TTP. There are a number of difficult to recruit to roles and specialists in PHW and some regional teams are looking at how they can increase colleagues' skills to deliver non-specialist work. There are opportunities to look more broadly at which tasks can only be done by public health protection and environmental health specialists, and which can be done by other officials. There could also be opportunities to reduce specialist attendance at meetings by providing guidance outside meetings or identifying areas where non-specialist support is 'good enough'.

9 **Our letter on preparations for the end of Brexit** describes some of the workforce pressures associated with Brexit.

Influencing the public to follow public health protection guidance and requirements

2.7 It is crucial that people who test positive or are told to self-isolate by TTP services follow the rules to avoid infecting anyone else. We found local, regional, and national examples of approaches to influence public behaviour. But without information on whether people are self-isolating it has been difficult to judge the success of this aspect of TTP. Even if effective, TTP is only part of the response to limiting the spread of COVID-19. Since April, the Office for National Statistics has worked with partners to test and survey a sample[10] of people living in the UK to understand more about COVID-19. In October, **the survey** showed that only 34% of people who tested positive for COVID-19 reported any symptoms. These results would suggest that a significant number of people with the virus would not go through TTP at all. It is therefore essential that the population understand and comply with wider measures to prevent infection.

2.8 Many of the professionals we spoke to told us influencing public behaviour has been a huge challenge, particularly as the public grow weary of the pandemic and restrictions on their everyday lives. We also heard that the public have been confused by changing rules, especially when the rules differ across the UK nations. Local intelligence shows that people who do not follow the rules fall into various age groups and are from various backgrounds, in different parts of Wales. Health boards, local authorities, PHW and the Welsh Government have been trying to influence public behaviour in various ways, but getting people to do the right thing remains a considerable challenge. There is a further risk that once people receive their vaccination against COVID-19, they will think there is less need to comply with social distancing and other measures to control the spread of the virus.

10 From October the sample was 150,000 people.

Applying the learning from the TTP programme to other programmes and future ways of working

2.9 Although COVID-19 has presented unprecedented challenges, the pandemic has also provoked significant positivity in the way in which public and third sector organisations have responded. These are evident throughout the TTP programme.

2.10 The scale and challenge of the pandemic has brought organisations together with a common goal of limiting the spread of the virus and protecting the population of Wales. True partnership has been displayed with organisations sharing skills and resources to put teams in place to deliver the TTP agenda, and staff redeployed across a whole spectrum of activities regardless of the organisation in which they may normally work. The concept of mutual aid between different organisations and across different parts of Wales has provided much needed support to parts of the system that may be under increased pressure and sharing the load across Wales as a whole, regardless of organisational and geographical boundaries.

2.11 Processes have been put in place in a matter of days, which in normal times, would have taken months or years. New roles have also been created, with new staff recruited, onboarded, and trained within weeks. A single once-for-Wales IT solution was procured, developed, and implemented within six weeks, enabling organisations to connect to each other and provide a single source of information. It is worth contrasting this with what has typically happened in the past with IT solutions taking years to develop and then implement, with public sector bodies frequently using different versions of the system which struggle to connect to each other.

2.12 The TTP programme has clearly demonstrated that the public service has the ability to work well across organisational and professional boundaries, and to work at pace to get things done. As the attention moves on to different responses to the pandemic, such as the current vaccination rollout programme, and then ultimately, the recovery and resetting of services once the significant peaks in the pandemic start to reside, it is important that the positive learning from the TTP programme is captured and used to shape the way that public sector organisations work together and tackle challenges in the future.

Appendices

1 Sampling and testing analysis pathway for Wales (as at December 2020)

1 Sampling and testing analysis pathway for Wales (as at December 2020)

Who can have the test?	Where are the samples taken?	Where are the samples analysed?	
		Lighthouse Labs	Welsh NHS labs
Symptomatic residents in the community	Regional drive-through testing unit	Most samples	Some samples
Symptomatic residents in hotspot or outbreak areas (including care homes)	Mobile testing unit	Most samples	Some samples
Symptomatic residents in the community	Local walk-in unit	Most samples	Some samples
Symptomatic residents in the community	Home testing kits	All samples	
Symptomatic care home residents and staff	Care home test from the UK government portal	All samples	
Asymptomatic care home staff tested on a weekly basis	Satellite units	Most samples	Some samples
Hospital inpatients	Hospitals		All samples
Hospital outpatients	Community testing unit		All samples
Key workers[11]	Community testing unit		All samples

11 A list of key workers are set out at **gov.wales/coronavirus-critical-key-workers-test-eligibility**. Some key workers may access the testing pathway by presenting as a symptomatic resident in the community.

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Report Title:	**Response to Audit Wales Assessment of progress against previous ICT recommenations – Cardiff and Vale University Health Board**						
Meeting:	Audit Committee				**Meeting Date:**	06.04.21	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**
Lead Executive:	**Director of Digital and Health Intelligence**						
Report Author (Title):	**David Thomas, Director of Digital and Health Intelligence**						

Background and current situation:
Audit Wales completed an assessment of progress against previous ICT recommendations for Cardiff and Vale University Health Board.

The attached Management Response (appendix 1) provides a detailed response to each recommendation, referenced to the original recommendations.

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

The Digital and Health Intelligence directorate continues to implement its structure to deliver against a long term vision and strategy by building strong foundations on which sustainable developments can be achieved.

The priority of the digital team for the past 12 months has been to respond to the rapidly changing landscape resulting from the Covid pandemic, whilst delivering progress towards its long term strategy and previous Audit Wales recommendations.

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

The Health Board has implemented or progressed all recommendations previously received and continues to strengthen its information and cyber security resources.

The dramatic increase in remote working and adoption of new digital platforms eg Teams, has been a challenge to the Health Board's ICT Infrastructure and key areas have received further investment to ensure resilience.

The new directorate structure is nearing completion and this will enable further progress, particularly in the areas of cyber security, service delivery and digital operations.

Recommendation:

Audit Committee members are asked to note and approve the management response as shown at appendix 1.

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 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		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 – Cardiff and Vale Management response

Ref	Area for improvement	Management response	Completion date	Responsible officer
Exhibit 4: New Recommendations for 2020				
R1	Include external audit recommendations, in addition to internal audit recommendations as part of the DHIC audit tracker.	**Implemented** All audit recommendations are incorporated into the relevant Audit Tracker including: • Internal Audit Tracker • Regulatory Tracker • Welsh Audit	Feb 2021	David Thomas
R2	Ensure that appropriate arrangements are in place for the DHIC to have enough oversight and assurance over Information governance.	**Implemented** Information Technology and Governance Sub-Committee has been superseded by incorporating Information Governance as a standing agenda item for DHIC which meets quarterly.	April 2020	David Thomas
R3	Ensure that information asset owners are formally and regularly made aware of their role and responsibilities	In Progress All information assets have a named owner. The IAO role and responsibilities will need to be incorporated into job descriptions.	Sept 2021	James Webb
R4	Rollout appropriate and regular offline information governance training to employees without PC access.	In Progress 66% of staff are IG training compliant including both online and classroom training (Feb 2021) There is a communication and engagement plan to increase uptake of mandatory training, which has been delayed by Covid work pressures.	June 2021	James Webb
R5	The Board should regularly seek assurance that their critical systems would be recoverable in a disaster recovery scenario.	**Implemented** Hosting and back up documentation is in place for all critical Health Board systems and applications. The UHB has a documented IT Disaster Recovery Plan. All Clinical Boards have been made aware of their Disaster Recovery and Business Continuity responsibilities. Disaster Recovery arrangements have been validated on multiple occasions, including recent data restore actions and successful network disaster recovery alternative fall back routing arrangements.	Feb 2021	Nigel Lewis

Detailed Report				
Information Technology (2018) R4	The Health Board should complete a review of the structure and governance of its information and information technology functions to support delivery of the strategic digital approach.	In Progress Key Heads of Digital Transformation and Digital Operations roles have been recruited to in Jan 2021. IG, cyber and information security roles are being advertised.	March 2021	
R1 The Health Board needs to focus its attention on strengthening its information governance arrangements in readiness for the General Data Protection Regulations (GDPR) & developing training on Caldicott, data protection.				
R1-A	A - updating the information governance strategy;	**Implemented** Governance strategy was presented to the board in Summer 2019. This was followed up with Information Governance Policy published in Jan 2020.	January 2020	James Webb
R1-B	B - putting in place arrangements for monitoring compliance of the primary care information governance toolkit;	**Implemented** NWIS provide data protection service for GP practices. CAV do not monitor clinical board compliance with the primary care information governance toolkit.	January 2021	James Webb
R1-C	C - developing and completing an Information Asset Register	**Implemented** Each Clinical Board hold an individual Information Asset Register that are submitted centrally to CAV IG dept. In addition there is an Asset Register for all Corporate systems. All Assets have a named owner. This information is held by Information Governance team.	Previously reported	James Webb
R1-D	D - ensuring that an identified data protection officer is in place; and	**Implemented** A dedicated (interim, pending the finalisation of the directorate restructure) Data Protection officer and Information Governance Manager is in place.	Previously reported	James Webb
R1-E	E - improving the uptake of information governance training.	In Progress 66% of staff are IG training compliant including both online and classroom training (Feb 2021) Compliance has reduced due to Covid related work pressures across the UHB..	Sept 2021	James Webb
R1	The Health Board should complete the outstanding actions from the Information Commissioner's Office (ICO)	In Progress Superseded by ICO 2020 recommendations.	June 2021	James Webb

	2016 review of the Health Board's data protection arrangements.			
Information Governance R2	The Health Board should achieve full compliance with the General Data Protection Requirement by May 2019.	In Progress Superseded by ICO 2020 recommendations. GDPR action plan is standing agenda item at DHIC. Governance & Assurance 25 actions, 5 have been completed.	Review progress at DHIC mtgs in June & Oct 2021	James Webb
Information Governance R3	The Health Board should improve its response times to requests for information from Freedom of Information Act and Data Protection Subject Access Requests.	In Progress FOIA average compliance for 2019/20 was 85%. April-July 2020 dropped to 42% Aug-Nov 2020 risen to 72% full year average not yet available. SAR requests 2019/20 completeness was 77% this has increased to generally reach 90% with an exception in October 2020 caused by Covid pressures.	April 2021	James Webb
IM&T Resilience (2018) R5	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.	Implemented As per Exhibit 4:R5. Hosting and back up documentation is in place for all critical Health Board systems and applications. The UHB has a documented IT Disaster Recovery Plan. All Clinical Boards have been made aware of their Disaster Recovery and Business Continuity responsibilities. Disaster Recovery arrangements have been validated on multiple occasions, including recent data restore actions and successful network disaster recovery alternative fall back routing arrangements.	Feb 2021	Nigel Lewis
Information Technology (2017) R2	To ensure resilience to security issues, such as cyber-attacks, the Health Board should consider identifying a dedicated resource for managing IT security.	In Progress Interim cyber security resources acquired via agency, pending the completion of the IT Security structure, which is in progress	March 2021	David Thomas

Archwilio Cymru
Audit Wales

Assessment of progress against previous ICT recommendations – Cardiff and Vale University Health Board

Audit year: 2019

Date issued: March 2021

Document reference: 1940A2020-21

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

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

The Health Board has made some progress since previous ICT audits, like developing the Digital and Health Intelligence directorate, improving information governance compliance and working towards increasing its cyber capabilities, but disaster recovery arrangements do not appear to have moved on and the information governance action plan for implementing ICO recommendations and GDPR is still ongoing.

Summary report

Introduction

1 Audit Wales has previously undertaken reviews relating to information governance and information technology which resulted in recommendations being made to Cardiff and Vale University Health Board (the Health Board). The reviews included:

- ICT Disaster Recovery and Business Continuity (2012);
- IT back up arrangements (2012); and
- Caldicott arrangements for information confidentiality requirements (2013)

2 **Exhibit 1** summarises the overall conclusions from each of these reviews.

Exhibit 1: overall conclusions from previous ICT reviews

Review name and date	Key conclusions
ICT Disaster Recovery and Business Continuity (2012)	While the Health Board's ICT infrastructure was largely resilient and departments have identified ways to maintain clinical services in the event of ICT failure, business continuity and disaster recovery plans were not being adequately documented, tested or scrutinised.
IT back up arrangements (2012)	There is scope to make further affordable improvements in backup and restore arrangements, which would significantly enhance protection of the Health Board's key clinical systems.
Caldicott arrangements for information confidentiality requirements (2013)	Whilst arrangements are in place to comply with data confidentiality, the Health Board needs to strengthen its Caldicott arrangements to ensure they are fully effective.

Source: Audit Wales

3 In 2014, we carried out a follow-up review (Combined follow up of Informatics and Communications Technology audits) of the earlier reviews set out in **Exhibit 1**. The review sought to answer the question 'Has the Health Board made progress in addressing the key issues and recommendations highlighted in our previous ICT reports?'

4 Our findings concluded that 'the Health Board had made progress in addressing some of the issues raised in previous reviews, but we made seven new recommendations to ensure that key areas continued to be addressed. In making this conclusion, we found that:

- The Health Board did not have a standard approach to disaster recovery and business continuity planning, with plans less established in clinical departments, than in the ICT department. Testing of disaster recovery and business continuity plans and training in these clinical areas was also limited;
- Caldicott governance arrangements had been strengthened but there remained a need to develop training on Caldicott, data protection and information confidentiality; and
- Clinical departments and ICT had agreements in place to identify data owners and responsibilities for backups, but some agreements remained unsigned and the testing of backups remained ad hoc.

5 More recently our Structured Assessment work at the Health Board in 2017 and 2018 made the following recommendations, set out in **Exhibit 2**.

Exhibit 2: structured assessment recommendations made in 2017 and 2018

Recommendations
Information Governance (2017) R1 The Health Board needs to focus its attention on strengthening its information governance arrangements in readiness for the General Data Protection Regulations (GDPR), which come into force in May 2018. This should include: a. updating the information governance strategy; b. putting in place arrangements for monitoring compliance of the primary care information governance toolkit; c. developing and completing an Information Asset Register; d. ensuring that an identified data protection officer is in place; and e. improving the uptake of information governance training.
Information Technology (2017) R2 To ensure resilience to security issues, such as cyber-attacks, the Health Board should consider identifying a dedicated resource for managing IT security.

Recommendations

Information Governance (2018)

R1 The Health Board should complete the outstanding actions from the Information Commissioner's Office (ICO) 2016 review of the Health Board's data protection arrangements.

R2 The Health Board should achieve full compliance with the General Data Protection Requirement by May 2019.

R3 The Health Board should improve its response times to requests for information from Freedom of Information Act and Data Protection Subject Access Requests.

Information Technology (2018)

R4 The Health Board should complete a review of the structure and governance of its information and information technology functions to support delivery of the strategic digital approach.

R5 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.

Source: Audit Wales

6 In 2019, we decided that a follow up review would provide a timely opportunity to determine the progress that the Health Board has made on key (re-occurring in some cases) issues and relevant recommendations highlighted in our original reports.

7 Some of our previous recommendations and conclusions have overlapping themes, which we have considered when carrying out this follow-up review. As such, we have set out our findings under three themes that we believe the previous recommendations fall within. These are ICT governance, information governance, and IM&T resilience. We have set out to provide a picture of where the Health Board stands within each of the themes, using recommendations identified within the Structured Assessment work of 2017 and 2018 as focal points.

8 In undertaking this work, we interviewed Health Board staff to discuss progress and issues and requested and reviewed relevant documentation.

9 A summary of our findings is set out in the following section with more detailed information provided in **Appendix 1**. The findings reflect fieldwork that was

undertaken prior to the Covid-19 pandemic[1], however, where possible we have looked to update our findings on actions that have taken place since our fieldwork was undertaken

Our findings

10 We conclude that the Health Board has made some progress since previous ICT audits, like developing the Digital and Health Intelligence directorate, improving information governance compliance and working towards increasing its cyber capabilities, but disaster recovery arrangements do not appear to have moved on and the information governance action plan for implementing ICO recommendations and GDPR is still ongoing. We found that:

- A review and restructure of the Health Board's information and information technology functions to support delivery of the strategic digital approach is nearing completion;
- The Health Board has strengthened some areas of its information governance arrangements e.g. by improving response times to requests for information from Freedom of Information Act and Data Protection Subject Access Requests, but other areas still need further and continued improvement e.g. the uptake of appropriate training and management of information assets.
- The Health Board is working on strengthening its information and cyber security resources, but the resilience of key systems is still undertested.

11 The status of progress against each of the previous structured assessment recommendations is set out in **Exhibit 3**.

Exhibit 3: status of previous recommendations

Total number of recommendations	Implemented	In progress	Limited progress
11[2]	3	4	4

Source: Audit Wales

[1] In March 2020, the Auditor General for Wales suspended all onsite performance audit work, which included the clearance of draft reports, to allow NHS bodies to focus their attention on responding to the Covid-19 pandemic.

[2] Each sub-part of a recommendation counts as a single recommendation.

Recommendations

12 In undertaking this work, we have identified a number of new recommendations. These are set out in **Exhibit 4**. These are in addition to the recommendations that remain outstanding from the 2017 and 2018 structured assessments.

Exhibit 4: new recommendations for 2020

Recommendations	
R1	Include external audit recommendations, in addition to internal audit recommendations as part of the DHIC audit tracker.
R2	Ensure that appropriate arrangements are in place for the DHIC to have enough oversight and assurance over Information governance.
R3	Ensure that information asset owners are formally and regularly made aware of their role and responsibilities.
R4	Rollout appropriate and regular offline information governance training to employees without PC access.
R5	The Board should regularly seek assurance that their critical systems would be recoverable in a disaster recovery scenario.

Source: Audit Wales

Detailed report

Assessment of progress

13 The following table sets out our assessment of progress against previous recommendations.

Recommendation	Status	Progress
ICT governance R4 The Health Board should complete a review of the structure and governance of its information and information technology functions to support delivery of the strategic digital approach. (2018)	Implemented	During the latter half of 2019, the new Director of Digital & Health Intelligence, appointed in April 2019, carried out a directorate restructure. The new structure (**Appendix 2**) was planned to be in place by the end of the 2019 calendar year. As part of the directorate restructure, the information governance team merge with IT security and cyber security to form a team which reports directly to the Director of Digital and Health Intelligence The 2018 structured assessment reported that 'This year the Information Governance and Information Technology sub-committee has overseen the work of the Informatics Department. The sub-committee's focus on operational matters has been detrimental to more strategic issues such as overseeing strategic plan delivery and managing assurances. ICT and Information Governance (IG) now feed into a new Digital Intelligence and Health Committee (DHIC), the terms of reference of which were approved at the 28 November 2018 Board meeting. The Committee held its first meeting in August 2019 and will now meet three

Recommendation	Status	Progress
		times a year. Reporting to the Board, the Independent Member for ICT chairs the committee which has representation from key Executive officers. A newly created Digital Design Group was due to meet before the end of 2019 calendar year and will report to the DHIC. It is here that consideration and decisions relating to digital plans will be made. The Digital Design Group will be made up of Clinical Board Directors, Executives and Clinicians. Other reporting groups beneath the DHIC are under review. The DHIC maintains an audit tracker, but it only refers to internal audits at this stage. There is no evidence of tracking against external audits, such as previous Audit Wales ICT and IG recommendations. This makes it difficult for us to follow progress against our recommendations, and when or if they have been implemented. A new digital strategy 2020-2025 was approved at the July 2020 Board Meeting. Internal audit plan to review the Health Board's approach to developing the digital strategy in 2021-22, based upon their work when reviewing the creation of Aneurin Bevan University Health Board's digital strategy. This should help to inform the adequacy of the strategy. The section on cyber security is in complete but is understood that the strategy will evolve and change as local and national initiatives become clearer and are implemented. According to the DHIC 'A Work Plan to support the emerging Digital Strategy consists of multiple projects and programmes, both local and national which are grouped under the following headings: • Digitally included population • Digitally enabled workforce • Modern Architecture & Infrastructure.

Recommendation	Status	Progress
		The Health Board is developing a roadmap for delivery and is awaiting on the release of funding from the Welsh Government as part of its delivery. It was successful in gaining a Welsh Government Digital Funding allocation for 2019-20 of circa £3 million of capital and revenue to help commence the delivery of a programme of Digital Infrastructure transformation.
Information governance R1 The Health Board needs to focus its attention on strengthening its information governance arrangements in readiness for the General Data Protection Regulations, which come into force in May 2018. This should include (2017):		
a. updating the information governance strategy;	Limited progress	There is no specific information governance strategy document that sets out the Health Board's long-term IG vision and targets in a clear way, as per the 2016 Information Commissioners Office (ICO) data protection audit report recommendation. An overarching information governance policy which would support the strategy went to the DHIC on 3 December 2019 for approval, and is currently going through a ratification process, It is consolidated from the four national policies, information governance, IT security, email use, and internet use.
b. putting in place arrangements for monitoring	Limited progress	The Information Governance team does not actively monitor compliance of primary care Information Governance. The Primary Care team has its own Information Governance group, as well as its own clinical board. The Information Governance manager has identified

Recommendation	Status	Progress
compliance of the primary care information governance toolkit;		that GPs are responsible for their own information governance, and NWIS fulfil the role of data protection officer for them. Internal audit has however previously highlighted that there has been no checking that clinical boards are ensuring compliance, and there is limited visibility from the Information Governance team to clinical boards.
c. ensuring that an identified data protection officer is in place;	Implemented	A dedicated (interim, pending the finalisation of the directorate restructure) Data Protection officer and Information Governance manager is in place.
d. developing and completing an Information Asset Register; and	In progress	Work is still ongoing in relation to developing information asset registers (IAR). There is a single IAR for all major IT systems and each clinical board also has their own register which, according to the Health Board's information governance action plan, are variable in completion. The ICO data protection audit report in 2016 asked the Health Board to consider if these IARs will feed into a Health Board wide IAR or who will have oversight of all Information Assets across the organisation. The Information Governance team are in the process of contacting all information asset owners (IAOs) and requesting that they submit their IARs centrally so they can create an overarching register recognising that these need to be locally maintained on an ongoing basis. They aimed to complete the central register by December 2019. There is a list of IAOs, but only for the major IT systems. One reason suggested for this is that job roles change regularly so such a list would be difficult to maintain. We have

Recommendation	Status	Progress
		previously recommended that the Health Board allocate IAO responsibilities to an individual's job descriptions, so that they are formally aware of their responsibilities. In addition to this, the Information Governance action plan (resulting from the ICO audit) says that the issue of where responsibility lies in relation to the management of corporate information assets e.g. IT systems that have multiple users such as PMS, still needs to be resolved.
e. improving the uptake of information governance training	In progress	In 2018, compliance levels with online information governance training was 69%. For 2019, the level reached 72% as of December 2019. This is not a large increase in update, and below the national target of 95%, but providing offline information governance training, and accounting for it, may provide a clearer (and improved) picture of information governance training uptake in the future. The information governance staff training uptake statistics available (and reported upon) are based on the on-line training uptake. A lot of staff do not have access to PCs, so the Health Board has designed a training package, which will be delivered by directorate training officers, due to limited capacity in the Information Governance team to deliver it to everybody required. This has only been done in one area so far (Cardiac Thoracic) as part of a pilot to obtain feedback before rolling out to the other areas.
R1 The Health Board should complete the outstanding actions from the Information Commissioner's Office	Limited progress	The ICO data quality review gave limited assurance and made 66 recommendations. According to the July 2019 version of the Information Governance Improvement Plan, which was shared at the August 2019 DHIC, 40 of these recommendations are either still 'partially complete', or not complete. This compares to 56 in October 2018.

Recommendation	Status	Progress
(ICO) 2016 review of the Health Board's data protection arrangements. (2018)		In February 2020 the Information Commissioner's Office (ICO) undertook an audit of the Health Board's Information Governance & Accountability and Cyber Security. The ICO has upgraded its assurance in these areas to 'reasonable', and new recommendations have been made. In a paper to the July 2020 DHIC the Information Governance Manager states that acting upon these recommendations will be dependent on implementation of the new Digital Health and Intelligence structure, which includes a bespoke Cyber Security Department will enable the completion of the ICO recommendations.
R2 The Health Board should achieve full compliance with the General Data Protection Requirement by May 2019. (2018)	In progress	Since the creation of the Health Board's 2016 ICO recommendations action plan, there has been an internal audit on GDPR preparedness and the rollout of GDPR itself, both of which came with additional actions. These actions are supposed to now form part of one overarching information governance action plan, but we have only identified the actions from the ICO review within it. As specific GDPR actions are not easily identifiable, it is difficult to comment on the current level of GDPR compliance. It is anticipated that the Health Board's action plan to meet GDPR compliance will now be based upon recommendations made by the ICO's audit of the Health Board's Information Governance & Accountability and Cyber Security that was undertaken in February 2020.
R3 The Health Board should improve its response times to requests for information from	Implemented	The FOIA request backlog has decreased as the Information Governance team has increased its capacity. The FOIA response rate within the required time was at 86% at April 2019, which dropped to 79% in June 2019, due to annual leave of those who deal with the request. At October 2019, the rate was over 90%. This has improved significantly compared to the 40% reported in the 2018 structured assessment. In order to maintain or increase its

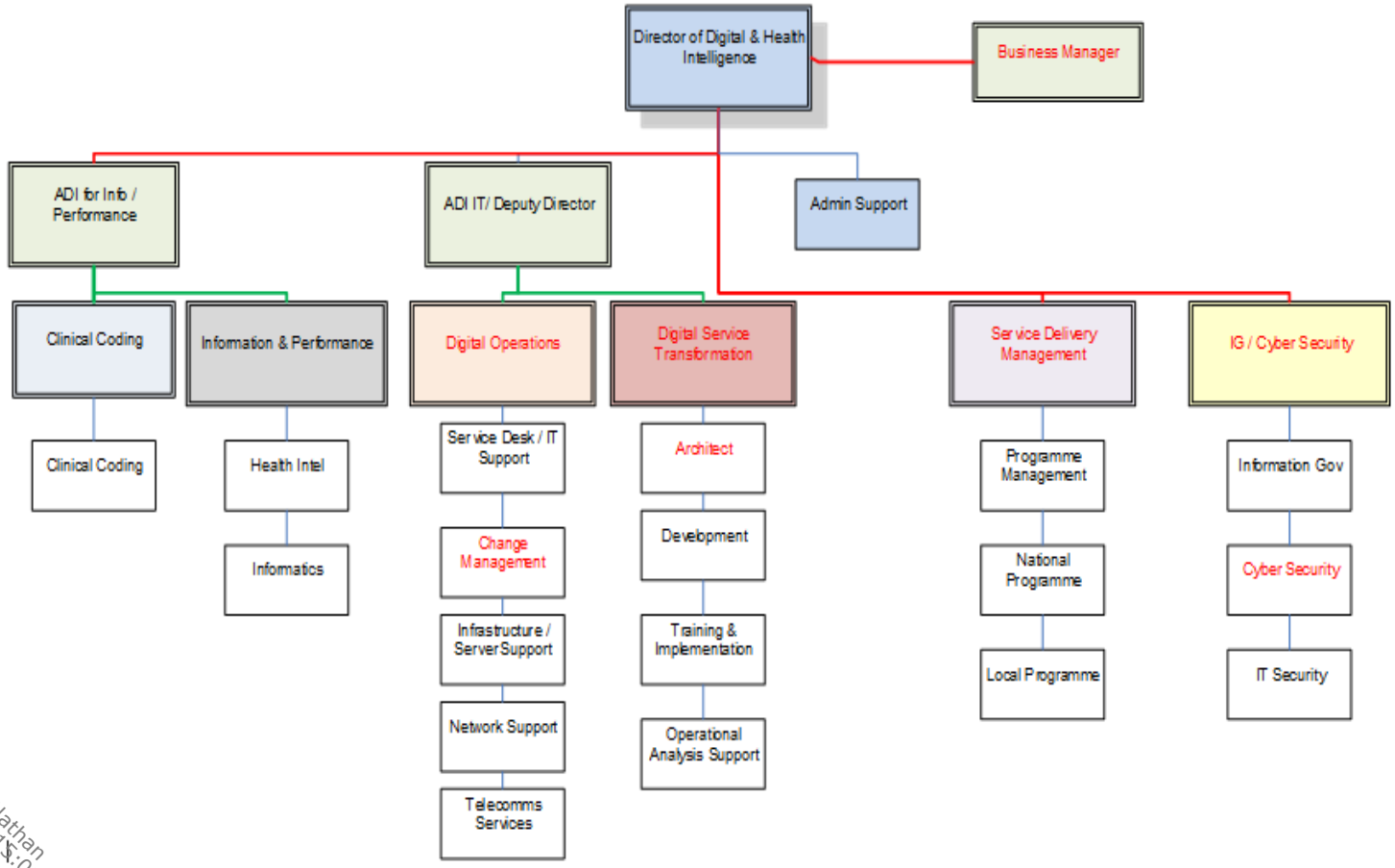
Recommendation	Status	Progress
Freedom of Information Act (FOIA) and Data Protection Subject Access Requests. (2018)		ability to respond to FOIA requests, the Health Board should consider the impact of annual leave on its response rate and mitigate any associated risks. The Data Protection Act (DPA) Subject Access Requests (SAR) response rate is over 90% for staff data requests, which are dealt with by the Information Governance team. This is fairly static compared to the previous year. The Medical Records Access Team manage Patient Data SARs. The average compliance for April 2019 was 60.5%, increasing to above 83% in June 2019. This compares significantly better to the 44% compliance highlighted in the 2018 structured assessment. Compliance with FOI and SAR response rates are monitored by the DHIC. The Health Board should aim to consistently meet compliance targets for FOIA requests and SARs.
IM&T resilience R5 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. (2018)	Limited progress	In 2014, we commented that 'Disaster recovery is still a mixed responsibility between ICT and the specific clinical departments'. This is still the case. The Health Board's current list of IT hosted or backed up servers states that, 'the list includes data from draft documents that may not have been confirmed by system managers or data owners or may only have been confirmed many years ago and never re-validated for changes.' In this instance our recommendation from our 2012 IT backup arrangements review '(Clearly identify all named data owners across the Health Board and confirm their delegated responsibility for ensuring all data is backed up appropriately') is still relevant. If lists of data owners for systems are not kept up to date, or data owners are not formally aware of their responsibilities, there is a risk of a gap in system backups, disaster recovery, and business continuity arrangements. Full disaster recovery testing on key systems is not carried out. Staff interviewed state that disaster recovery testing is not possible on any of the Health Board's critical systems, and

Recommendation	Status	Progress
		that it would require substantially more resources than the Health Board currently invests in IT to undertake such activity and would also require substantial input on any given disaster recovery test by the service departments in question. Staff also believe that it would also come at substantial risk to the services concerned in case data was lost in the process. Conversely however, the information governance action plan states (in response to the ICO recommendation 'Ensure there are suitable disaster recovery plans in place covering all business critical records.') that the Health Board has partially implemented the recommendation, and '…disaster recovery and business continuity plans need to be tried, tested and regularly reviewed'. This is a conflicting message, because the Health Board says that it needs to try, test, and regularly review its plans, but then on the other hand states that it is unable to do this. This message needs some clarity and consistency. Without carrying out appropriate disaster recovery testing, there is a risk that the Health Board does not have assurances that its critical systems are adequately resilient and/or could be recovered if an incident or disaster scenario occurred.
R2 To ensure resilience to security issues, such as cyber-attacks, the Health Board should consider identifying a dedicated resource for managing IT security. (2017)	In progress	The Health Board requested funding for three-years from the Welsh Government to support its cyber security plans. £186,000 revenue and £250,000 capital for the first year, with requirements that the revenue element would need to be annually recurring. The first year's funding was confirmed in October 2019, to support investment in cyber resource and infrastructure. Recruitment and procurement plans are now underway. The Health Board believe that delays in the Welsh Government releasing funding has held back its ability to developing its cyber specialisms and has had to re-prioritise staff workloads to deal with cyber, having a knock-on effect on other areas of delivery. It is not anticipated that current staff will be retrained, but specialist staff will be employed. The

Recommendation	Status	Progress
		Health Board is looking to take on three new members of staff in this area (including a Head of Cyber Security) as part of the proposals for the new Digital and Health Intelligence directorate structure. As other health boards will be looking to take on similar staff, recruitment area is likely to be competitive. As referred to earlier in this report, cyber security will become part of a joint team with information security and information governance, reporting directly to the Director Digital and Health Intelligence. Cyber Security Updates also now occur at the DHIC. The May 2019 Internal Audit cyber security review highlighted that 'Although there is an Information Security Policy, together with other related policies, there is no structured mechanism for providing regular updates or reminders to staff on good practice related to cyber security. Studies have shown that in general, employee actions or mistakes have led to approximately 50% of breaches. As such, this leads to an increased risk to the Health Board. It recommended that 'Regular cyber security "bulletins" should be published via the intranet, with reminders of good practice.' This action is still in progress. The Health Board does have a bespoke cybersecurity training package available to staff. This however is not mandatory, but staff are encouraged to do it. The findings from the February 2020 ICO audit into cyber security and information governance should provide further guidance to the Health Board in relation to its IT security.

Appendix 1

The new Digital & Health Intelligence directorate structure



Appendix 2

Management response

The following table sets out the Health Board's management response to the recommendations arising from this work (**to be added after the report and management response has been considered by Audit Committee**).

Ref	Area for improvement	Management response	Completion date	Responsible officer

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Catherine Phillips
Director of Finance
Cardiff & Vale UHB

Reference: AV/MJ

Date issued: 5 March 2021

Dear Catherine

Audit fee outturn for the past year and the fee estimate for the year ahead

I hope you are settling in well to your new role at the Health Board. I look forward to meeting you on 17 March. In the meantime, I am writing to you about our audit fee.

When I presented our 2021 Audit Plan to the Audit and Assurance Committee on 9 February, I could not confirm the audit fee within the Audit Plan. This was because our 2021-22 Fee Scheme was due to be considered by the Senedd's Finance Committee, later that month. The Finance Committee duly considered and approved the Fee Scheme, which you can now access on our website. You will note that the approved fee rates are unchanged from last year.

As intended, I can now provide you with an update on our fee outturn for the past year and our fee estimate for 2021. The figures are exhibited on page 2. In summary, this year's fee estimate is £10,000 (2.6%) higher than last year's fee estimate; and £5,000 (1.3%) lower than last year's actual fee.

You will note from the exhibit that, going forward, we will be providing separate fee estimates for our financial audit work on the Health Board's accounts[1] and its Charitable Fund. My colleague Mark Jones discussed this change with Chris Lewis last month. I will of course be communicating the Charitable Fund fee to the trustee independent members (those charged with governance) in due course.

[1] The audit of the Performance Report, Accountability Report and Financial Statements.

The overall performance audit fee for 2021 remains the same as the previous year and all fees shown are exclusive of VAT, which is not charged to you. Our planning is ongoing and changes to our programme of audit work, and therefore the fee, may be required if any new risks emerge. I shall make no changes to this year's fee estimate without first discussing them with you.

Exhibit 1: audit fee

Audit area	Fee estimate for 2021 (£)	Fee estimate for 2020 (£)	Actual fee for 2020 (£)
Financial audit work			
• Health Board	225,000	235,000[2]	250,000[3]
• Charitable Fund	20,000	0	0
Financial audit total	**245,000**	**235,000**	**250,000**
Performance audit work:			
• Structured Assessment	70,141	60,437	60,437
• All-Wales thematic reviews	72,128	70,640	70,6340
• Local projects	13,383	24,575	24,575
Performance audit total	**155,652**	**155,652**	**155,652**
Total fee	**400,652**	**390,652**	**405,652**

[2] The 2020 audit fee includes the cost of the audit of the Charitable Fund. The Health Board billed the Charitable fund £10,000, as it has done for many years.

[3] The actual billable fee was £15,000 higher than the fee estimate. The additional cost relates to the audit of the Charitable Fund.

We intend to present this letter to the Audit and Assurance Committee on 6 April. In the meantime, please do not hesitate to contact me if you wish to discuss any of the above.

Yours sincerely,

Anthony Veale
Engagement Director

Report Title:	**Review the System of Assurance**								
Meeting:	Audit Committee						**Meeting Date:**	06/04/21	
Status:	**For Discussion**	**x**	**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

Cardiff and Vale UHB Board have a number of tools in place which already provide assurance. However, in setting out to review the system of assurance I felt it was important to recognise that this range of tools could be further developed into a more comprehensive Assurance Framework thereby improving assurance and governance of the Health Board.

This report sets out how an Assurance Framework could be developed to aid the Board not only in providing overall assurance but also identifying areas of weakness.

Developing an Assurance Framework for the Board would also further improve the governance of the Health Board and support the achievement of the Health Boards Strategic objectives

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

Assurance is a term often used although not always fully defined or understood. Within the NHS it has become an ever important concept. The introduction (over 10 years ago) of the requirement for a Chief Executive, as Accountable Officer, to write and publish an Annual Governance Statement (Accountability report) made sure that public sector organisations were able to demonstrate they were properly informed about the totality of their risks and governance frameworks.

Over a number of years organisational failures have been attributed to poor governance and/or failings in risk management. The response to these failings has been more controls being put in place via legislation and the publication of codes of governance. Unfortunately failures have continued to occur therefore focus needs to shift to Boards knowing and understanding what is being undertaken in their name.

The aim of developing a comprehensive Assurance Framework will be to ensure that there is a common understanding of what is meant by assurance and its importance in a well-functioning Health Board.

The Assurance Framework will be underpinned by a robust governance framework with clearly defined and understood strategic objectives, a developed maturity in relation to risk management and effective internal controls.

It is important to note that the aim of the Assurance Framework will be to add value to the Health Board by eliminating duplication of effort and resources, reducing the burden of bureaucracy and to provide a central point of expertise in relation to governance, risk management and assurance.

Tools which comprise the Assurance Framework:

For a fully developed Assurance Framework to be in place there are a number of tools which can be used in order to provide evidence that the controls are working or indeed not working. By using the tools to map the various sources of assurance issues, gaps in controls and/or gaps in assurance can be identified much like the Board Assurance Framework but across the whole organisations.

These include:

- Board Assurance Framework
- Internal Assurance Reviews
- External Reviews e.g. HIW
- Health Board Commissioned reviews
- Regulatory and accreditation systems
- Internal Audit Reviews
- Clinical Audit
- External Audit / Audit Wales Reviews
- Stakeholder Feedback
- Assurance Map
- Assurance Directory

Reporting and use of the information

The various mechanisms and tools will enable the information which is produced to be assessed in terms of its value thereby enabling any gaps in assurance to be identified and reported at an appropriate level and addressed where necessary. This will mean that weaknesses will be identified in a more systematic way.

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

Below is a list of assurance tools already in place (noting that the list is not exhaustive) at Cardiff and Vale UHB:

Tool	In place yes/no
Board Assurance Framework	Yes
Internal Assurance Reviews	Yes
External Reviews e.g. HIW	Yes
Health Board Commissioned reviews	Yes
Regulatory and accreditation systems	Yes
Internal Audit Reviews	Yes
Clinical Audit	Yes
External Audit / Audit Wales Reviews	Yes

Stakeholder Feedback	Yes
Assurance Map/s	No
Assurance Directory	No

An **assurance map** could be created to obtain clarification in relation to assurance currently provided . There is more than one purpose for a map and it will depend on who wants the assurance and why. One map cannot be everything to everyone particularly in a large complex organisation such as Cardiff and Vale UHB. Therefore a number of different maps should be produced at various levels of the organisation. The mapping of assurances can identify gaps as well aswell as duplications of assurance thereby reducing the amount of irrelevant information provided.

An **assurance directory** is a central register of assurances, detailing the types and value (age, relevance, reliability, independence) of assurance.

You can also assess the level of assurance that you are receiving from the tools in place. There are three levels of assurance (lines of defence) that can be sought and these are:

Level 1 – Management
Level 2 – Oversight functions such as Committees of the Board
Level 3 – Independent (audits, reviews and inspections)

Below are some examples of some sources of assurance already in place at Cardiff and Vale UHB describing the scope and level of asurance already provided. By mapping this out further and developing an Assurance Framework the Board would be able to idenfity the gaps in assurance more easily.

Tool	Scope	Process	Type	Level		
				1	2	3
Board Assurance Framework	Describes risks to achievement of key objectives	Discussed with Executives, Reported to Board and audited annually as part of risk mangement arrangements	Written	✓	✓	✓
Internal Audit	All areas related to corporate goveranance, risk management and internal control	HOIAO and individual review reports	Written			✓

You can also map out assurances on a given topic, area, target or risk to gain assurance or identify where more assurance may be required.

Recommendation:

For the Audit Committee to approve the development of a comprehensive Assurance Strategy for the implementation of a Framework of 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	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	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	

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.*

Report Title:	**Draft Accountability Report 2020-2021**									
Meeting:	Audit Committee						**Meeting Date:**	6/4/21		
Status:	**For Discussion**	**x**	**For Assurance**		**For Approval**		**For Information**	**x**		
Lead Executive:	**Director of Corporate Governance**									
Report Author (Title):	**Interim Head of Corporate Governance**									

Background and current situation:

1. **BACKGROUND**

In response to the unprecedented COVID-19 situation and the effect it has had on government entities, HM Treasury has reviewed the financial reporting requirements for 2020-21. In order to ease the burden on preparers of government annual reports and accounts (ARAs), minimum reporting requirements as per the Financial Reporting Manual (FReM) are in place for a limited time and only relate to non-audited elements of ARAs. Entities may go beyond the minimum requirements where they are able to.

NHS bodies are required to publish, as a single document, a three-part annual report and accounts which includes:

a. The **Performance Report**, which must include:
   - An overview
   - A Performance analysis

b. The **Accountability Report** demonstrates how the UHB meets key accountability requirements to the Welsh Government and is required to have three sections:
   - **The Corporate Governance Report** - This explains the composition and organisation of the UHB's governance structures and how they support the achievement of the entity's objectives.
   - **Remuneration and Staff Report** - This contains information about the remuneration of senior management, fair pay ratios, sickness absence rates etc.
   - **National Assembly for Wales Accountability and Audit Report** - This contains a range of disclosures on the regularity of expenditure, fees and charges, compliance with the cost allocation and charging requirements set out in HM Treasury guidance, material remote contingent liabilities, long-term expenditure trends, and the audit certificate and report.

c. The **Financial Statements**

For 2020-21,

- there will be no requirement to prepare a separate Annual Quality Statement. However, there is a still a need to provide assurance on quality governance arrangements within the Annual report,
- entities applying the FReM are permitted to omit the performance analysis section of the Performance Report. Where content is common between the Performance Overview and the Annual Governance Statement it will not be necessary to duplicate the information.
- there is no requirement to report in the Annual Report and Accounts against the Sustainability Reporting Requirements, however C&VUHB will include this information in

the report to demonstrate its commitment to the achievement of the WBFG objectives.

The structure adopted is the one described in the FReM. NHS bodies may omit headings or sections where they consider that these are not relevant but all of the content outlined in the manual should be included.

2.CURRENT SITUATION

2.1 Accountability Report

The draft Annual Report provides useful information to our public and staff, holds us accountable for what we do and both celebrates our achievements and acknowledges our challenges and what we intend to do about them. The draft Accountability Report for 2020-2021 is presented at ***Appendix 1*** for information. There are a number of gaps in information which will be completed as the information becomes available in April and May 2021.

The timetable for developing the Annual report in readiness for submission to Welsh Government a single unified document by 11 June 2021 is outlined in Table 1 below:

Table 1 – Timetable for Creating C&VUHB Annual Report 2020-2021

Date	Task
29 March	Draft report to Management Executives Group
31 March	Draft Accountability report to be submitted to Internal Audit & Audit Wales
6 April	Internal Audit to receive draft Performance Report (including Wellbeing Statement Sustainability) and the Accountability report
26 April	Draft Accountability, remuneration and staff report reviewed by Management Executive Group
29 April	Board Development Session Board Approve Accounts for Submission to WG & WAO
30 April 12 noon	**Draft Accounts to be submitted to HSSG Finance and Audit Wales**
7 May	**Draft Performance Report Overview, Accountability Report (including the Annual Governance Statement), and Draft Remuneration Report be submitted to HSSG Finance and Audit Wales**
7 May	Send the document to the Medical Illustration Team for graphic design work
13 May	Audit Committee Workshop Endorse Sign off by Board draft Performance Report (including Wellbeing Statement Sustainability) and the Accountability report
13 May	Send any updates from Audit Committee to the Medical Illustration Team for graphic design work

10 June	Comments back from WG to be incorporated for approval of the Final Annual Report by Audit Committee
11 June	**Final Annual Report and Accounts to be submitted by to Welsh Government HSSG Finance and Audit Wales to, as a single unified PDF document.**
11 June	Send the final Annual Report to Cardiff Council's Welsh Language Translation unit
15 June	WG to issue Debtor & creditor Matrix Income and expenditure matrix by 15 June 2021
5 July	Send Welsh version to Medical Illustration Team to design Welsh version
19 July	Bilingual version of the Annual Report available
22 July	Send Bilingual Annual Report 2020-2021 out in Annual General Meeting (AGM) papers
29 July	Present bilingual Annual Report 2020-2021 to the AGM
29 July	Publish on website, email to key stakeholders etc

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

The Audit Committee is requested to discuss and support the content of the Accountability Report, providing any feedback that is relevant to its objective, to the Director of Corporate Governance by Wednesday, 13 May 2021, in order to provide assurance to the Board that a robust governance process was enacted during the year.

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

The Government Financial Reporting Manual (FReM) sets out core guidance for preparing government annual reports and accounts in the United Kingdom. It complements guidance on the handling of public funds published separately by the relevant authorities in England and Wales, Scotland and Northern Ireland, where these are issued.

The Welsh Ministers have directed that the Chief Executive should be the Accountable Officer of Cardiff & Vale University Health Board. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and or the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Welsh Government.

Similar to all other large corporate bodies the Health Board is required to publish an annual report each year by the end of July. These are presented formally at the annual public

meeting, which is also held in July each year. The content is prescribed by regulation but in essence the annual report is an important public facing document that provides an oversight of what has been happening during the year within the Health Board, how we have been performing and how we have spent our money.

Recommendation:

The Audit Committee are requested to:

- **NOTE** the minimum reporting requirements outlined in Chapter 3 of the Financial Reporting Manual (FReM) guidance for collating an Annual Report for 2020-2021 as a consequence of the COVID-19 pandemic,
- **NOTE** and **DISCUSS** the draft Accountability Report 2020-2021, acknowledging that there are gaps in information, which will be completed in April/May 2021**,**
- **NOTE** that an Audit Committee Workshop is being held on the 13 May 2021 to endorse Sign off by the Board on the draft Performance Report (including Wellbeing Statement Sustainability) and the Accountability 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	✓
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	✓	Involvement	✓

Equality and Health Impact Assessment Completed:	Not Applicable

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Part 2a
Accountability Report

Chapter 2a Accountability Report

SCOPE OF THE ACCOUNTABILITY REPORT

The purpose of the accountability section of the annual report is to meet key accountability requirements to the Welsh Government, provides an overview of the governance, accountability arrangements and structures that were in place across C&VUHB during 2020-2021. It includes:

- Corporate Governance Report
- Remuneration and Staff Report
- Parliamentary Accountability and Audit Report

11. CORPORATE GOVERNANCE REPORT

11.1 Directors Report

The Composition of the Board

Part 2 of The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 sets out the required membership of the Boards of Local Health Boards, the appointment and eligibility requirements of members, the term of office of independent members and associate members. In line with these Regulations, the Board of Cardiff and Vale University Health (the Health Board) comprises 20 voting members, with additional 3 non-voting members including:

- a chair;
- a vice-chair;
- officer members;
- independent members; and
- associate members.

The Board provides leadership and direction to the organisation and is responsible for governance, scrutiny and public accountability, ensuring that its work is open and transparent by holding its meetings in public. As a result of the public health risk linked to the pandemic the UK and Welsh Government (WG) stopped public gatherings of more than two people and it is therefore not possible to allow the public to attend meetings of our board and committees since March 2020.

The members of the Board are collectively known as “the Board” or “Board members”; the officer and independent members (which includes the Chair) are referred to as Executive Directors and Independent Members respectively. All Independent Members and Executive Director Members have full voting rights.

The Health Board has 10 Independent Members (including Chair and Vice-Chair), all of whom are appointed by the Minister for Health and Social Services. There are 9 Executive Directors.

In addition, Welsh Ministers may appoint up to 3 Associate Members. Associate Members have no voting rights. There are also 2 Director posts and the Board Secretary who form part of the Executive Team who also have no voting

rights.

Before an individual may be appointed as a member or associate member they must meet the relevant eligibility requirements, set out in Schedule 2 of The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulation 2009, and continue to fulfil the relevant requirements throughout the time that they hold office. The Regulations can be accessed via the following link: http://www.wales.nhs.uk/governance-emanual/regulations-constitution-membershipand-

Voting Members of the Board During 2020-2021

During 2020-2021, the following individuals were full voting members of the Board of the Health Board:

Name	Role	Dates	Board Committee Membership
INDEPENDENT MEMBERS			
Charles Janczewski	Chair	Interim Chair April-Jun 2021 Chair Jun 2020 -March 2021	• Board • Board of Trustee • Mental Health & Capacity Legislation (MHCL) • Quality, Safety & Experience (QSE) • Audit • DHIC • RATS • Strategy & Delivery
Michael Imperato	Vice Chair	April 2020- March 2021	• Board • Board of Trustee • Health & Safety • MHCL • QSE • Audit • DHIC • RATS • Strategy & Delivery
Professor Gary Baxter	Independent Member - University	April 2020- March 2021	• Board • Board of Trustee • QSE • DHIC • Strategy & Delivery
Eileen Brandreth	Independent Member Information Communication and Technology	April 2020- March 2021	• Board • Board of Trustee • MHCL • Audit • DHIC • RATS
Councillor Susan Elsmore	Independent Member Local Authority	April 2020- March 2021	• Board • Board of Trustee • Charitable Funds • QSE • RATS

Name	Role	Dates	Board Committee Membership
Akmal Hanuk	Independent Member Local Community	April 2020- March 2021	• Board • Board of Trustee • Charitable Funds • Health and Safety • MHCL • QSE • RATS
Sara Mosely	Independent Member Third (Voluntary) Sector	April 2020- March 2021	• Board • Board of Trustee • Charitable Funds • MHCL • RATS • Strategy & Delivery
Dr Rhian Thomas	Independent Member Capital & Estates	April 2020- March 2021	• Board • Board of Trustee • Health and Safety • RATS • Strategy & Delivery
John Union	Independent Member Finance	April 2020- March 2021	• Board • Board of Trustee • Charitable Funds • Audit • RATS
Dawn Ward	Independent Member Trade Union	April 2020- January 2021	• Board • Health and Safety • QSE • Audit
Executive Director Members			
Len Richards	Chief Executive	April 2020- March 2021	• Board • Board of Trustee • DHIC • RATS
Robert Chadwick	Executive Director of Finance	April 2020- ???	• Board • Board of Trustee • Charitable Funds • QSE • Audit • DHIC
Christopher Lewis	Interim Executive Director of Finance	??? – 28th February 2021	• Board • Board of Trustee • Charitable Funds • QSE • Audit • DHIC
Catherine Phillips	Executive Director of Finance	1st March 2021- 31st March 2021	• Board • Board of Trustee • Charitable Funds • QSE • Audit • DHIC

Name	Role	Dates	Board Committee Membership
Dr Stuart Walker	Executive Medical Director	April 2020- March 2021	• Board 7 • Board of Trustee • QSE • Audit • Strategy & Delivery
Ruth Walker	Executive Director of Nursing	April 2020- March 2021	• Board • Board of Trustee • Charitable Funds • Health and Safety • QSE • MHCL • Strategy & Delivery
Steve Curry	Chief Operating Officer	April 2020- March 2021	• Board • Board of Trustee • MHCL • QSE • Audit • Strategy & Delivery
Abigail Harris	Executive Director of Strategic Planning	April 2020- March 2021	• Board • Board of Trustee • Strategy & Delivery
Dr Fiona Jenkins	Executive Director of Therapies and Life Sciences	April 2020- March 2021	• Board • Board of Trustee • Charitable Funds • QSE • Strategy & Delivery
Martin Driscoll	Executive Director of Workforce & OD	April 2020- 28 Feb 2021	• Board • Board of Trustee • Health and Safety • Audit • RATS • Strategy and Delivery
Rachel Gidman	Interim Executive Director of Workforce & OD	1-31 March 2021	• Board • Board of Trustee • Health and Safety • Audit • RATS • Strategy and Delivery
Fiona Kinghorn	Executive Director of Public Health	April 2020- March 2021	• Board • Board of Trustee • QSE • Strategy and Delivery

On 23 March 2020 the Welsh Government suspended all Ministerial Public Appointment campaigns with immediate effect, and this suspension was lifted in September 2021. During

2020-2021, there were three independent member vacancies for Trade Union, ICT and the Vice Chair position, all of which were filled successfully.

During 2020-2021, there were two executive director vacancies, which were filled as follows:

- Catherine Phillips, Executive Director of Finance from 1 March 2021,
- Rachel Gidman, Interim Executive Director of Workforce & organisational Development (WODS) from 1 March 2021

Associate Members/Non-Voting Members of the Board During 2020-2021

During 2020-2021, there were 3 Associate Members and 2 non-voting officer members of the Board, as outlined in the tables below:

Name	Role	Dates	Board Committee Membership
ASSOCIATE MEMBERS			
Geoffrey Simpson	Interim Chair, Stakeholder Reference Group	April 2020- March 2021 New SRG Chair need to check when from	• Board
Sue Bailey	Chair, Healthcare Professionals' Forum	April 2020- March 2021- has resigned check date -NF	• Board
Lance Carver	Director of Social Services, Vale of Glamorgan	April 2020- March 2021	• Board

Name	Role	Dates	Board Committee Membership
NON-VOTING MEMBERS			
Nicola Foreman	Director of Corporate Governance	April 2020- March 2021	• Board • Board of Trustee • Charitable Funds • Health and Safety • MHCL • QSE • Audit • DHIC • RATS • Strategy and Delivery
Allan Wardaugh	Chief Clinical Information Officer	April 2020- March 2021	• Board

The Annual Governance Statement also contains further information in respect of Board and Committee Activity.

Audit Committee

The membership of the Audit Committee during 2020-2021, providing the required expertise was as follows:

Name	Role	Dates
INDEPENDENT MEMBERS		
John Union	Committee Chair	April 2020- March 2021
Eileen Brandreth	Committee Vice Chair	April 2020- March 2021
Dawn Ward	Independent Member Trade Union	April 2020- January 2021

Declaration of Interests

Details of company directorships and other significant interests held by members of the Board which may conflict with their responsibilities are maintained and updated on a regular basis. A Register of Interests is available on the Health Board's website by clicking on the following link ADD LINK or a hard copy can be obtained from the Board Secretary on request.

Personal Data Related Incidents

Information on personal data related incidents which have been formally reported to the Information Commissioner's office and "serious untoward incidents" involving data loss or confidentiality breaches and details of how the risks to information are managed are detailed on page XX of the Annual Governance Statement.

Environmental, Social and Community Issues

These are included on page xx of the Annual Governance Statement.

Statement of Public Sector Information Holders

As the Accountable Officer of the Cardiff & Vale University Health Board, and in line with the disclosure requirements set out by the Welsh Government and HM Treasury, I confirm that the Health Board has complied with the cost allocation and charging requirements set out in HM Treasury guidance during the year.

Signed by.....

Len Richards, Chief Executive

Date.....

11.2. Statement of Accounting Officers Responsibilities

The Welsh Ministers have directed that the Chief Executive should be the Accountable Officer of Cardiff & Vale University Health Board.

The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Welsh Government.

I can confirm that:

- To the best of my knowledge and belief, there is no relevant audit information of which Cardiff & Vale University Health Board Board's auditors are unaware, and I have taken all steps that ought to have been taken to make myself aware of any relevant audit information and established that the auditors are aware of that information.
- Cardiff & Vale University Health Board's annual report and accounts as a whole are fair, balanced and understandable and I take personal responsibility for the annual report and accounts and the judgements required for determining that it they are fair, balanced and understandable.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed by.....

Len Richards, Chief Executive

Date.....

Statement of Directors' Responsibilities in Respect of the Accounts

The directors are required under the National Health Service Act (Wales) 2006 to prepare accounts for each financial year.

The Welsh Ministers, with the approval of the Treasury, direct that these accounts give a true and fair view of the state of affairs of the Cardiff & Vale University Health Board and of the income and expenditure of the Cardiff & Vale University Health Board for that period.

In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting principles laid down by the Welsh Ministers with the approval of the Treasury
- make judgements and estimates which are responsible and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the account.

The directors confirm that they have complied with the above requirements in preparing the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the authority and to enable them to ensure that the accounts comply with the requirements outlined in the above mentioned direction by the Welsh Ministers.

By Order of the Board
Signed:
On behalf of the Chairman: Charles Janczewski……Dated: ……2021

Chief Executive: Len Richards…… Dated: ……2021

Director of Finance: Catherine Phillips ……Dated: ……2021

Part 2a

Annual Governance Statement

11.3 ANNUAL GOVERNANCE STATEMENT

1.Scope of Responsibility

The Board is accountable for Governance, Risk Management and Internal Control. As Chief Executive of the Board, I have responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and the organisation's assets for which I am personally responsible. These are carried out in accordance with the responsibilities assigned by the Accountable Officer of NHS Wales.

This Annual Governance Statement details the arrangements in place during 20202-2021 to discharge my responsibilities as the Chief Executive Officer of the Health Board, and to manage and control the Health Board's resources. It also details the extent to which the organisation complies with its own governance arrangements, in place to ensure that it fulfils its overall purpose, which is that it is operating effectively and delivering quality and safe care to patients, through sound leadership, strong stewardship, clear accountability, robust scrutiny and challenge, ethical behaviours and adherence to our set values and behaviours. It will set out some of the challenges and risks we encountered and those we will continue to face going forward.

At the time of preparing this Annual Governance Statement, the UHB and the NHS in Wales continues to face unprecedented and increasing pressure in planning and providing services to meet the needs of those who are affected by COVID-19, whilst also planning to resume other activity where this has been impacted.

The required response has meant the whole organisation has had to work very differently both internally and with our staff, partners and stakeholders and it has been necessary to revise the way the governance and operational framework is discharged. In recognition of this, Dr Andrew Goodall, Director General Health and Social Services/NHS Wales Chief Executive wrote to all NHS Chief Executives in Wales, with regard to "COVID-19 – Decision Making and Financial Guidance". The letter recognised that organisations would be likely to make potentially difficult decisions at pace and without a firm evidence base or the support of key individuals which under normal operating circumstances would be available.

Nevertheless, the organisation is still required to demonstrate that decision-making has been efficient and will stand the test of scrutiny with respect to compliance with Managing Welsh Public Money and demonstrating Value for Money after the COVID-19 crisis has abated and the organisation returns to more normal operating conditions.

To demonstrate this the organisation is recording how the effects of COVID-19 have impacted on any changes to normal decision making processes, for example through the use of a register recording any deviations from normal operating procedures. Where relevant these, and other actions taken have been explained within this Annual Governance Statement.

The Annual Governance Statement details the arrangements in place for discharging the Chief Executive's responsibilities to manage and control the UHB's resources during the financial year 2020-2021; however due to the ongoing situation with

COVID-19, this year's Statement is extended to cover the period up to the date of its approval on 29 June 2020 especially around the UHB's response to the ongoing pandemic. It also sets out the governance arrangements to ensure probity, that strategic and delivery plans are in place, risks mitigated and that we have appropriate controls to govern corporate and clinical situations.

Planning has and will remain fluid and responsive to incoming data, and the Health Board is now adjusting its planning assumptions as it anticipates that it will experience a series of peaks in demand for critical care and bed capacity over the next 8–12 months, the timing and scale of which is currently unknown. Therefore, the Health Board is developing careful plans to restart normal services on a clinically prioritised basis whilst maintaining all essential services, alongside managing increased demand from COVID-19, and understanding the impacts of suspended/scaled back services on delivery, quality and safety, finances and performance.

Escalation and Intervention Arrangements

Following a tripartite meeting between Welsh Government, HIW and Audit Wales in early October, we were notified that we will be maintaining our rating of 'routine arrangements.' The Director General of Health & Social Services/Chief Executive NHS Wales also recognised the professional and considered way in which the NHS and the UHB responded to the extraordinary circumstances of the pandemic response

During the period 2020-2021, with the exception of the impact of the Covid 19 pandemic, no serious issued were identified to affect NHS delivery, quality and Safety of care and organisational effectiveness, and Cardiff & Vale UHB have continued to be monitored through "routine arrangements" since December 2019[1].

Integrated Medium Term Plans (IMTP) (check with Planning)

In March 2020 the Health Board received confirmation from the Minister for Health and Social Services, that our three year Integrated Medium Term Plan (IMTP) was approved by Welsh Government. The IMTP is a statutory document and marks a significant step forward. This was the first time in three years that this had been approved by Welsh Government and alongside improving our position from targeted intervention to enhanced monitoring this was a double achievement.

In March 2020, due to the COVID-19 pandemic the IMTP process was paused and Quarterly Frameworks were introduced for NHS Wales. Organisations were required to produce quarterly plans addressing the priorities set out in these frameworks. This enabled the Health Board to allow all resources to be redirected to sustaining key services.

The monitoring of its progress is embedded in our approach to performance management and governance across the UHB.

[1] Written Statement: Escalation and Intervention Arrangements (7 October 2020) | GOV.WALES

Our Governance Framework

Standing Orders and Scheme of Reservation and Delegation

At a local level, Health Boards in Wales must agree Standing Orders for the regulation of proceedings and business. They are designed to translate the statutory requirements set out in the LHB (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day to day operating practice, and, together with the adoption of a scheme of matters reserved to the Board; a Scheme of Delegation to officers and others; and Standing Financial Instructions, they provide the regulatory framework for the business conduct of the UHB and define - its 'ways of working'. These documents, together with the range of corporate policies set by the Board make up the Governance Framework. These are available from XXX. The Board approved the All Wales Model Standing Orders, Reservation and Delegation of Power for Standing Orders at its xxxxxxx Board meeting. The Board functions as a corporate decision-making body with Executive Directors and Independent Members being equal members, sharing corporate responsibility for all decisions and playing a key role in monitoring performance against strategic objectives and plans.

The principal role of the Board is to exercise effective leadership, direction and control, including:

- Setting the overall strategic direction of the UHB;
- Establishing and maintaining high levels of corporate governance and accountability including risk management and internal control;
- Ensuring delivery of the UHB's aims and objectives through effective challenge and scrutiny of performance across all areas of responsibility;
- Ensuring delivery of high quality and safe patient care;
- Building capacity and capability within the workforce to build on the values of the UHB and creating a strong culture of learning and development;
- Enacting effective financial stewardship by ensuring the UHB is administered prudently and economically with resources applied appropriately and efficiently;
- Instigating effective communication between the UHB and its community to ensure its services are planned and responsive to identified needs;

.

The Board, subject to any directions that may be made by the Welsh Ministers, is required to make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Health Board may be carried out effectively, and in a manner that secures the achievement of its aims and objectives.

As part of its response to COVID-19, the Board agreed in April 2020, its approach to ensuring the appropriate level of Board oversight and scrutiny to discharge its responsibilities effectively, whilst recognising the reality of Executive focus and time constraints. Part of the response is in respect of ways of working, which must adapt continually during such a pandemic; however, part of the response required temporary variation from its Standing Orders (SOs) and Reservation and Delegation of Powers. To ensure that the Health Board can facilitate agile decision making and reduce unnecessary bureaucracy, without compromising strong governance, it agreed a temporary variation to parts of the Standing Orders.

The Board and its Committees

The UHB Board has been constituted to comply with the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. In addition to responsibilities and accountabilities set out in terms and conditions of appointment, Board members also fulfil a number of Champion roles where they act as ambassadors for these matters.

The Board provides leadership and direction to the organisation and is responsible for governance, scrutiny and public accountability. It ensures that its work is open and transparent by holding its meetings in public and where private meetings are held the meeting agendas are also published. The Board is supported by a number of Committees, each chaired by an Independent Member. All Committees are constituted to comply with The Welsh Government Good Practice Guide – Effective Board Committees. The Committees, which meet in public (except the Remuneration and Terms of Service Committee), provide their minutes and a written report by the Committee Chair to each Board meeting. This enables all Board Members to be sighted on the major issues and contribute to assessment of assurance and provide scrutiny against the delivery of strategic objectives.

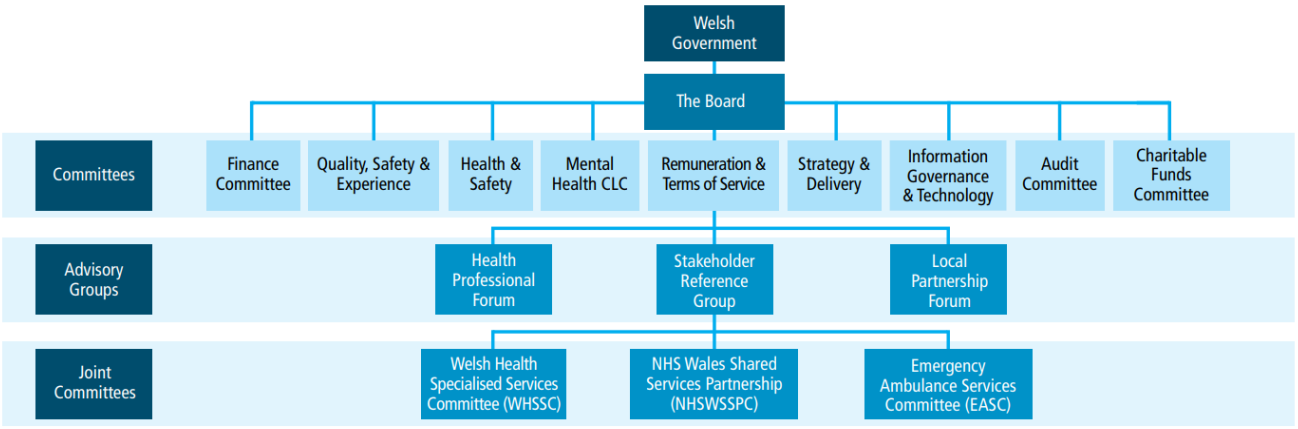
Board papers are usually published on the UHB's website 10 days prior to each meeting, however this was reviewed reduced to 7 days during the first wave of the Covid-19 pandemic, however since then Board Papers have been published 10 days prior to the meeting and in line with Standing Orders further information see section xx.

A breach log is maintained to capture any departures from these timescales and reports delayed or not received. The website also contains a summary of each Committee's responsibilities and Terms of Reference. All action required by the Board and Committees is included on an Action Log and at each meeting, progress is monitored. The Action Logs are also published on the UHB's website. The papers for Board meetings can be accessed here and papers for Committee meetings here. All Committees annually review their Terms of Reference and Work Plans to support the Board's business. Further, in line with Standing Orders, each Committee produces an annual report for the Board, the annual reports for 2020-2021 can be accessed at: Annual Reports

Committees also work together on behalf of the Board to ensure that work is planned cohesively and focusses on matters of greatest risk that would prevent us from meeting our mission and objectives. To ensure consistency and links between Committees, the UHB has a Governance Coordinating Group, chaired by the Chair of the UHB.

The Health Board's Board and Committee structure in place during 2020-2021, is outlined in Figure 1 below.

Figure 1 – C&VUHB Governance Structure 2020-2021



Effective Governance During the Covid 19 Pandemic

In March 2020, the Health Board focused on essential business only, and established a COVID 19 Command and Control Governance Structure to facilitate its planning and preparations for the emerging global COVID-19 pandemic. This was supported by a Covid 19 Board Governance Group and the approach was agreed by the Board in May 2020 - https://cavuhb.nhs.wales/files/board-and-committees/board-2020-21/26-05-2020-final-board-published-pdf/

The Board recognised that in a fast moving pandemic such as COVID-19, governance arrangements must be strengthened, in order to receive assurance on key issues such as:

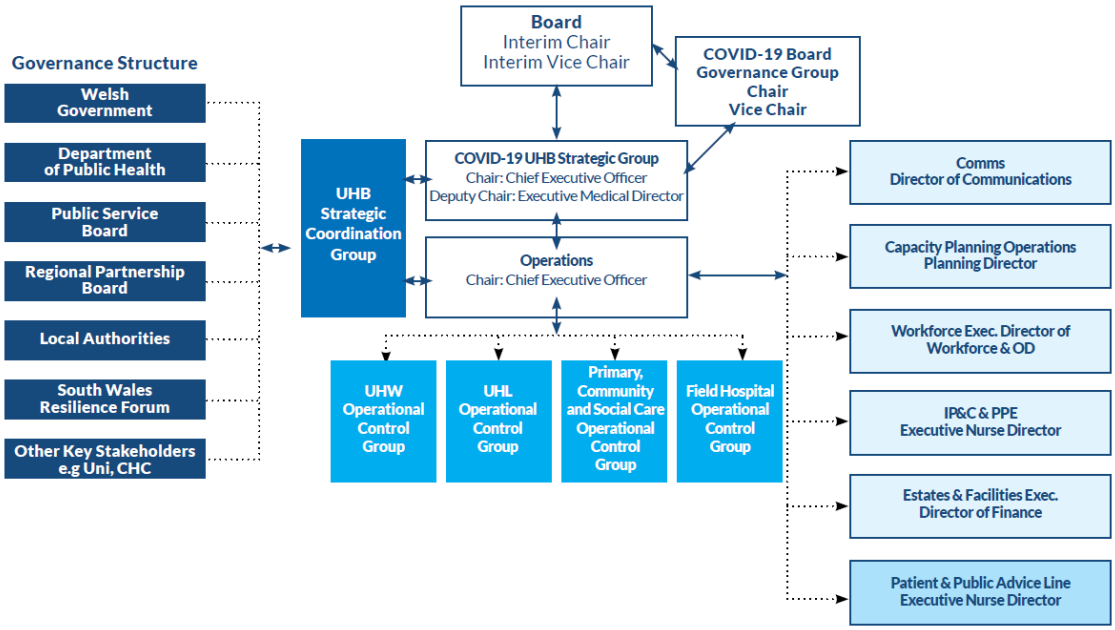
- service preparedness and the response to the pandemic;
- clinical leadership;
- engagement and ownership of developing plans;
- health and wellbeing of staff;
- proactive, meaningful and effective communication with staff at all levels; and
- health and care system preparedness.

The Board considered and agreed new ways of working to ensure the appropriate level of Board oversight and scrutiny to discharge its responsibilities effectively, whilst recognising the reality of Executive focus and time constraints, and its inability to hold meetings in public due to introduction of social distancing measures and restrictions on public gatherings.

Figure 1 below outlines the Governance and Delivery Arrangements for the Management of COVID-19:

Figure 1 Governance and Delivery Arrangements for the Management of Covid 19

UHB Governance and Delivery Arrangements for the Management of COVID-19



The COVID 19 Board Governance Group was set up in April 2020 to ensure that there was appropriate scrutiny and governance over the decision making process during the COVID 19 period and to provide assurance to the Board that this was taking place. The Board Governance Group will able to sign off Chairs actions plus other significant decisions (which would normally be presented to the Board) on a weekly basis which would normally have required the Chair, CEO and consultation with 2 IMs to take place. All actions approved by this Group were ratified by the Board in line with the normal process for Chairs actions.

The COVID 19 Board Governance Group met on a weekly basis and the minutes, resultant actions and the decision log of that meeting were shared with the whole Board. The Group comprised of the Interim Chair, Interim Vice Chair, Chair of Audit Committee, CEO plus a relevant Executive Director. The Director of Corporate Governance was also in attendance.

The COVID 19 Strategic Group met twice weekly and was Chaired by the Chief Executive with the Vice Chair role being undertaken by the Medical Director. The meeting also comprised of all Executive Directors, the Director of Transformation and Information, Director of Corporate Governance and the Director of Communications. The Group made decisions about strategic matters which were captured through minutes, and an action log. The decision log from the Strategic Group was presented to the COVID 19 Board Governance Group for decisions, which the Strategic Group did not have the authority to authorise.

The Operational Group met daily, and was Chaired by the Chief Operating Officer. It was attended by the Triumvirate from the Clinical Boards plus other Executive Directors. It reported into the Strategic Group and took decisions to the Group which required the authority of the CEO and the Executive Directors.

The Operational Structure moved away from the Clinical Board Structure to a site based structure each led by a Local Co-ordination Centre which was open 7 days a week from 8am – 8pm. The four areas were:

- University Hospital for Wales
- University Hospital for Llandough
- Surge Hospital
- Community

Each site had a triumvirate in place which was led by the Clinical Board Director.

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.
- the swift decisions taken by the Board Governance Group and Strategic Group were presented to the Board as part of the Chair's Report for retrospective scrutiny and approval,
- 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.
- In revising its governance arrangements, the Health Board did not reference the Welsh Government guidance on discharging Board Committee responsibilities during COVID-19[2] due to the fact they were not published until the end of April 2020.

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.

Decisions from the COVID 19 Board Governance Group .

Board & Committee Meetings during COVID 19

The Board continued to meet on a bi monthly basis on a quorum basis only and draft minutes from the Board on decisions made were published within 7 days of the Board meeting. Decisions from the COVID 19 Board Governance Group were ratified by the Board in line with the Chair's actions process.

To facilitate as much transparency and openness as possible, the Health Board agreed to:

[2]Guidance for NHS Board's on committee responsibilities during COVID-19
https://gov.wales/guidance-nhs-boards-committee-responsibilities-during-covid-19

- Meetings were held at Woodlands House with Skype facilities,
- Those who attended in person were be required to adhere to social distancing requirements. These arrangements were in line with the revised arrangments agreed between the NHS Wales Board Secretaries Group and Welsh Government,
- The Board did not meet in person therefore Members of the Public were unable to attend or observe,
- The agenda's for the Board and for the Committees of the Board were kept to a minimum and they were agreed between the Chair and Executive Lead as per normal arrangements,
- Publish agendas as far in advance as possible – ideally 7 days,
- Oral reporting which will be captured in the meeting minutes,
- Publish reports as far in advance as possible – recognising that some may be tabled and therefore published after the event. As detailed above there may be the need to increase our use of oral updates to reports based on more concise papers,
- Draft public Board minutes to be available within 1 week of the meeting,
- Provision for written questions to be taken from Board Members who are unable to attend at board meeting and response provided immediately following the meeting,
- A clear link to our website pages and social media accounts signposting to further information will be published,
- Amend the website (which constitutes our official notice of Board meetings) and explain why the Board is not meeting in public.

As Accountable Officer, given the ongoing covid 19 situation this approach will remain under constant review with the Chair and the Board Secretary, and further variations will be brought to the attention of the Board, as we continue to respond to COVID-19 and try to resume and maintain normal business throughout the year.

The following paper was presented to the Board 28 May 2020 detailing the governance principles that were designed to help focus consideration of governance matters during the covid pandemic, the revised governance Structure to reflect the Gold Command and Control arrangements, the terms of reference for the Covid 19 Board Governance Group, the revised schedule of Board and Committee meetings, and the continuation of the variation to Standing Orders
https://cavuhb.nhs.wales/files/board-and-committees/board-2020-21/26-05-2020-final-board-published-pdf/

Composition Of The Board

The UHB Board has been constituted to comply with the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. The Board functions as a corporate decision-making body. Executive Directors and Independent Members are full and equal members and share corporate responsibility for all the decisions of the Board.

The Board provides leadership and direction to the organisation and is responsible for governance, scrutiny and public accountability. It ensures that its work is open and transparent by holding its meetings in public and where private meetings are held the meeting agendas are also published.

The Board consists of 22 members (9 Executive Directors, 10 Independent Members and 3 Associate Members). The Board is supported and advised by the Director of Corporate Governance and the Chief Clinical Information Officer who also attend its meetings. Whilst Associate Members take part in public Board meetings, they do not hold any voting rights. Biographies of all our Board members can be found here: Board Members.

Items Considered by the Board in 2020-2021 included:

- Approval of the Annual Accounts,
- Accountability and Remuneration Reports for 2019-2020;
- The Capital Plan for 2019-20;
- Board Assurance Framework;
- Strategic Clinical Services Plan;
- Thoracic Surgery;
- Patient stories;
- Financial performance;
- Regular reports on Quality, Safety and Experience;
- Performance reports in relation to key national and local targets;
- Assurance reports from the Committees and Advisory Groups of the Board, Terms of
- Reference and Workplans;
- Nurse Staffing.

In addition to responsibilities and accountabilities set out in the terms and conditions of appointment, Board members also fulfil a number of Champion roles where they act as ambassadors for these matters such as carers and older people. The Board and Committee Membership and Champion roles during 2020-2021 is presented for information at ***Appendix 1*** to this statement.

There were 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) undertook the role of Vice Chair on an interim basis.

The Health Board warmly welcomed three new Independent members:

- Mike Jones, Independent Member, Trade Union commenced duties on 1 March 2021,
- David Edwards, Independent Member ICT commenced duties on 1 April 2021,
- Professor Ceri Phillips to the role of Vice Chair from the 1 April 2021.

The Health Board welcomed changes to the composition of the Executive Team:

- Catherine Phillips, Executive Director of Finance from 1 March 2021,
- Rachel Gidman, Interim Executive Director of Workforce & organisational Development (WODS) from 1 March 2021.

Committees

In line with Section 2 of the Health Board's Standing Orders which provides that "The

Board may and, where directed by the WG, must appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions", the Board has an established committee structure with each Statutory Committee chaired by an Independent Member, with other Committees chaired by an Independent or Associate Member (Finance). On behalf of the Board, they provide scrutiny, development discussions, assessment of current risks and performance monitoring in relation to a wide spectrum of the Health Board's functions and its roles and responsibilities.

The following Board Committees were in place during 2020-2021:

Committee	Items Considered
Audit Committee The role of the Audit Committee is to advise and assure the Board, and the Accountable Officer, on whether effective arrangements are in place to support them in their decision taking and in discharging their accountabilities in accordance with the standards of good governance determined for the NHS in Wales.	• Internal Audit Plans were submitted to each meeting providing details relating to outcomes, key findings and conclusions; • Audit Wales reports on current and planned audits; • Declarations of Interest Reports; • Regulatory Compliance Tracking Reports; • Internal & External Audit Tracking Reports; • Post Payment Verification and Counter Fraud Reports; • Annual Accounts, Accountability and Remuneration Reports for 2019-2020; • Losses and Special Payments.
Finance Committee The purpose of this Committee is to advise and assure the Board in discharging its responsibilities with regard to its current and forecast financial position, performance and delivery.	• IMTP; • Cost Reduction Programme; • Finance Risk Register; • Financial Monitoring Returns; • Dragon's Heart Hospital
Strategy and Delivery Committee The purpose of this Committee is to advise and assure the Board on the development and implementation of the UHB's overarching strategy, "Shaping our Future Wellbeing", and key enabling plans. This includes all aspects of delivery of the strategy through the IMTP and any risks that may hinder achievement of the objectives set out in the strategy, including mitigating actions against these.	• Shaping our Future Wellbeing Progress Reports; • Capital Plan; • Clinical Services Plan; • A Healthier Wales; • Commercial Developments; • Employment Policies; • Key Organisational Performance Indicators; • Workforce Plan; • IMTP.
Mental Health and Capacity Legislation Committee	• Mental Capacity Act and Mental Health Act Monitoring Reports;

This Committee advises the Board of any areas of concern relating to responsibilities under mental health legislation, and provides assurance that we are discharging our statutory duties under the relevant legislation.	• Deprivation of Liberty Safeguards Internal • Audit Report; • Mental Health Measure; • Children and Adolescent Mental Health Service; • Healthcare Inspectorate Wales visit.
Quality, Safety and Experience Committee The purpose of the Quality, Safety and Experience Committee is to **provide advice** to the Board with regard to the quality and safety of health services and the experience of patients, including public health, health promotion and health protection activities.	• Community Health Council (CHC) reports • Patient Stories • Patient experience framework • Annual Quality Statement 2019-2020 • HIW reports and progress • Concerns Annual report • Ombudsman Annual Letter
Charitable Funds Committee The purpose of the Charitable Funds Committee is to make and monitor arrangements for the control and management of the UHB's Charitable Funds. Cardiff and Vale Health Charity is the official charity supporting all the work of the UHB. The Charity was created on 3 June 1996 by Declaration of Trust and following reorganisations of health services, was amended by Supplementary Deed on 12 July 2001 and 2 December 2010. The UHB is the Corporate Trustee for the Charity. The UHB delegates responsibility for the management of the funds to the Charitable Funds Committee. The aim of the Corporate Trustee (Trustee) is to raise and use charitable funds to provide the maximum benefit to the patients of the UHB and associated local health services in Cardiff and the Vale of Glamorgan, by supplementing and not substituting government funding of the core services of the NHS.	• Charitable Funds Bids Panel Report • Finance Monitoring Report • Staff Benefits Group Report • New Charitable Funds applications • Charitable funds strategy • Health charity annual report • Arts annual report • Investment update

The reports, workplan and terms of reference for the Commitees I published on our website Committees and Advisory Groups - Cardiff and Vale University Health Board (nhs.wales)

The table at ***Appendix x, page xx*** sets out details of the Chair, Chief Executive, Executive Directors and Independent Members and confirms Board and Committee membership for 2020-2021, meetings attended during the tenure of the individual and any Champion roles performed. The table on page xx sets out Board and Committee Dates for 2020-2021.

The Chair of each Committee reports to the Board on the Committees' activities outlining key risks and highlighting areas which need to be brought to the Board's

attention in order to contribute to its assessment of assurance and provide scrutiny against the delivery of objectives. The Committees, as well as reporting to the Board, also work together on behalf of the Board to ensure, where required, that cross reporting and consideration takes place and assurance and advice is provided to the Board and the wider organisation. Further, in line with Standing Orders, each Committee has produced an annual report, for 2019/20, setting out a helpful summary of its work.

All Committees have undertaken a review of their Terms of Reference in 2020-2021 Copies of Committee papers and minutes, a summary of each Committee's responsibilities and Terms of Reference are available on the Health Board's website: xxxxxx

Each Committee will maintain a Table of Actions that is monitored at meetings. Each of the main Committees of the Board is supported by an underpinning subcommittee structure reflecting the remit of its roles and responsibilities.

Advisory Groups & Joint Committees

In support of the Board, the UHB is also required to have three Advisory Groups. Due to the pressures associated with COVID-19, the UHB stood down the meetings of some of its Committees, as summarised in the below table. This action was approved by the Board Governance Group described below and ratified at the Board meeting on 28 May 2020.

These are:

Stakeholder Reference Group (SRG)

The SRG is formed from a range of partner organisations from across the UHB area. Its role is to provide independent advice on any aspect of UHB business. It facilitates full engagement and active debate amongst stakeholders from across the communities served by the UHB, with the aim of presenting a cohesive and balanced stakeholder perspective to inform UHB planning and decision making.

This may include:

- Early engagement and involvement in the determination of the UHB's overall strategic direction,
- Provision of advice on specific service improvement proposals prior to formal consultation,
- Feedback on the impact of the UHB's operations on the communities it serves.

Significant issues upon which the SRG was engaged during 2020-2021 included:

- Tertiary Services Plan,
- The Strategic Equality Plan,
- Integrated Medium Term Plan 2020-23
- Priority Setting,
- Move More, Eat Well Plan 2020-23,
- Annual Quality Statement,
- University Hospital of Wales 2.

Local Partnership Forum (LPF)

The LPF meets six times a year and is the formal mechanism for the UHB and Trade Union/ Professional Organisation Representatives to work together to improve health services. Its purpose, as set out in the Terms of Reference, falls into four overarching themes: communicate, consider, consult and negotiate, and appraise.

The LPF is co-chaired by the Chair of Staff Representatives and the Executive Director of Workforce and Organisational Development. Membership is made up of Staff Representatives (including the Independent Member for Trade Unions), the Executive Team and Chief Executive, the Director of Corporate Governance, the Assistant Directors of Workforce and Organisational Development and the Head of Workforce Governance.

The LPF receives for noting regular reports from the Employment Policy Sub Group and Staff Benefits Group. Significant issues considered by the LPF during 2019-20 include:xxxxxx

Healthcare Professionals' Forum (HPF)

The HPF comprises representatives from a range of clinical and healthcare professions within the UHB and across primary care. It has provided advice to the Board on professional and clinical issues it considers appropriate. This Advisory Group is currently undergoing review and therefore has not met during 2019- 20. The UHB has a number of mechanisms to seek clinical input, for example a representative of the Consulting body attended Board meetings, feeding in comment from Consultant engagement on key issues such as major trauma and thoracic surgery. Reviewing this Advisory Group's Terms of Reference, membership and developing its work programme and function to best use these mechanisms, establish a robust structure and avoid duplication was a governance priority for 2020-21. Terms of Reference and minutes of all the Advisory Groups are available via the following link: http://www.cardiffandvaleuhb.wales.nhs.uk/boardcommittees- and-advisory-groups

Welsh Health Specialised Services Committee (WHSSC)

WHSSC was established in 2010 by the seven health boards to ensure the population has fair and equal access to the full range of specialised services. Hosted by Cwm Taf Morgannwg University Health Board, the health board is represented on the joint committee by the Chief Executive and regular reports are received by the board.

Emergency Ambulance Services Committee (EASC)

EASC is a joint committee of the seven health boards, with the three NHS trusts as associate members, and was established in April 2014. It has responsibility for the planning and commissioning of emergency ambulance services on an all-Wales basis. Hosted by Cwm Taf Morgannwg University Health Board, the health board is represented on the joint committee by the Chief Executive and regular reports are received by the board.

NHS Wales Shared Services Partnership (NWSSP) Committee

The NWSSP Committee was established in 2012 and is hosted by Velindre NHS Trust. It looks after the shared functions for NHS Wales, such as procurement, recruitment and legal services. The health board's representative is the Director of Workforce and OD and regular reports are received by the board.

Partnerships and All Wales Services

The UHB delivers a range All Wales services including:

- Adult Cystic Fibrosis Centre;
- Artificial Limb and Appliance Service;
- Medical Genetics Service;
- Veterans NHS Wales

Much of the funding for these services comes from the Welsh Health Specialist Services Committee. In addition, the UHB and Cardiff University have a long and established track record of working together to deliver exceptional services through cutting edge innovation. Such partnership working has led to the establishment of Cardiff Medicentre a business incubator for biotech and medtech startups, and the Clinical Innovation Partnership.

Board & Committee Activity (Check with Nikki)

As a consequence of the Covid 19 Pandemic it is acknowledged that in these unprecedented times, there are limitations on Boards and Committees being able to physically meet where this is not necessary and can be achieved by other means. In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the organisation is required to meet in public. As a result of the public health risk linked to the pandemic the UK and Welsh Government stopped public gatherings of more than two people and it has therefore not been possible to allow the public to attend meetings of our board and committees since March 2020.

To ensure business was conducted in as open and transparent manner as possible during this time the following actions were taken:

Recordings of our meetings began in March 2020, and we began to live stream meetings from July 2020. To ensure business was conducted in as open and transparent manner as possible during this time the Board agreed a number of actions at its meetings in May 2020 – the report can be accessed via the following link xxxxxxx

An assessment was also made to ensure business continuity and agile decision making through the review of the reservation and delegation of powers/scheme of delegation. We ensured they business decisions were captured, maintained and reported appropriately through minutes, resultant actions and the decision log.

As the duration of the pandemic and the subsequent measures to be taken to mitigate spread are not yet known it will be necessary to keep this under review.

Board papers are published on the UHB's website 10 days prior to each meeting and Committee papers a week prior to each meeting. A breach log is maintained to capture any departures from these timescales and reports delayed or not received. The website also contains a summary of each Committee's responsibilities and Terms of Reference. All actions required by the Board and Committees is included on an Action Log and at each meeting, and progress is monitored at each meeting. The Action Logs are also published on the UHB's website.

There is a clear patient and staff centred focus by the Board at the meetings, demonstrated by the presentation of patient and staff stories at the start of each meeting.

Attendance is formally recorded within the minutes, detailing where apologies have been received and deputies have been nominated. The dates, agendas and minutes of all public meetings can be found on our website xxxxxxx.

Further, in line with Standing Orders, each Committee produces an annual report for the Board, the annual reports for 2020-2021 can be accessed at: Annual Reports Committees also work together on behalf of the Board to ensure that work is planned cohesively and focusses on matters of greatest risk that would prevent us from meeting our mission and objectives. To ensure consistency and links between Committees, the UHB has a Governance Coordinating Group, chaired by the Chair of the UHB.

Public Appointments

On 23 March 2020 the Welsh Government suspended all Ministerial Public Appointment campaigns with immediate effect. However, this was lifted in September 2020 and we resumed the appointments process warmly welcomed three new Independent members:

- Mike Jones, Independent Member, Trade Union commenced duties on 1 March 2021,
- David Edwards, Independent Member ICT commenced duties on 1 April 2021,
- Professor Ceri Phillips to the role of Vice Chair from the 1 April 2021.

Public interest Declaration

Each Board Member has stated in writing that they have taken all the steps that they ought to have taken as a Director in order to make auditors aware of any relevant audit information. All Board Members and Senior Managers and their close family members (including Directors of all Hosted Organisations) have declared any pecuniary interests and positions of authority which may result in a conflict with their responsibilities. No material interests have been declared during 2020-2021, a full register of interests for 2020-2021 is available upon request from the Director of Corporate Governance.

Board and Committee Membership & Attendance 2020-2021

The Board has been constituted to comply with the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. In addition to responsibilities and accountabilities set out in terms and conditions of appointment, Board members also fulfil a number of Champion roles where they act as ambassadors for these matters. Table x outlines the Board and Committee Membership and the record of attendance for the period April 2020-March 2021:

Table x - Board and Committee Membership and the record of attendance for the period April 2020-March 2021

Name	Position	Area of Expertise/ Representation Role	Board Committee Membership and Record of Attendance	Champion Roles
Charles Janczewski	Chair (Interim Chair April-Jun 2021)		• Board 7/8 • Board of Trustee 5/5 • Mental Health & Capacity Legislation (MHCL) 1/3 • Quality, Safety & Experience (QSE) 1/5 • Audit 2/7 • DHIC 2/3 • RATS 4/5 • Strategy & Delivery 3/5	Disability Characteristic
Michael Imperato	Vice Chair	Legal	• Board 7/8 • Board of Trustee 5/5 • Health & Safety ¾ • MHCL 3/3 • QSE 5/5 • Audit 1/7 • DHIC 3/3 • RATS 4/5 • Strategy & Delivery 4/5	Age protected characteristic
Professor Gary Baxter	Independent Member	University	• Board 5/8 • Board of Trustee 2/5 • QSE 2/5 • DHIC 1/3	

Name	Position	Area of Expertise/ Representation Role	Board Committee Membership and Record of Attendance	Champion Roles
			• Strategy & Delivery 3/5	
Eileen Brandreth	Independent Member	Information Communication and Technology	• Board 6/8 • Board of Trustee 4/5 • MHCL 3/3 • Audit 7/7 • DHIC 3/3 • RATS 2/5	Lead for Children and Young People and Maternity Age protected characteristic
Councillor Susan Elsmore	Independent Member	Local Authority	• Board 6/8 • Board of Trustee 4/5 • Charitable Funds 2/5 • QSE 4/5 • RATS 0/5	Transgender protected characteristic
Akmal Hanuk	Independent Member	Local Community	• Board 7/8 • Board of Trustee 3/5 • Charitable Funds 4/5 • Health and Safety 3/4 • MHCL 2/3 • QSE 2/5 • RATS 1/5	Race protected characteristic

Name	Position	Area of Expertise/ Representation Role	Board Committee Membership and Record of Attendance	Champion Roles
Sara Mosely	Independent Member	Third (Voluntary) Sector	• Board 6/8 • Board of Trustee 4/5 • Charitable Funds 2/5 • MHCL 3/3 • RATS 3/5 • Strategy & Delivery 4/5	Welsh Language Champion, Equality and Human Rights
Dr Rhian Thomas	Independent Member	Capital & Estates	• Board 6/8 • Board of Trustee 4/5 • Health and Safety 2/4 • RATS 4/5 • Strategy & Delivery 5/5	Religion protected characteristic
John Union	Independent Member	Finance	• Board 6/8 • Board of Trustee 2/5 • Charitable Funds 2/5 • Audit 7/7 • RATS 4/5	Sex/Gender protected characteristic
Geoffrey Simpson	Associate Member	Interim Chair, Stakeholder Reference Group	• Board 0/8	
Sue Bailey	Associate Member	Chair, Healthcare Professionals' Forum	• Board 2/8	
Lance Carver	Associate Member	Director of Social Services, Vale of Glamorgan	• Board 2/8	
Len Richards	Chief Executive		• Board 7/8 • Board of Trustee 1/5 • DHIC 1/3 • RATS 4/5	Race protected characteristic
Robert Chadwick & Christopher Lewis	Executive Director of Finance	Finance	• Board 7/8 • Board of Trustee 5/5 • Charitable Funds 5/5 • QSE 1/5	

Name	Position	Area of Expertise/ Representation Role	Board Committee Membership and Record of Attendance	Champion Roles
			• Audit 7/7 • DHIC 3/3	
Dr Stuart Walker	Executive Medical Director	Medical / Quality & Safety	• Board 7/8 • Board of Trustee 1/5 • QSE 4/5 • Audit 1/7 • Strategy & Delivery 5/5	
Ruth Walker	Executive Director of Nursing	Nursing / Quality & Safety	• Board 7/8 • Board of Trustee 3/5 • Charitable Funds 4/5 • Health and Safety 1/4 • QSE 5/5 • MHCL 3/3 • Strategy & Delivery 2/5	Transgender protected characteristic
Steve Curry	Chief Operating Officer	Operations	• Board 7/8 (Deputy for one) • Board of Trustee 2/5 • MHCL 2/3 • QSE 1/4 • Audit 1/7 • Strategy & Delivery 3/5 (Deputy for one)	Age protected characteristic
Abigail Harris	Executive Director of Strategic Planning	Estates & Planning	• Board 7/8 • Board of Trustee 5/5 • Strategy & Delivery 4/5	Welsh Language Champion
Dr Fiona Jenkins	Executive Director of Therapies and Life Sciences	Therapies and Life Sciences	• Board 7/8 • Board of Trustee 5/5 • Charitable Funds 4/5 • QSE 2/5	Disability Characteristic

Name	Position	Area of Expertise/ Representation Role	Board Committee Membership and Record of Attendance	Champion Roles
			• Strategy & Delivery 1/5	
Martin Driscoll & Rachel Gidman	Executive Director of Workforce & OD	Workforce	• Board 7/8 • Board of Trustee 5/5 • Health and Safety 1/4 • Audit 1/7 • RATS 4/5 • Strategy & Delivery 5/5	Religion protected characteristic
Fiona Kinghorn	Executive Director of Public Health	Public Health	• Board 6/8 • Board of Trustee 4/5 • QSE 2/5 • Strategy & Delivery 5/5	Sex/Gender protected characteristic
Dawn Ward (term ended January 2021)	Independent Member	Trade Union	• Board 6/8 • Health and Safety 2/4 • QSE 4/5 • Audit 5/8	

Name	Position	Area of Expertise/ Representation Role	Board Committee Membership and Record of Attendance	Champion Roles
Non-Voting Members				
Nicola Foreman	Director of Corporate Governance	Governance	• Board 7/8 • Board of Trustee 5/5 • Charitable Funds 4/5 • Health and Safety ¾ • MHCL 2/3 • QSE 5/5 • Audit 7/7 • DHIC 3/3 • RATS 4/5 • Strategy & Delivery 5/5	Disability Characteristic

Name	Position	Area of Expertise/ Representation Role	Board Committee Membership and Record of Attendance	Champion Roles
Allan Wardaugh	Chief Clinical Information Officer	Digital	• Board 5/8	

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurances of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

It is recognised that the system of internal control underwent significant adaptation during the last quarter of 2020/21 and up to the date of approval of the accounts, as a consequence actions were taken to adapt and evolve, and put new controls in place which are likely to continue into 2021-2022. Sections xx and xx provide further information on this.

Capacity to handle risk

Cardiff and Vale University Health Board's systems of control are designed to manage risk to a reasonable level rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The Health Board's system of control is based on an ongoing process designed to identify and prioritise the risks to the achievement of its policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

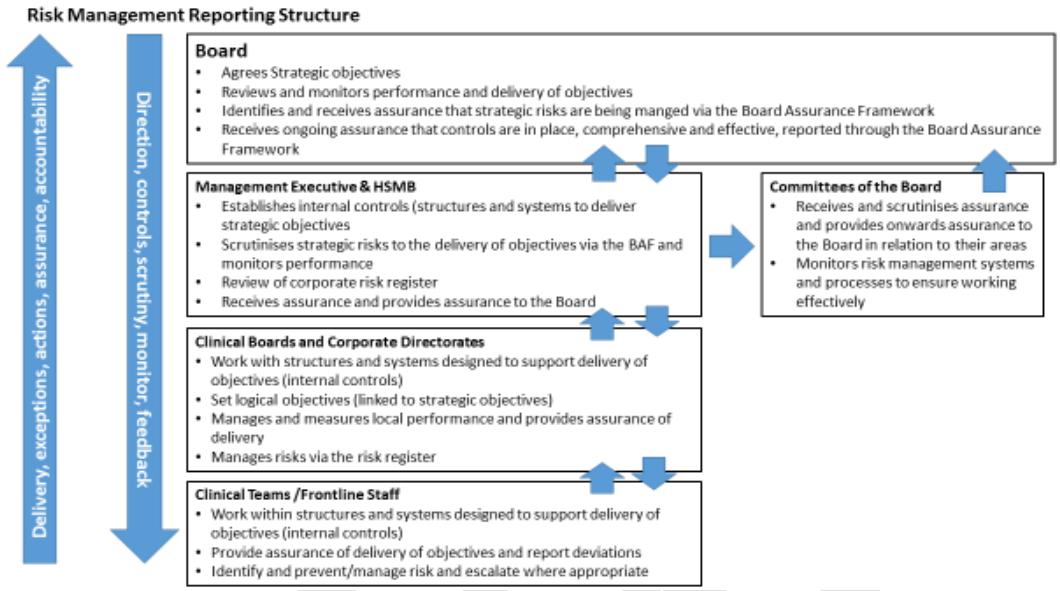
The Health Board is committed to developing and implementing a Risk Management and Board Assurance Framework that identifies, analyses, evaluates and controls the risks that threaten the delivery of its strategic objectives. The Health Board's Assurance Framework (BAF) is used by the Board to identify, monitor and evaluate risks which impact upon Strategic Objectives and is considered alongside other key management tools, such as the Corporate Risk Register, performance and quality dashboards and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

The Health Board's Risk Management and Board Assurance Framework Strategy ("the Strategy") sets out responsibilities for strategic and operational risk management for the

Board and staff throughout the organisation and describes the procedures to be used in identifying, analysing, evaluating and controlling risks to the delivery of strategic objectives.

Strategic risks are significant risks that have the potential to impact upon the delivery of Strategic Objectives and are raised and monitored by the Executive Team and the Board. Operational risks are key risks that affect individual Clinical Boards and Corporate Directorates and are managed within the Clinical Boards and Corporate Directorates and if necessary, escalated through the Health Board's risk reporting structure (See Appendix 1).

Figure 1 – Risk Management Reporting Structure



The Board Assurance Framework (BAF) is an integral part of the system of internal control and defines the extreme potential risks (15 & above) which impact upon the delivery of Strategic Objectives. It also summarises the controls and assurances that are in place or plans to mitigate them. The BAF aligns principal risks, key controls and assurances on controls alongside each of the Health Boards strategic objectives.

Gaps are identified where key controls and assurances are insufficient to reduce the risk of non-delivery of objectives. This enables the development of an action plan for closing the gaps and mitigating the risks which is subsequently monitored by the Board for implementation.

The Strategy applies to those members of staff that are directly employed by Cardiff and Vale University Health Board and for whom Cardiff and Vale University Health Board has legal responsibility and is intended to cover all the potential risks that the organisation could be exposed to.

A copy of the Strategy can be found at the following link:
[To be added]

The objectives of Strategy are to:

- minimise impact of risks, adverse incidents, and complaints by effective risk identification, prioritisation, treatment and management;
- maintain a risk management framework, which provides assurance to the Board that strategic and operational risks are being managed effectively;

- maintain a cohesive approach to corporate governance and effectively manage risk management resources;
- ensure that risk management is an integral part of Cardiff and Vale University Health Board's culture;
- minimise avoidable financial loss, or the cost of risk transfer through a robust financial strategy;
- ensure that Cardiff and Vale University Health Board meets its obligations in respect of Health and Safety.

At the outset of 2020/21 the Health Board maintained a Board Assurance Framework (BAF) and, in response to the Covid-19 pandemic, a separate Covid - 19 BAF document, which identified the risks posing the greatest risk to the delivery of the Health Board's Strategy 'Shaping our Future Wellbeing' generally and also from a Covid-19 perspective. Following the Health Board's May 2020 Board meeting it was agreed that a single unified BAF document would be used moving forward that included risks that had transpired following the onset of Covid-19 rather than maintaining two separate documents. As of March 2021 the following risks were identified as posing the greatest risk to the delivery of the Health Board's strategic objectives:

1. Workforce
2. Financial Sustainability
3. Sustainable Primary and Community Care
4. Patient Safety
5. Sustainable Culture
6. Capital Assets
7. Test, Trace and Protect
8. The risk of inadequate planned care capacity
9. Risk of Delivery of IMTP

Alongside the Board Assurance Framework, the Health Board also maintains a Corporate Risk Register that identifies the extreme operational risks (those scored at 15/25 or higher) that the Health Board is facing.

Following the introduction of the Corporate Risk Register in November 2019 the document underwent a significant period of development and after review and scrutiny at a number of private Board meetings the Register was formally shared with the public at the Health Board's January 2021 Board meeting.

As of March 2021 there were 25 Extreme risks detailed on the Corporate Risk Register with the following score profile:

- 7 risks rated at 15/25;
- 8 risks rated 16/25; and
- 10 risks rated 20/25.

Details of these risks and the Health Board's Corporate Risk Register Report and the Health Board's Board Assurance Framework and covering report for March 2021 can be found at the following link:

[To be added]

Management of Risk

Overall responsibility for the Risk Management and Board Assurance Framework Strategy lies with the Director of Corporate Governance who has delegated responsibility for managing the development and implementation of the Risk Management and Board Assurance Framework Strategy. Arrangements are in place to effectively assess and manage risks across the organisation, which includes the ongoing review and updating of the Board Assurance Framework and the Corporate Risk register so that the Board maintains a line of sight on the Health Boards key strategic and operational risks. During 2020/21 the Director of Corporate Governance established the Health Board's Risk and Regulation Team (comprised of the Head of Risk and Regulation and two Risk and Regulation Officers) to further develop and imbed the Health Board's Risk Management Strategy across the Health Board.

The Director of Corporate Governance retains control of the BAF and meets with Executive Leads for BAF risks on a bi-monthly basis to ensure that the risks detailed in BAF are regularly updated to include new and emerging risks to service areas so that the entries provide an accurate and contemporaneous reflection of the risks faced by the Health Board.

The BAF is also presented to the Board for scrutiny and approval on a bi-monthly basis and the Audit and Assurance Committee, as a sub-committee of the Board, has oversight of the process through which the Board gains assurance in relation to the management of the BAF.

The Risk and Regulation team monitor and maintain the Corporate Risk Register. Each Corporate Department and Clinical Board has responsibility to maintain a comprehensive risk register which forms the basis of the risks that are reflected within the Corporate Risk Register. The Risk and Regulation team regularly meet with Clinical Board and Corporate Department risk leads to review and monitor their Clinical Board/Corporate Department and local level risk registers to ensure that they accurately record the risks that their areas are encountering and to assist those areas in considering new and emerging risks to their service. Following that exercise extreme operational risks, those scored 15/25 or higher, are recorded on the Corporate Risk Register and reported to the Board for scrutiny and approval on a bi-monthly basis (in public since January 2021). Any risks that are identified as having the potential to impact on the Health Board's Strategic Objective are added to the BAF. Each risk detailed on the Corporate Risk Register is also linked to a strategic link contained in the BAF to ensure that risks are appropriately monitored and escalated.

The key risks detailed in the BAF and Corporate Risk Register are also shared at relevant sub-committees of the Board for further scrutiny and discussion. The BAF risks are reviewed at the following sub-committees of the Board:

1. Workforce – Strategy and Delivery Committee
2. Financial Sustainability – Finance Committee
3. Sustainable Primary and Community Care – Strategy and Delivery Committee

4. Patient Safety – Quality, Safety and Experience Committee
5. Sustainable Culture – Strategy and Delivery Committee
6. Capital Assets - Finance Committee & Strategy and Delivery Committee
7. Test, Trace and Protect - Strategy and Delivery Committee
8. The risk of inadequate planned care capacity - Strategy and Delivery Committee
9. Risk of Delivery of IMTP - Strategy and Delivery Committee

The Corporate Risk Register entries are referred to those committees detailed on the Corporate Risk Register. In January 2021 all Mental Health Risks were discussed and scrutinised at the Mental Health and Capacity Legislation Committee and in February 2021 Patient Safety Risks were shared at the Quality, Safety and Patient Experience Committee.

The Health and Safety team provide staff with training in the management of functional work place risk management processes and assessments. The management of the Health Board's Corporate Risk Management Training is managed by the Risk and Regulation team.

The Risk and regulation team offer training sessions to risk leads through targeted training programmes that are informed by the team's regular interactions with clinical boards and corporate departments. Alongside this the team have provided, since March 2021, a weekly virtual Risk Management online training session which is available to the all staff members. The Risk and Regulation Teams training plan is designed to embed a consistent approach to the management, scoring and recording of risk from ward to board across the Health Board.

The risks detailed in the BAF and Corporate Risk Register are considered when determining the Health Board's risk appetite. The Health Board acknowledges that the delivery of healthcare cannot be achieved unless risks are taken, as well as the subsequent consequences and mitigating actions. It also ensures that risks are not considered in isolation and are taken following consideration of all the risks flowing through the organisation.

On 29th October 2020 the Board agreed to use the Good Governance Institute (GGI) Risk Appetite Matrix to set its risk appetite (current (Cautious) and 'working towards' (Open) positions).

In December 2020 alternate methods of describing Risk Appetite were examined and it was determined that adding sub-elements to the GGI Matrix (particularly those giving greater emphasis to patients and workforce) would enable better application of risk appetite at an operational level. Example of potential sub-elements were revealed to the Board on 17th December 2020 and a further draft of the Health Board's Risk Appetite Matrix was shared with the Management Executive team with a view to utilise the document as part of the Health Board's Risk Appetite delivery plan for 2021/22.

Communicating and consulting with internal and external stakeholders and partners, as appropriate, at each stage of the risk management process and concerning the process as a whole is important. The frequency of the communication will vary depending upon the severity of the risk and is discussed and agreed with the stakeholders and partners as necessary. This process is led by the person nominated as the lead to manage the risk and for communication with external stakeholders this will be the appointed executive director lead for the risk. As the designated lead for Risk Management the Director of Corporate Governance also attends the Health Board's Stakeholder

Reference Group to brief public stakeholders on the activities of the Board including the management or risk.

Risk Management During Covid-19

As a consequence of responding to the Covid 19 pandemic, the health board re-evaluated its operational approach to ensure that it was able to meet the ever changing service demands posed by the pandemic. During 2021/21 the Health Board's Clinical Board directorates re-organised their operational structure so that clinical activity was managed by local command centres based in the Community and at Key Hospital Sites (University Hospital of Wales, University Hospital Llandough and the Health Board's Surge Hospitals) in place of the historic clinical board command structures to allow Clinical Board's to respond at speed to the pandemic.

To support the Command Centres in their approach and to ensure that the areas remained accountable in terms of board governance, transaction execution and statutory compliance commitments Local Command Centre Risk Registers were established to feed into the Corporate Risk Register so that the Health Board remained sighted on the activities undertaken within command centres. The local command centre risk registers ran alongside Clinical Board Risk Registers and provided a second layer of assurance to the Health Board that operational risks were being managed appropriately throughout the year.

Planning Arrangements (Abigail Harris and Jonathan Watts)

There has been a considerable impact on planning during the year and the main Annual Report will provide a statement as to the arrangements for planning and delivery during the year.

In March 2020 the IMTP process was paused and quarterly planning arrangements introduced during 2020-21. Quarterly plans were required, from all organisations, aligned to the priorities in the Quarter 1, Quarter 2 and Quarter 3/Quarter 4 frameworks which were issued throughout the year.

The AGS must comment on whether, at the date of signing of the accounts and the AGS, the LHB / NHS Trust had submitted a Board approved IMTP for 2020-2023 in accordance with the NHS Planning Framework and the status of this in terms of approval by Welsh ministers. Letters were sent to all organisations in March 2020 regarding the assessment process to date and the status of their IMTPs.

MANDATORY DISCLOSURES

In addition to the need to report against delivery of the Health and Care Standards and the Standards for Health Services in Wales, the Health Board is also required to report that arrangements are in place to manage and respond to the following governance issues:

Health and Care Standards (Carol end of May/June q&s committee)

In 2017-18 a revised set of Health and Care Standards were issued to NHS Wales. In particular, a new standard for Governance, leadership and Accountability was introduced. The health service needs to consider the following criteria for meeting the standard:

- Health services demonstrate effective leadership by setting direction, igniting passion, pace and drive, and developing people.
- Strategy is set with a focus on outcomes, and choices based on evidence and people insight. The approach is through collaboration building on common purpose.
- Health services innovate and improve delivery, plan resource and prioritise, develop clear roles, responsibilities and delivery models, and manage performance and value for money.
- Health services foster a culture of learning and self-awareness, and personal and professional integrity.

[The Annual Governance Statement should provide a summary of the steps the organisation is taking to demonstrate that they operate in accordance with this governance standard and the wider standards framework.]. Awaiting information in annual self-assessment

Equality, Diversity & Human Rights (Rachel Gidman)

The UHB is required, under the Equality Act 2010 to produce a **Strategic Equality Plan (SEP)** every four years. The purpose of a Strategic Equality Plan is to document the steps the organisation is taking to fulfil its Public Sector Equality Duty) under the Equality Act 2010. In preparing and revising its Strategic Equality Plan the UHB is required to engage appropriately and have due regard to relevant equality information.

The current SEP Caring about Inclusion 2020-2024 has a number of key delivery objectives and is premised on the basis of embedding equality, diversity and human rights, and Welsh Language, into UHB business process. The SEP is closely aligned to our ten-year strategy 'Shaping Our Future Wellbeing', our Intermediate Medium Term Plan as well as the Well-being of Future Generations Act 2015. This is the first year of the current four-year Plan.

Cardiff and Vale University Health Board will continue to look to meet and go beyond our legal obligations, and to apply the principles that sit within the Equality Act and the Public Sector Equality Duty (PSED) to all our thinking, planning and decision making.

This has included the publication of our Strategic Equality Plan (SEP) which was reviewed in light of recent events that took place in 2020 around issues of inequality. Reducing Health Inequality is a strategic aim of the organisation as set out in our 'Shaping Our Future Wellbeing' Strategy[3].

As an organisation we, as with the rest of NHS Wales, have faced, and continues to face challenges, both in terms of our role as an employer and as a service provider. We have come under intense pressure of demand for some of our services and there has been untold impact on our staff.

The publication of the BAME COVID-19 Socioeconomic Subgroup Report has given us an opportunity to reflect and learn whilst the organisation works on its Strategy Equality Plan - Caring about Inclusion. For example, in July 2020, our Management Executive received a presentation from the Equality Manager and the Assistant Director of Organisational Development laying out some initial first steps in "Improvement for Inclusion". It was recognised and accepted that inequality cannot be tackled half-heartedly or by sporadic, one-off, disconnected initiatives: that our actions need to be well planned, strategic, sustainable and taken seriously.

The organisation has decided that each Executive Director will take responsibility for a specific protected characteristic as this work develops. Our CEO, to demonstrate his personal commitment to this work, is taking the lead for the protected characteristic of Race.

A further review of some of our employment policies has led to the development of a new Equality, Inclusion and Human Rights Policy. The Health Board wants to build a reputation for demonstrating outstanding practice in the field of employment relations and service delivery and will work to ensure that equality, inclusion, diversity and human rights principles are owned, valued and demonstrated by everyone within the organisation - the Board, members of staff and those who provide services on behalf of the organisation.

Cardiff and Vale University Heath Board has a long history of strong partnership working. We will be looking to work alongside others in strengthening work to tackle inequality. For example, we are leading the work on the health Workstream of Cardiff Council's developing Race Equality Taskforce.

On a wider partnership scale, our SEP was developed with other public bodies. Our public bodies' partnership involved: Natural Resources Wales, Arts Council of Wales, National Museum Wales, HEFCW, Welsh Language Commissioner, Careers Wales, Welsh Venue Authority, HEIW, ESTYN, Sport Wales and Velindre University NHS Trust. Our aim is to ensure our Equality Objectives for 2020-2024 will address the health related challenges set out in *Is Wales Fairer? 2018*. These public bodies were keen to take steps to agree shared objectives and wanted to take forward a collaborative approach involving the sharing of resource, insight and expertise. This approach promotes smarter working and creates capacity for widening stakeholder and community engagement. Uniting behind shared objectives has the potential to

[3] http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/10%20-%20UHB%20Shaping%20Our%20Future%20Wellbeing%20Strategy%20Final.pdf

influence further collaborative working and shared practice, promoting greater impact across the public sector and public services in Wales contributing significantly to tackling inequalities and the 'prevention agenda'. Focus was also aimed at ensuring the objectives themselves, and the long-term aims to which they will contribute, are the right ones.

Although language is not a protected characteristic under the Equality Act 2010 - the protection of the Welsh language is taken forward under separate legislation (the Welsh Language (Wales) Measure 2011 and related Standards) - it has long been recognised that the equality and Welsh language policy agendas complement and inform each other. It is further supported through the Goal within the Wellbeing of Future Generations Act – A Wales of vibrant culture and thriving Welsh language. Our aim is to sustain and reinforce that principle through our new Strategic Equality Objectives and ensure they serve to promote and protect the Welsh language

Control measures are in place to ensure that the organisation complies with the requirements of equality, diversity and human rights legislation are complied with, including:

- Developing and producing a new Strategic Equality Plan – Caring about Inclusion 2020- 2024;
- The Annual Equality Report;
- Equality reports to the Strategy and Delivery Committee on the UHB's objectives and actions;
- Reports/Updates to the Centre for Equality and Human Rights as requested;
- Outcome Report to the Welsh Government Equalities Team regarding sensory loss;
- Provision of evidence to the Health and Care Standards self- assessment;
- Equality and Health Impact Assessments to ensure that the organisation demonstrates due regard to equality, diversity and human rights when making decisions and developing strategies or policies.
- Following the killing of George Floyd in May, the subsequent Black Lives Matter protests that took place over the summer highlighted the systemic inequality that Black, Asian and/or Minority Ethnic (BAME) people face not only in the USA but also here in the UK. Also it has been found that Black, Asian and/or Minority Ethnic groups are disproportionately affected by COVID-19, with available statistics suggesting that these groups are up to two times more likely to die from the disease than 1/5 10/294 their white counterparts. In light of this, in an edition of Chief Executive Officer Connects our Chief Executive asked members of staff from Black, Asian and/or Minority Ethnic backgrounds to share their experiences of working in the UHB and the issues of inequality they have faced. A report into their experiences will be shared with the Board in early 2021,
- all our executives have taken up a leadership role across the nine protected characteristics specified in the Equality Act 2010 (age, disability, gender identity, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation), the CEO is the disability lead.
- some of our staff are members of both the Welsh Government Race Equality Action Plan Group and the Cardiff Race Equality Task Force
- On 30 January 2021 a Memorandum of understanding (MOU) was signed with the British Association of Physicians of Indian Origin (BAPIO). This was the first

of its kind for the UHB and BAPIO, and it demonstrates our commitment and willingness to drive forward meaningful and tangible change. Cardiff and Vale UHB is an inclusive employer which thrives on the diversity of its staff, benefiting hugely from the multiple cultures, heritages and nationalities we have in our employment.

The UHB has an Equality, Diversity and Human Rights Policy which sets out the organisation's commitment to promoting equality, diversity and human rights in relation to employment, service delivery, goods and service suppliers, contractors and partner agencies. It is accessible to the public as well as staff. The UHB aims to ensure that no individual or group receives less favourable treatment either directly or indirectly.

Further information on application of the equality, diversity and human rights legislation in relation to our workforce can be found at Section xx.

Welsh Language Regulations - The Welsh Language Standards (No. 7) Regulations 2018 (WLO)

Regulations making the Welsh language standards applicable to health boards and trusts were made by the Welsh Assembly in March 2018 (The Welsh Language Standards No.7 Regulations 2018) and they came into force at the end of June 2018. The Welsh Language Commissioner has since issued compliance notices to health boards and trusts and they started to comply with standards from 30 May. The Health Board's Welsh Language Group oversees progress and reports to the Strategy and Delivery Committee. The C&VUHB Welsh Language Report 2020-2021 can be accessed here xxxxxxxadd link.

During 2020-2021 the organisation continued with its efforts to implement the requirements of the Welsh Language Standards, working closely with services to ensure they all conform. We have been working hard to raise awareness of the requirements of the Standards through corporate induction of all new staff, mandatory training for current staff as well as other events taking place across the organisation.

Due to the COVID-10 pandemic the Ceredigion National Eisteddfod planned for 2020 has was postponed until 2022. However, we continued to promote our commitment towards the Welsh Language as outlined below.

The **Welsh Language Standards** placed on the UHB may provide challenges at times but they also provide us with many opportunities which allow us to develop ourselves as individuals and more importantly, as a wider team.

Meddwl Cymraeg
Think Welsh

In the past, it was often noted that many departments and individuals displayed a reluctance and weariness of the Welsh Language Standards and their intentions. In

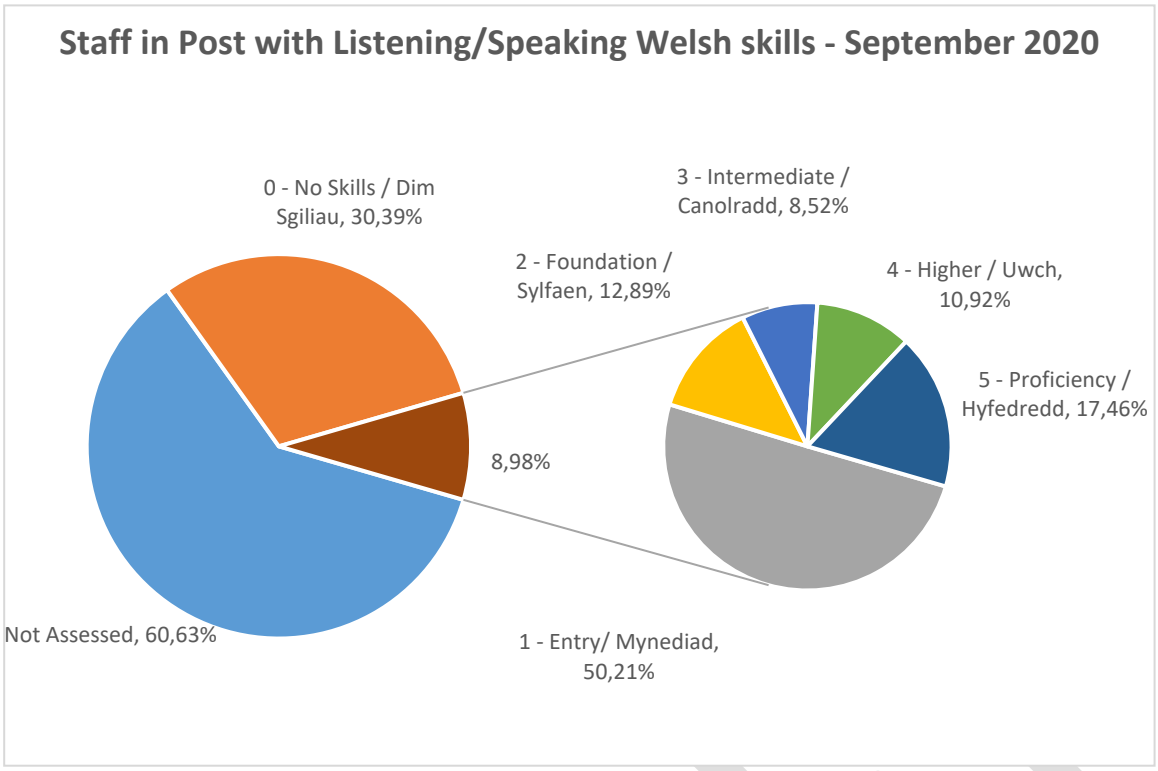
2020/21 we launched an internal campaign to raise awareness of the language, asking staff to 'Think' how considering the Welsh language may improve the service that they provide. This encourages staff to consider how the Welsh Language can be incorporated into their everyday roles, and about the role they can play in encouraging the growth of the language within the UHB and amongst colleagues.

Access to the Health board's services in Welsh, while showing external stakeholders that Welsh is increasingly at the forefront of the Health Board's thinking, will ultimately improve the level of care our patients receive.

The following have been implemented in line with the ideals and aspirations of the Welsh Language Standards and the Meddwl Cymraeg – Think Welsh campaign:

- Reviewed all Standards and acquired updates from the standard owners by utilising 'Verto' project management software which monitors the implementation and progress of our actions to meet the Welsh Language Standards. The system will allow us to determine the success of both the campaign and the implementation of the standards using a RAG rating system that outlines the closed, open and progressing standards. The overall plan will be successful when the 'Closed' green standards outnumber the 'Open' and 'Progressing' standards meaning the UHB is progressing towards full compliancy. We have now closed **68** of the **120** standards.
- Launched the Meddwl Cymraeg -Think Welsh campaign
- Re-established the Equality Strategy and Welsh Language Standards group
- Appointed two Senior Welsh Language Translators
- UHB website translation underway by Trosol, Wales' leading translation and subtitling company and all corporate social media accounts are now run bilingually
- UHB staff have been challenged to learning new Welsh Language skills as a New Years Resolution, training packs provided and future virtual lessons are being arranged
- Working in partnership with Capital and Estates department to ensure that signage is bilingual across all UHB sites
- Pilot Admissions Pack for Welsh Speaking Patients currently being implemented within Mental Health, Paediatrics and ICU with the intention of rolling out to all wards
- Collaborating with Cardiff University School of Medicine in relation to Medical students receiving training through the medium of Welsh whilst on placement
- Coordinating a collaboration on behalf of the Arts and Health Charity within the Noah's Ark Childrens Hospital for a Wales in space themed wall for patients and staff to raise awareness of the Welsh Language and culture which will allow both Welsh speaking and non-Welsh speaking patients to engage with before surgery thus helping to calm and distract the young patients

In 2020/21 there were 6 complaints related to compliance with the Welsh Language Standards. These are all being investigated and where possible have been rectified.



Emergency Preparedness (Abigail Harris)

NHS organisations must ensure that they have a Major Incident Plan that complies with the Civil Contingencies Act (2004) and associated Welsh Government Guidance. Most recently a combination of the Major Incident and Business Continuity Plans have been utilised in response to COVID-19.

The scale and impact of the pandemic has been unprecedented, and necessitated action at both a local and national level. The requirement to plan and respond to the pandemic presented a number of challenges to the UHB. The predicted impact on the organisation and population health was significant. This identified risks that dictated the activation of the Local Resilience Forum (LRF) Strategic Coordination Group (SCG).

A degree of uncertainty remains as to the overall impact on both immediate and longer term delivery of services by the organisation. However, a detailed proposal for Recovery detailing prioritised and appropriate action involving all appropriate partners has been produced. This will be supported by a robust risk management framework and the ability to identify, assess and mitigate risks which may impact on the ability to achieve UHB strategic objectives.

As previously highlighted the need to plan and respond to the COVID-19 pandemic presented a number of challenges to the organisation. A number of new and emerging risks where identified. Whilst the organisation did have a major incident and business continuity plan in place, as required by the Civil Contingencies Act 2004, the scale and impact of the pandemic has been unprecedented. Significant action has been taken at a national and local level to prepare and respond to the likely impact on the organisation and population. This has also involved working in partnership on the multi-agency response as a key member of the Strategic Co-ordination Group. There does remain a level of uncertainty about the overall impact this will have on the immediate and longer term delivery of services by the organisation, although I am confident that all appropriate action is being taken.

The organisation continues to work closely with a wide range of partners, including the Welsh Government as it continues with its response, and planning into the recovery phase. It will be necessary to ensure this is underpinned by robust risk management arrangements and the

ability to identify, assess and mitigate risks which may impact on the ability of the organisation to achieve their strategic objectives.

Environmental, Social and Community Issues

Our mission is **"Caring for People, Keeping People Well",** and our vision is that a person's chance of leading a healthy life should be the same wherever they live and whoever they are.

Cardiff and Vale University Health Board's 10-year transformation and improvement strategy, Shaping Our Future Wellbeing, is our chance to work collaboratively with the public and the Cardiff and Vale UHB workforce to make our health board more sustainable for the future. Together, we can improve equity for all of our patients - both today and tomorrow click here **Shaping Our Future Wellbeing - Cardiff and Vale University Health Board**

We believe that everyone should have the opportunity to lead longer, healthier and happier lives. But with an ageing population and changing lifestyle habits, our health and care systems are experiencing increasing demand.

Vale of Glamorgan Public Services Board Climate Change Charter Public sector partners in the Vale of Glamorgan have formally expressed their commitment to tackling climate change by agreeing a Vale Public Services Board Climate Change Charter https://www.valepsb.wales/en/Our-Progress/Tackling-Climate-Change-in-the-Vale-ofGlamorgan.aspx.

The development of the Charter follows discussions over the last 14 months including a workshop held in November 2019 with young people where we were joined by members of the UHB's Youth Board alongside enthusiastic youngsters from local schools and the Vale Council's Youth Forum. Natural Resources Wales has taken a lead in this work, which fully aligns to the UHB's Sustainability Action Plan approved at the November 2020 Board. The Charter signs partners up to a set of principles including leading by example, taking positive action and reducing our impact, while recognising that approaches and plans for implementation within individual Organisations may differ. We wanted to bring this work to the attention of the Board and for the Board to support the Charter ahead of a formal launch by the PSB in February; the aim is for this to provide a catalyst for engagement with the wider community on the issues and how we can make a difference in line with the commitments in the charter.

All hospital grounds in Cardiff and Vale Health Board Area are now Smoke-Free Our hospital grounds are now smoke-free. New laws introduced across Wales on 1 March, build on the smoking ban introduced in 2007 and will protect more people from harmful second-hand smoke and help those trying to quit. Anyone found breaking the law by smoking in the hospital grounds could face a £100 fine. The health board has been instrumental in supporting a smoke-free hospital environment and was the first health board in Wales to introduce a full No Smoking Ban across all hospital sites.

Further information on can be found in the performance report.

Carbon Reduction Delivery Plans (ABI? Thom)

The UHB has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements as based on UKCIP 2009 weather projections to ensure that the UHB's obligation under the Climate Change Act and the Adaptation Reporting requirements are complied with. Further information on key activities being undertaken in relation to environmental, social and community issues and carbon reduction delivery can be found in the Sustainability Report.

The organisation has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements as based on UKCIP 2009 weather projections to ensure that the organisation's obligation under the climate change Act and the Adaptation Reporting requirements are complied with.

Comment on the above should clearly identify whether there is compliance, or not, and if there are weaknesses or significant issues, these should be clearly identified along with actions to be taken.

Quality Governance Arrangements (check with Carol Evans)

An essential feature of our control framework is ensuring there is a robust system for measuring and reporting on the quality of our services. Our Quality Safety and Experience Committee provides timely evidence based advice to the Board to assist it in discharging its functions and meeting its responsibilities with regards to quality and safety as well as providing assurance in relation to improving the experience of all those that come into contact with our services.

The Annual Quality Statement forms part of our reporting process and provides an opportunity for us to describe in an open and honest way how we are ensuring all of our services are addressing local need and meeting the required high standard.

Ministerial Directions and Welsh Health Circular's (WHC'S)

Ministerial Directions issued by the Welsh Government during 2020-2021 have been considered and where appropriate implemented. Where appropriate, the Board or one of its Committees is also sighted on the contents of WHCs.

The following are essential features of an Annual Governance Statement per HMT guidance: Within the AGS, the NHS organisation needs to reference Ministerial directions received and comment upon the adoption / actions in response to the requirements in the context of the governance of the organisation e.g. confirm if subsequently significant issues have arisen in the implementation actions. The following table is an example of how Ministerial Directions could be referenced

Ministerial Directions/Date of Compliance	Date/Year of Adoption	Action to Demonstrate implementation/response
Continuation of immunisation programmes during the COVID-19 pandemic: letter from CMO (WHC/2020/006)	6 April 2020	Circulated to key staff and managers and discussed at appropriate meeting.
Reuse of end of life medicines in hospices and care homes during COVID-19 (WHC/2020/008)	30 April 2020	Circulated to key staff and managers and discussed at appropriate meeting.

Ministerial Directions/Date of Compliance	Date/Year of Adoption	Action to Demonstrate implementation/response
The national influenza immunisation programme 2020 to 2021 (WHC/2020/009)	21 May 2020	Circulated to key staff and managers and discussed at appropriate meeting.
Temporary amendments to model standing orders, reservation and delegation of powers (WHC 2020/011)	9 July 2020	Circulated to key staff and managers and discussed at appropriate meeting. Standing Orders amended and approved by Board
Clinical assessment of COVID-19 in the community (WHC/2020/012)	4 Aug 2020	Circulated to key staff and managers and discussed at appropriate meeting.
The national influenza immunisation programme 2020 to 2021 (WHC/2020/013)	14 Aug 2020	Circulated to key staff and managers and discussed at appropriate meeting.
Ear Wax Management Primary and Community Care Pathway (WHC/2020/014)	29 Sept 2020	Circulated to key staff and managers and discussed at appropriate meeting.
Policy on single use and reusable laryngoscopes (WHC/2020/015)	22 Sept 2020	Circulated to key staff and managers and discussed at appropriate meeting.
Support for GP premises liabilities (WHC/2020/018)	1 Oct 2020	Circulated to key staff and managers and discussed at appropriate meeting.
Health and wellbeing support for NHS health boards and trusts workforce (WHC/2020/019)	30 Oct 2020	Circulated to key staff and managers and discussed at appropriate meeting.
Procedure for the performance management, removal or suspension of NHS non-officer board members (WHC/2020)/016)	10 Dec 2020	Circulated to key staff and managers and discussed at appropriate meeting. Policy developed?
NHS Wales Annual Planning framework: health circular (WHC/2020/022)	14 Dec 2020	Circulated to key staff and managers and discussed at appropriate meeting.
EU exit: continuity of medicine supply at the end of the transition period (WHC/2020/023)	22 Dec 2020	Circulated to key staff and managers and discussed at appropriate meeting.
Clinical assessment of COVID-19 in the community (WHC/2020/024)	22 Dec 2020	Circulated to key staff and managers and discussed at appropriate meeting.
Health board allocations: 2021 to 2022 (WHC/2020/025)	22 Dec 2020	Circulated to key staff and managers and discussed at appropriate meeting.
Suspected cancer pathway: guidelines (WHC/2021/001)	14 Jan 2021	Circulated to key staff and managers and discussed at appropriate meeting.
Health board and trust champions: assessment of roles (WHC/2021/002)	19 Jan 2021	Circulated to key staff and managers and discussed at appropriate meeting.
The national influenza immunisation programme 2021 to 2022 (WHC/2021/004)	19 Feb 2021	Circulated to key staff and managers and discussed at appropriate meeting.
Senedd Election 2021: letter to NHS health boards and trusts (WHC/2021/003)	11 Mar 2021	Circulated to key staff and managers and discussed at appropriate meeting.

Ministerial Directions/Date of Compliance	Date/Year of Adoption	Action to Demonstrate implementation/response
Elections to Senedd Cymru May 2021: guidance for NHS Wales (WHC/2021/006)	10 Mar 2021	Circulated to key staff and managers and discussed at appropriate meeting.
The Healthy Child Wales Programme: 6 week post-natal GP physical examination of babies (WHC/2021/007)	11 Mar 2021	Circulated to key staff and managers and discussed at appropriate meeting.
Check if more before 31 March		

The Welsh Health Circulars (WHCs) published by Welsh Government during 2020-2021 can be viewed at: https://gov.wales/healthcirculars#Circulars2019

Regulatory and Inspection Reports Nikki

A formal system is in place to track regulatory and inspection reports against statutory requirements. These reports are made available to the appropriate Board Committee and are discussed at Management Executives and Health System Management Board which includes the entire leadership team of the organisation. Quarterly follow ups also take place with the Executive Leads.

In 2019-20 we have strengthened our system for tracking recommendations and regulatory compliance. Three tracking reports have been implemented which capture: Internal Audit reviews, Audit Wales reviews and regulatory compliance.

These reports are monitored at each Audit Committee and were first presented there on 30 September 2019. The follow-up review undertaken by Internal Audit has provided Reasonable assurance. Our focus in 2020-21 is on addressing the high number of outstanding recommendations that remain.

Data Security and Information Governance (James Webb))David Thomas exec lead)

Risks relating to information are managed and controlled in accordance with the UHB's Information Governance Policy through the Digital Health and Intelligence Committee, which is chaired by an Independent Member.

The Executive Medical Director, as Caldicott Guardian, is responsible for the protection of patient information. All Information Governance issues are escalated through the Digital Health and Intelligence Committee. The Committee papers can be viewed here: Digital & Health Intelligence Committee papers.

The following items were considered by the Committee in 2020-2021:

- Digital Strategy;
- GDPR Audit Action Plan;
- IT Delivery Programme;
- Information Governance Compliance Reports;
- Information Governance Risk Register;
- Information Governance Policy.

The Senior Information Risk Owner (SIRO) provides an essential role in ensuring that identified information security risks are addressed and incidents properly managed. Following the ICO audit, which took place in February 2020, the UHB has received 'reasonable assurance' on its assurance and compliance and 'reasonable assurance' on Cyber Security. An action plan, which incorporated outstanding recommendations from the ICO audit in 2016, the Internal Audit on GDPR compliance, the

Audit Wales 2018 Structured Assessment and the Caldicott Principles in Practice (CPiP) will be superseded by recommendations from the ICO 2020 audit. The action plan is a standing agenda item at the Digital Health and Intelligence Committee. The 'urgent' recommendations for both
the assurance and compliance and Cyber Security audits are:

- The UHB urgently needs to put in place an appropriate policy document to support the
  accuracy of determined lawful bases as required by Schedule 1 of the Data Protection Act 2018;
- The organisation should consider mandating the Cyber Awareness e-learning solution
  for staff who routinely handle digital patient information, have email accounts or who have any responsibility for digital information security in their roles or where supervising others;
- The ICO recommends that Information Governance and cyber security training is refreshed annually;
- The organisation should put in place regular Training Needs Analysis for staff with responsibilities for managing information securely;
- The organisation should ensure that any trainers put in place to deliver cybersecurity training are themselves trained to deliver that information effectively and field any questions.

The Board has strict responsibilities to ensure personal data and information is held securely. All information governance related incidents are investigated and reviewed by the Information Governance Group.

During the period April 2020 and March 2021 there were xxx personal data security incidents which needed to be reported to the Information Commissioners Office (ICO).

The first related to xxxxxxxa letter with a partial address which did not arrive with the intended recipient.

Staff training numbers have steadily increased over the year with the current compliance at the end of March 2020 reaching xx%, an increase of x% over the past 12 months.

There has been a focus on keys areas that have the most impact in terms of compliance with the following key areas being progressed:

- Establishment of a GDPR Task & Finish Group, reporting through the Information Governance Group and Quality, Safety & Risk Committee
- GDPR Communications Campaign for managers and staff including intranet site, briefings, newsletters and posters
- Development and on-going population of an organisational-wide Information Asset Register •
- Personal Data Breaches Procedure (to meet the requirement to report data breaches within 72 hours)
- Data Protection Impact Assessment (DPIA) Procedure (to meet the requirement to ensure a "privacy by design" approach and accountability requirements) •
- Development of privacy notices
- Contractual reviews by local procurement.

In addition, advice and support is available to contractor professions, who as independent contractors, retain legal responsibility for the personal identifiable data that they hold.

The UHB continues to reinforce awareness of key principles of Data Protection legislation. This includes the overarching principle that users must only handle data in accordance with people's data
protection rights.

UK Corporate Governance Code (check with Nikki)

Whilst there is no requirement to comply with all elements of the Corporate Governance Code for Central Government Departments, the Health Board considers that it is complying with the main principles of the Code where applicable, and follows the spirit of the Code to good effect and is conducting its business openly and in line with the Code. This has been informed by the Audit Wales "Doing it Differently, Doing it Right? Governance in the NHS during the COVID-19 crisis – Key themes, lessons and opportunities" report[4] published in January 2021 which focuses on how NHS bodies have governed during the COVID-19 crisis, with a particular focus on putting citizens first, decision making and accountability, and gaining assurance.

An assessment against the code was undertaken ??????. There were no reported/identified departures from the Corporate Governance Code during the year. A detailed assessment will be undertaken against the code, however, this has been delayed due to the impact of the COVID-19 response. A full assessment against the Code utilising the framework developed by the Deputy Board Secretary Peer Group will be undertaken by December 2021.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the Executive officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

Further sources of assurances are identified within the Board's own performance management and

[4] Doing it Differently, Doing it Right? | Audit Wales

assurance framework and include, but are not limited to:

- Direct assurances from management on the operation of internal controls through the upward chain of accountability
- Internally assessed performance against the Health and Care Standards
- Results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management
- Reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period
- Reviews completed by external regulation and inspection bodies including the Audit Wales and
  Healthcare Inspectorate Wales (HIW).

The effectiveness of the system of internal control is maintained and reviewed by the Committees of the Board in respect of assurances received. This is also supported by the BAF with high risks being closely monitored by Board and the respective Committees.

Governance, Leadership and Accountability (Jacqui check with governance team)

Due to pressures around COVID-19 the annual electronic self-assessment to review Board / Committee effectiveness, including the quality of data received by the Board and whether we meet the Health and Care Standard for Governance, Leadership and Accountability is not yet concluded.

The self-assessment has however been circulated to Board and Committee members, and results captured will feed into the continuing Board effectiveness work and action plan for 2020-21.

A Board/Committee review was commissioned in 2020-2021 where views of members were sought and feedback was that a more forward looking and strategic approach is needed. A workshop was planned to follow this through but due to COVID-19 this was put on hold; this work will also recommence in 2020-21.

Board and Committee Effectiveness

I have overall responsibility for risk management and report to the Board regarding the overall effectiveness of risk management across the Health Board. My advice to the Board is informed by reports on internal controls received from all its Committees and in particular the Audit Committee, Quality, Safety & Experience Committee the Finance Committee and the Strategy & Delivery Committee ensuring alignment and connections with the Board's business. The Quality, Safety & Risk Committee also provides assurance relating to issues of clinical governance, patient safety, patient experience and the application of the Health and Care Standards. In addition, reports submitted to the Board by the Executive Team identify risk issues for consideration.

each of the Health Board's Committees have considered a range of reports relating to their areas of business during the last year, which have included a comprehensive range of internal audit reports and external audit reports and reports on professional standards and from other regulatory bodies. The Committees have also considered and advised on areas for local and national strategic developments and new policy areas.

Each Committee develops an annual report of its business and the areas that it has covered during the last year and these are reported in public to the Board. Overall I consider the arrangements supporting the system of internal control in place within C&VUHB to be appropriate. However, recognising the issues raised within the 2020 WAO Structured Assessment report 2020[5] and significant matters of concern raised within external review reports, it is clear we have areas where some internal control and quality governance elements need to be strengthened.

Committee Effectiveness Survey

Add this in chase Luke if Sian's work was issued

Escalation and Intervention Arrangements

Following a tripartite meeting between Welsh Government, HIW and Audit Wales in early October, we were notified that we will be maintaining our rating of 'routine

[5] Cardiff and Vale University Health Board - Structured Assessment 2020 | Audit Wales

arrangements.' The Director General of Health & Social Services/Chief Executive NHS Wales also recognised the professional and considered way in which the NHS and the UHB responded to the extraordinary circumstances of the pandemic response

During the period 2020-2021, with the exception of the impact of the Covid 19 pandemic, no serious issued were identified to affect NHS delivery, quality and Safety of care and organisational effectiveness, and Cardiff & Vale UHB have continued to be monitored through "routine arrangements" since December 2019[6].

Internal Audit (wait for Audit committee April)

Internal audit provide me as Accountable Officer and the Board through the Audit Committee with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered in accordance with public sector internal audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit Committee and is focussed on significant risk areas and local improvement priorities.

The overall opinion by the Head of Internal Audit on governance, risk management and control is a function of this risk based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

The programme has been impacted by the need to respond to the COVID-19 pandemic with some audits deferred, cancelled or curtailed as the organisation responded to the pandemic. The Head of Internal Audit is satisfied that there has been sufficient internal audit coverage during the reporting period in order to provide the Head of Internal Audit Annual Opinion. In forming the Opinion the Head of Internal Audit has considered the impact of the audits that have not been fully completed.

The Head of Internal Audit Opinion

As a result of the COVID-19 pandemic and the response to it from the UHB Internal Audit has not been able to complete its audit programme in full.

However, sufficient audit work has been undertaken during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

During April 2020-March 2021 xx Internal Audit outputs had been anticipated at year end however due to the impact of COVID-19 the final position is: 37 Final reports, 2 Draft reports and 7 which were either removed or deferred into the 2020-21 Internal Audit plan. Where changes were made to the audit plan then the reasons were presented to the Audit Committee for consideration and approval. The significance of these deferred audits has been taken into account when assessing the ratings for the assurance domains and the overall assurance opinion.

For those audits that were either at the draft report stage or are work in progress, an appropriate approach will be agreed with the UHB to complete and finalise those audits for formal submission to the Audit Committee at a later date.

[6] Written Statement: Escalation and Intervention Arrangements (7 October 2020) | GOV.WALES

The following audits could not be completed due to the COVID-19 outbreak. This was reported to the Audit Committee at its meeting on xx April 2021.

Audit Topic
xxxxx

The scope of this opinion is confined to those areas examined in the risk based audit plan which has been agreed with senior management and approved by the Audit Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement.

The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

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.

 Reasonable	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.

In reaching this opinion the Head of Internal Audit has identified that ... [draw from the HIA annual report to highlight any particular assurance domains; also highlight any limitations in scope which may have impacted the opinion]

Limited Assurance

During the year internal audit issued the following audit reports with a conclusion of limited assurance:

• [Name of audit, issues leading to conclusion, action plans agreed/ action taken, follow-up audit findings, etc.]

As part of this narrative, it is a Welsh Government requirement that a summary of the conclusions of the annual Audit Wales [formerly Wales Audit Office] Structured Assessments of the NHS body is included, along with narrative on any significant matters identified and actions taken.

An essential feature of the Annual Governance Statement is a comment upon the quality of data used by the board, and why the board finds it acceptable in making its assessment of the governance of the organisation.]

In addition to general comment upon the work of internal audit, and the HIA opinion, the AGS must also note any audits for which No or Limited Assurance have been received in year, and comments provided with regard to actions either taken or planned to address the key issues arising.

There are no audited areas in which the Board has No assurance.

External Audit - Audit Wales

The Auditor General for Wales is the UHB's statutory external auditor and the Wales Audit Office undertakes audits on his behalf. Since 1 April 2020 the Auditor General for Wales and the Wales Audit Office are known collectively as Audit Wales. Audit Wales scrutinises the UHB's financial systems and processes, performance management, key risk areas and the Internal Audit function.

The Annual Audit Report for 2020[7]

The following performance reviews were included in the Audit Wales 2020 Audit Plan. The resultant reports were presented to the Audit Committee and the review recommendations recorded in a tracking report which is provided to each Audit and Assurance Committee to provide assurance on their implementation. The Audit and Assurance Committee also reviews the outcomes of national reviews at each meeting.

Add table

The Annual Audit Report 2020 did not identify any material weaknesses in the Health Board's internal controls (as relevant to my audit) and concluded 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.
- 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 break even.
- 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.
- the Health Board demonstrates a commitment to counter-fraud, has suitable arrangements to support the prevention and detection of fraud and is able to respond appropriately where fraud occurs.

However, the audit report to drew attention to two disclosures in the accounts, relating to:

- the impact of COVID-19 on the valuation of the Health Board's land and buildings as at 31 March 2020; and
- the impact of a Ministerial Direction to the Permanent Secretary of the Welsh Government, instructing her to fund NHS clinicians' pension tax liabilities incurred by NHS Wales bodies in respect of the 2019-20 financial year.

Three important issues were brought to the attention of officers and the Audit Committee relating to some of the Health Board's accounting processes and

[7] [7] Cardiff and Vale University Health Board – Annual Audit Report 2020 | Audit Wales

underlying records. The Health Board did not achieve financial balance for the three-year period ending 31 March 2020, and although it had no other material financial transactions that were not in accordance with authorities nor used for the purposes intended, I issued a qualified opinion on the regularity of the financial transactions within the Health Board's 2019-20 accounts. Alongside my audit opinion, I placed a substantive report on the Health Board's financial statements to highlight the failure to achieve financial balance.

The Annual Audit Plan for 20201 has been set and was presented to the Audit and Assurance Committee on x March 2021 however COVID-19 will impact on Audit Wales audit work and as a result, this audit plan will be amended accordingly and changes fed back to the Audit and Assurance Committee.

Cardiff and Vale University Health Board - Structured Assessment 2020

The Audit Wales Structured Assessment for 2020[8] provides and assessment of the UHB's corporate arrangements for ensuring that resources are used efficiently, effectively and economically. can be viewed here
The Structured assessment for 2020 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.
- 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 break even.
- 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.

Modern Slavery Act 2015 – Transparency in Supply Chains (check with Claire Salisbury)

The Welsh Government's Code of Practice: Ethical Employment in Supply Chains was published in May 2017 to highlight the need, at every stage of the supply chain, to ensure good employment practices exist for all employees, both in the UK and overseas. It is expected that all NHS Wales organisations will sign up for the Code.

C&VUHB fully endorses the principles and requirements of the Code and the Modern Slavery Act 2015 and is committed to playing its role as a major public sector employer, to eradicate unlawful and unethical employment practices, such as:

- Modern Slavery and Human rights abuses;
- The operation of blacklist/prohibited lists;
- False self-employment;
- Unfair use of umbrella schemes and zero hours' contracts; and

[8] [8] Cardiff and Vale University Health Board - Structured Assessment 2020 | Audit Wales

- Paying the Living Wage.

The **following actions are already in place** which meet the Code's commitments:

- We have a Raising Concerns (Whistleblowing) Policy, which provides the workforce with a fair and transparent process, to empower and enable them to raise suspicions of any form of malpractice by either our staff or suppliers/contractors working on University Health Board premises;
- We have a target in place to pay our suppliers within 30 days of receipt of a valid invoice;
- We comply with the six NHS pre-employment check requirements to verify that applicants meet the preconditions of the role they are applying for. This includes a right to work check;
- We have introduced robust IR35 processes to ensure the fair and appropriate engagement of all workers and prevents individuals from avoiding paying Tax and National Insurance contributions;
- We do not engage or employ staff or workers on zero hours' contracts;
- We have in place an Equality and Diversity Policy which ensures that no potential applicant, employee or worker engaged is in any way unduly disadvantaged in terms of pay, employment rights, employment or career opportunities;
- We also seek assurances from suppliers, via the tender process, that they do not make use of blacklists/prohibited lists. We are also able to provide confirmation and assurances that they do not make use of blacklist/prohibited list information;
- In accordance with Transfer of Undertaking (Protection of Employment) Regulations any Health Board staff who may be required to transfer to a third party will retain their NHS Terms and Conditions of Service;
- We use the Modern Slavery Act (2015) compliance tracker by way of contracts procured by NHS Wales Shared Services Partnership (NWSSP) on behalf of the Health Board. NWSSP is equally committed to ensuring that procurement activity conducted on behalf of NHS Wales is undertaken in an ethical way. On our behalf, they ensure that workers within the supply chains through which they source our goods and services are treated fairly, in line with Welsh Government's Code of Practice for Ethical Employment in Supply Chains.

C&VUHB continues to work in partnership with relevant stakeholders and trade union partners to develop and implement actions which set out our commitment to ensure the principles of ethical employment within our supply chains are implemented and adhered to.

Conclusion

As Accountable Officer, based on the assurance process outlined above, I have reviewed the relevant evidence and assurances in respect of internal control. I can confirm that the Board and its Executive Directors are alert to their accountabilities in respect of internal control.

No significant internal control or governance issues have been identified or make specific reference to those significant issues which may have been identified above in this Statement.

[This conclusion should be unambiguous for the reader, clearly setting out if there were sound systems of internal control in place to support the delivery of policy aims and objectives. If issues are identified as being significant, the Annual Governance Statement should in the preceding narrative not only set out the issue but also what action is being taken to manage the issue].

During 2020-2021, we have again proactively identified areas requiring improvement and requested Internal Audit to undertake detailed assessments in order to manage and mitigate associated risks. A number of reports issued by Internal Audit concur with our view and have consequently provided the UHB with clear recommendations to ensure that focussed and urgent management actions are in place to address identified shortcomings. These actions are then monitored through the Board and its Committees to ensure appropriate assurances can be provided.

I am pleased to note sufficient progress made in relation to our Standards of Behaviour to warrant an Internal Audit finding of xxxxxx assurance on follow-up review. In addition, assurance is provided by the audits of Budgetary Control and the Core Financial systems which were both given xxxxxxx assurance.

Updated text needed
There have been significant improvements to risk management, with the BAF now an integral part of the UHB's risk management process. The UHB has an approved IMTP covering the years 2019-20 to 2021-22 however we have not achieved our financial duty of break even for the three years to 31 March 2020. We have operated within our capital resource for the three years to 31 March 2020 (subject to current audit), but have not done so for the same three-year period in respect of our revenue resource limit. More detail is provided in the Financial Statements, Note 2. If the UHB successfully delivers its current approved IMTP, it would achieve the Statutory Financial Duty to break even for the three years to 31 March 2022.

In 2019-20, the UHB received a Health and Safety Executive fine following the fall of a contractor on our premises. A great deal of work has been done within the UHB to improve our systems and processes around contractors and the Health and Safety Committee and the Board received reports to provide assurance around these lessons learned.

As indicated throughout this statement and the Annual Report the need to plan and respond to the COVID-19 pandemic has had a significant impact on the organisation, wider NHS and society as a whole. It has required a dynamic response which has presented a number of opportunities in addition the risks. The need to respond and recover from the pandemic will be with the organisation and wider society throughout 2020/21 and beyond. I will ensure our Governance Framework considers and responds to this need.

As a result of the COVID-19 governance structure put in place, the continuation of the Board and key Committees and continued presence of Executive Directors and Independent Members, I am confident that our systems of internal control have not been materially affected and am assured that there have been no significant internal control or governance issues during the time of pandemic.

In summary, my review confirms that the Board has sound systems of internal control in place to support the delivery of policy aims and objectives and that there are no significant internal control or governance issues to report for 2020-2021.

Signed by
Chief Executive:
Date

Part 2b

Remuneration and Staff Report

CARING FOR PEOPLE
KEEPING PEOPLE WELL

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Remuneration and Staff Report

TO BE ADDED

6.1 Staff Numbers

The UHB workforce profile identifies that approximately 76% of the workforce is female. This is not representative of the local community where a little more than half the population is female. The numbers of female and male directors, managers and employees as at 31st March 2021 were as follows:

	Female	Male	Total
Director	13	14	27
Manager	135	74	209
Employee	11386	3474	14860
Total	11534	3562	15096

6.2 Staff Composition

The charts below indicate the following challenges when determining optimal ways to deploy the current and future workforce and how to consider future supply against service priorities:

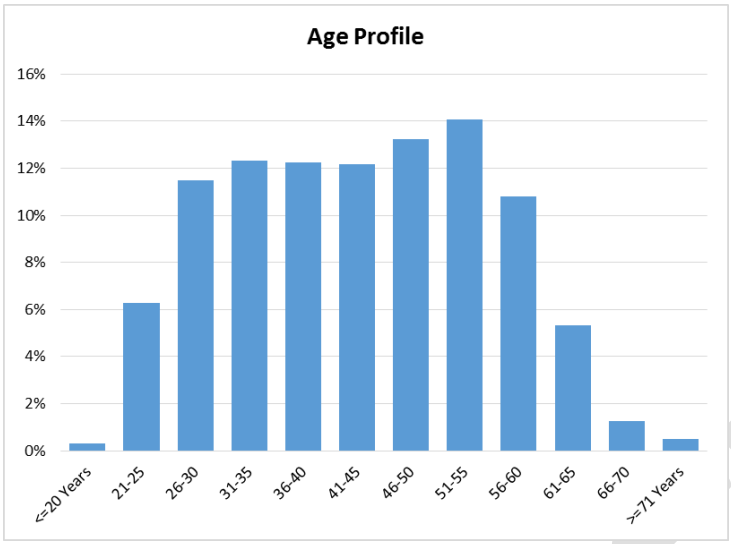
- The UHB has an aging workforce with the largest age categories being aged 46-50 years and 51-55 years (approximately 2000 staff in each of these categories). The impact of employees retiring from service critical areas is key in Clinical Boards undertaking local workforce planning.

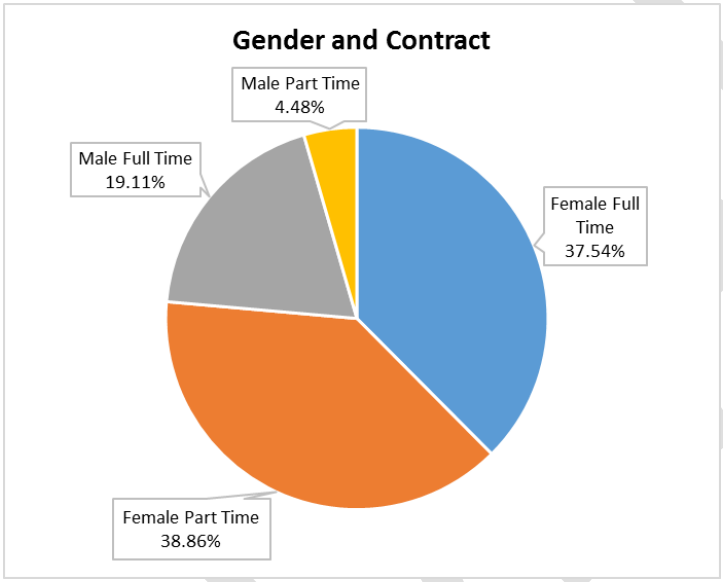
- The largest grade categories are staff in Agenda for Change Bands 2, 5 and 6. Continually reviewing skill mix and new ways of working is important in ensuring adequate future supply of skills in the right place and grade.

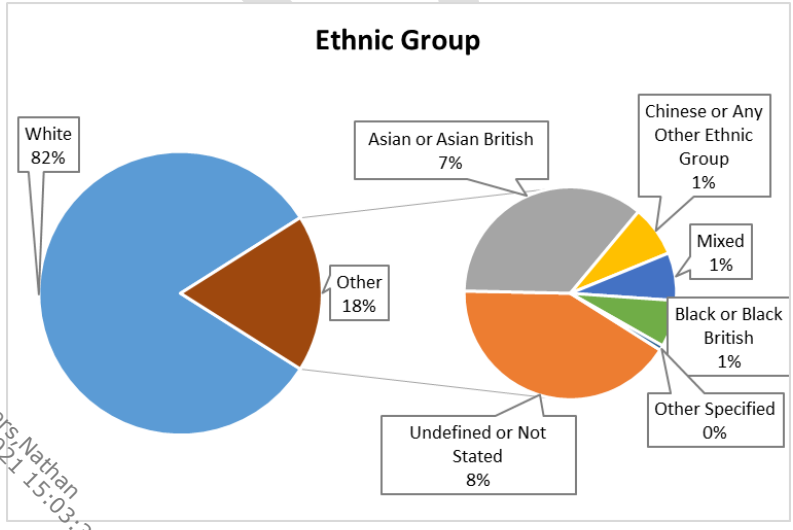
- The majority of the workforce is female (76%) with an even split in this group of full-time (38%) and part-time working (39%). Use of our employment policies, such as the Flexible Working Policy, is crucial to retaining talent and keeping staff engaged.

- The majority of the workforce is white (82%) with 11% in Black and Minority Ethnic categories and 7% not stated. The Strategic Equality Plan has a number of actions to continue review of our workforce in this regard to ensure it strives to reflect the local population where relevant e.g. in recruiting practices.

- The nursing and midwifery registered staff and unqualified nursing staff make up just over 42% of the total workforce. Given there is a recognised national shortage of registered nurses, the UHB has made nurse sustainability a high priority on its workforce agenda.







Saunders,Nathan
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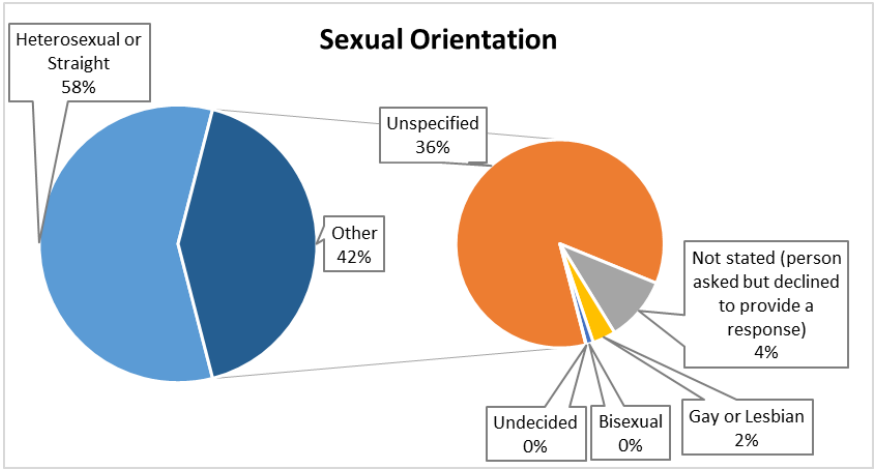
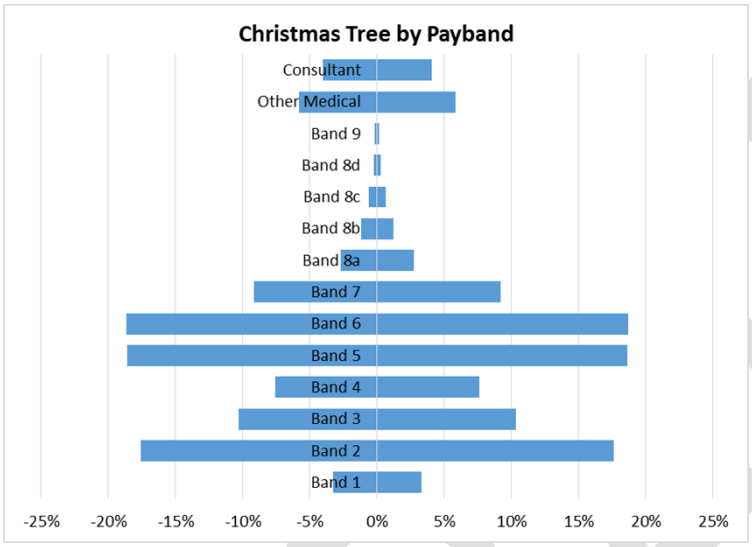
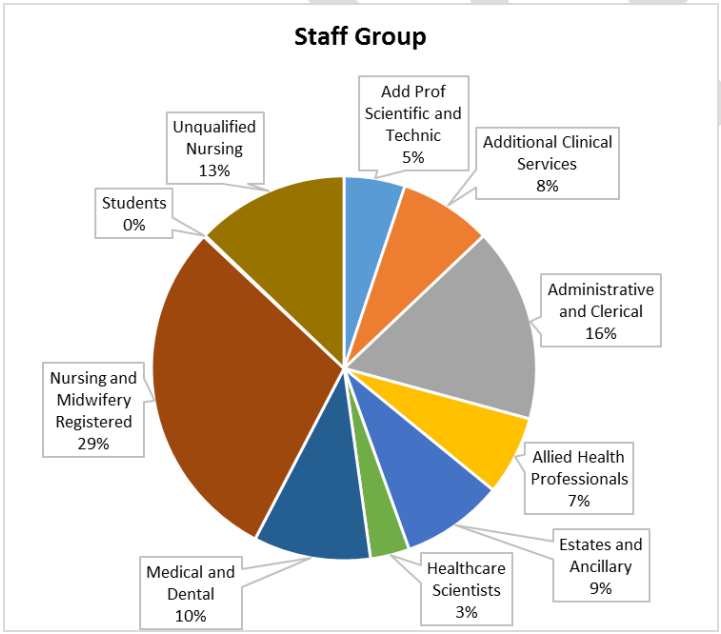
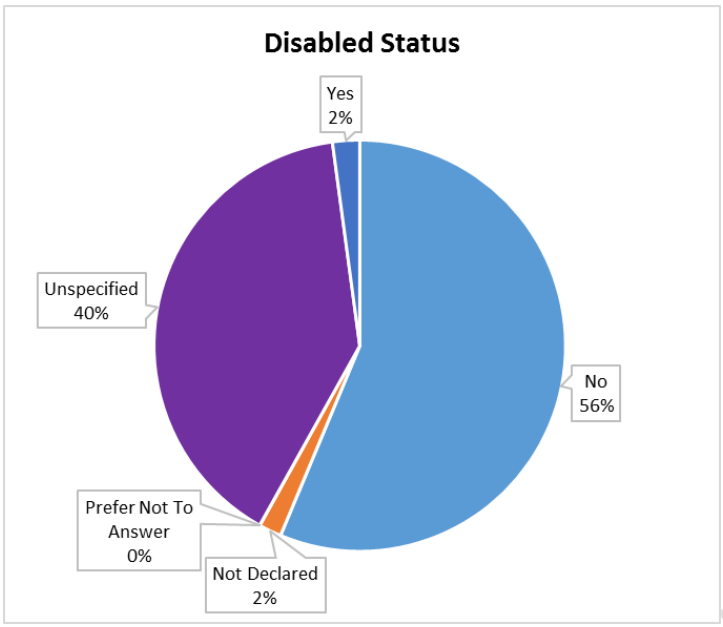






Workforce profile information collected for the UHB in March 2020 shows that 2.13% of staff consider themselves to have a disability, but this information is not known for a significant number of staff (41.54%).



N.B. Graphs are illustrative only at current time and contain data from March 2020 – March 2021 data will be added at the end of the month

6.3 Sickness Absence Data

The health and wellbeing of Cardiff and Vale UHB staff is of upmost importance, especially at this unprecedented time and much of the work carried out in 2020/21 has been described in the Performance Report.

The UHB has achieved both the Gold and Platinum Corporate Health Standards and has been recognised as an exemplar organisation. In2020/21 we have continued to use the learning from these standards to stretch our health and wellbeing activity even further, and have begun to prepare for re-assessment against the standards in ??.

Sickness absence remains a priority for the UHB. The cumulative sickness rate for the 12-month period up to and including March 2021 is **XXX%** which is XXX% above the 2020-21 year-end target of XXX%. CAN WE EXPLAIN HOW MUCH OF THIS IS DUE TO COVID?

XX% of this sickness was attributed to long-term absence and XX% to short-term absence. The UHB top reasons recorded for absence during 2020-21were Anxiety/Stress and Musculoskeletal.

The following table provides information on the number of days lost due to sickness during 2019-20 and 2020-21.

	2019-20	2018-19
	Number	Number
Days lost (long term)		
Days lost (short term)		
Total days lost		

Total staff years		
Average working days lost		
Total staff employed in period (headcount)		
Total staff employed in period with no absence (headcount)		
Percentage staff with no sick leave		

Cardiff and Vale UHB is passionate about caring for the wellbeing of its staff members. – nicky to update on return from AL (or ? covered in performance report)

6.4 Staff Policies

At Cardiff and Vale UHB we have 6 local UHB employment Policies:

- Recruitment and Selection
- Adaptable Workforce
- Employee Health and Wellbeing
- Learning Education and Development
- Equality, Diversity and Human Rights Policy
- Maternity, Adoption, Paternity and Shared Parental Leave

These set out our organisational commitments and what we are aiming to achieve. Each of them is supported by a number of Procedures which describe the processes to follow, roles & responsibilities, and any entitlements or obligations. This means there is less duplication, more transparency and information which is easier to understand. These are in addition to the ALL-WALES Policies which apply to us and all other Health Boards in Wales

All employment and other related Human Resources (HR), Workforce and Organisational Development (WOD) policies, procedures and guidelines are required to have at least two authors, i.e. a management and staff representative and they are subject to robust consultation processes. This includes publication on the UHB intranet for a period of at least 28 days and consideration at the Employment Policies Sub Group of the Local Partnership Forum.

In January 2021 the UHB published its revised **Equality, Inclusivity and Human Rights Policy**. This Policy replaces the previous Equality, Diversity and Human Rights Policy. The language has been updated throughout and it takes account of:

- the new Socio-Economic Duty
- the Welsh Language Standards
- the new Strategic Equality Plan- Caring About Inclusion 2020-2024

Having an Equality, Inclusion and Human Rights Policy shows that as an employer we are committed to providing meaningful equality of opportunity and inclusion for all employees, regardless of their protected characteristics (i.e. gender identity, marital status, race, ethnic origin, maternity status, nationality, national origin, sex, disability, sexual orientation, religion or age). Its remit goes beyond strict compliance with the law and acts as a reference point in the event of any subsequent disputes.

In light of recent events, such as the differential impacts of the pandemic on different population groups, the Black Lives Matter movement and case law decisions, the updated Policy has taken account of language change and a move from equality to inclusivity. The updated policy means that everyone is treated fairly throughout the recruitment and employment process; it is about addressing the balance so everyone feels equal and included within the workplace. It recognises that all employees should be treated as individuals and no judgements should be made based on stereotypes. Instead, all employees should feel understood, appreciated and valued for their own set of skills. The Policy sets out what we will do to achieve this.

The UHB is committed to ensuring that the recruitment and selection of staff is conducted in a systematic, comprehensive and fair manner, promoting equality of opportunity at all time, eliminating discrimination and promoting good relations between all. The **Recruitment and Selection Policy** sets out how we will attract, appoint and retain qualified, motivated staff with the right skills and experience to ensure the delivery of a quality service and support its values. This is supported by a number of procedures including the Recruitment and Selection Procedure, Fixed Term Contract Procedure and Professional Registration Procedure.

The UHB is committed to equal opportunities in recruitment, and demonstrates this by displaying the Disability Confident symbol (which replaces the 'two ticks' scheme) in all adverts, as well as Supporting Age Positive, Mindful Employer and Stonewall Cymru symbols.

The UHB is committed to supporting its employees and keeping them well. In 2019 we adopted a new **Employee Health and Wellbeing Policy** which sets out our commitment to encourage and empower employees to take personal responsibility for their lifestyle choices, health and wellbeing, and to guide manager on their roles and responsibilities.

The **NHS Wales Managing Attendance at Work Policy** assists managers in supporting staff when they are ill, manage their absence and help facilitate their timely return to work, but it is about more than that - it is also designed to help you know your staff and focus on their health and wellbeing to keep them well and in work.

The Managing Attendance at Work Policy includes a number of toolkits. One of these deals with reasonable/tailored adjustments – it reminds managers of our legal duty to make reasonable adjustments to ensure workers with **disabilities, or physical or mental health impairments**, are not disadvantaged when doing their jobs or during the recruitment process. The Policy states that not all illnesses are disabilities, however, if an employee is asking for support with a health and wellbeing condition, it

is best to provide the support accordingly, assuming it is proportionate to do so. There are many benefits to this including supporting the employee back into work and helping them remain in work.

We reviewed our **Redeployment Procedure** in 2020. This sets out the process by which suitable alternative employment is sought for employees who are unfit or no longer able to carry out the duties of their current post, either on a temporary or permanent basis. This can be for a number of reasons, including health. It is important that staff and managers are clear about their responsibilities and the process to be followed to ensure that everyone is treated fairly and equitably. Although the process of finding a redeployment opportunity is coordinated by Human Resources, the responsibility and ownership for actions taken is shared with the individual concerned and their substantive line manager, who are both expected to take all possible steps to find and pursue suitable opportunities. The Procedure aims to ensure that clear advice, support and guidance is provided to managers and employees regarding their role(s) in managing situations where employees need to be transferred into suitable alternative posts.

By making reasonable adjustments for staff with disabilities we have been able to retain a number of valued employees in their substantive role. Typical changes include reviewing case loads, changes to equipment used, purchase of specialist equipment and modifying their workplaces. We have worked with organisations such as Access to Work to support our disabled employees.

The Health Board has undertaken the opportunity to undertake a partnership approach with DFN Project Search. DFN Project Search is a one year, employment preparation programme that takes place entirely in the workplace. This will help to deliver the best employment outcomes for young adults from SEN education providers with learning disabilities and/or autism across the Cardiff and the Vale who are under-represented in the workforce. This will assist achieving part of the widen access into employment agenda.

6.5 Other Employee Matters

TO BE ADDED

- This is being completed by finance (Rhian Selwood) apart from one section on "…organisation's remuneration policy for directors and senior managers and how the policy has been implemented…"

6.6 Consultancy Expenditure

TO BE ADDED

6.7 Tax Assurance for Off-payroll Appointees

TO BE ADDED

Part 2b

National Assembly for Wales Accountability & Audit Report

National Assembly for Wales Accountability and Audit Report

TO BE ADDED APRIL/MAY 2021

7.1 Regularity of Expenditure

7.2 Fees and charges

7.3 Managing public money

7.4 Material remote contingent liabilities

7.5 The Certificate of the Auditor General for Wales to the Senedd

7.6 Report of the Auditor General to the Senedd

Part 3

Audited Financial Statements

(Annual Accounts)

Financial Statements

TO BE ADDED APRIL/MAY 2021

Foreword

These accounts have been prepared by the Local Health Board under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

Statutory background

The Local Health Board was established on 1 October 2009, following the merger of Cardiff & Vale NHS Trust, Cardiff Local Health Board and The Vale of Glamorgan Local Heath Board. The main purpose of the body being, the provision of healthcare to and the procurement of healthcare for the populations of Cardiff and the Vale of Glamorgan. In addition, as a Tertiary Centre the UHB serves the wider population across Wales (and the UK) via the provision of specialist and complex services.

Performance Management and Financial Results

Welsh Health Circular WHC/2016/054 replaces WHC/2015/014 'Statutory and Administrative Financial Duties of NHS Trusts and Local Health Boards' and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2019-20. The annual financial duty has been revoked and the statutory breakeven duty has reverted to a three-year duty, with the first assessment of this duty in 2016-17.

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result, the Primary Statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the LHB which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

Under the National Health Services Finance (Wales) Act 2014, the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3-year period, that its aggregate expenditure does not exceed its aggregate approved limits.

The Act came into effect from 1 April 2014 and under the Act the first assessment of the 3 year rolling financial duty took place at the end of 2016-17.

Conclusion and forward look

Going forward organisations will want to build on some of the innovative ways of working to improve healthcare quality and the safety of patients and staff across the whole patient pathway, to help evidence the duties of quality and candour set out in the Health and Social Care (Quality and Engagement) (Wales) Act 202

Appendix 1

Dates of Board and Committee meetings held during 2020-2021

Due to the pressures associated with COVID-19, the UHB stood down the meetings of some of its Committees, as summarised in the below table. This action was approved by the Board Governance Group described below and ratified at the Board meeting on 28 May 2020.

The Table x outlines dates of Board and Committee meetings held during **2020-2021,** highlighting any meetings that were inquorate:

Table 1 - Dates of Board and Committee meetings held during **2020-2021**

Board/Committee	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March
Board	x	28	29	30	x	24	x	26	17	28	25	25
Board of Trustee		26		23 Special		22		17 Special		26		
Audit Committee	21	28 Workshop	29 Special	07		08		17			09	
Charitable Funds		05	23 Special	08 Special		01		03				16
Digital Health & Intelligence			09	09 Special			08				11	
Finance	29	27	24	29	26	23	28	25	30	27	24	24
Health & Safety	30							24		5		30

Mental Health & Capacity Legislation				21			20			19		
Quality, Safety & experience	14		16			08	13 Special		15		16	
Remuneration & Terms of Service					06		09 & 15	04	16			26
Strategy & Delivery		12		14		15		10		12		09

All meetings held were quorate.

Table 2 - Dates of Advisory Group meetings held during **2020-2021**

Advisory Groups	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March
Stakeholder Reference				22		23		24		26		23
Healthcare Professional Forum												
Local Partnership Forum		21	18		03		22		09 & 16		12	

C&VUHB are also representatives on the following Joint Committees:

- Welsh Health Specialised Services Committee (WHSSC)
- Emergency Ambulance Services Committee (EASC)
- NHS Wales Shared Services Partnership Committee (SSPC)

Assurance reports/bulletins from the above Committees are captured on the Board agenda as required.

Cardiff and Vale
University Health Board
COVID-19: One Year On

#CAVOneYearOn

Report Title:	**Declarations of Interest, Gifts, Hospitality & Sponsorship**								
Meeting:	**Audit & Assurance Committee**					**Meeting Date:**	**6th April 2021**		
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**	**X**	
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

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 for the Financial Year 2020/21.

Standards of Behaviour messages have been shared via Global Emails and CEO connects in September, October and December 2020. Emails and ESR messages targeting staff members employed at Band 8A and above have also been circulated in November 2020, January, February and March 2021.

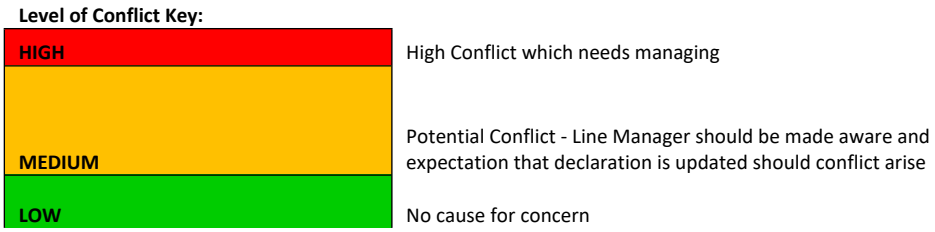
The Risk and Regulation team continue to work with colleagues from Betsi Cadwaladr University Health Board to put in place Declarations of Interest software from April 2021. The use of this software will modernise how the Risk and Regulation Team record and report on Declarations of Interest, Gifts, 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 February's meeting, when 713 declarations had been submitted, a further 1910 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:

- Two Hundred and Twenty Eight (228) Declarations of Interest declared (up from 144 in February 2021); four of which present as a potential conflict with the others presenting as no cause for concern. Those entries presenting as potential conflicts are categorised as follows:
  - One declaration that 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; and
  - Three declarations that concern external appointments and interests. The declarants for these interests have been asked to complete appropriate Secondary Employment and Interest forms so that they can be formally considered and managed by appropriate line managers.
- Two Thousand Three Hundred and Ninety Seven (2,397) Declarations of Interest with 'No Interest' declared (up from 569 in February 2021) which present no cause for concern

- Sixteen (16) Declarations of Gifts (up from 11 in February 2021) have been made. which present no cause for concern albeit 3 of the additional 5 declarations await further approval and sign off from an appropriate line manager.



To date 2641 Declarations have been received for the year 2020/21 (up from 713 in February 2021). Whilst it is accepted that this number will need to improve for 2021/22, assurance should be taken from the significant increase in returns since the February 2021 Committee meeting and the predicted increases expected in the new financial year following the adoption of the Betsi Cadwaladr UHB declarations of interest software.

Further Assurance can be taken from the Risk and Regulation Teams targeted approach for colleagues employed at Band 8A and above. At the end of financial year 2019/20 59% of staff banded 8a and above had returned their declaration forms. As of 26th March 2021 this figure has increased to 68% for the current financial year.

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 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	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.*

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	First Name	Surname	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)	UHB Address:	UHB Tel No:	Confirmed read & understood Standards of Behaviour Framework Policy
Low	Anna	Burgess	Pharmacist Team Leader	Pharmacy	8b	CD&T	29/09/2020	Yes	No	UHW	029 2184 4975	Yes
Low	Adam Joshua	Cann	Trainee Clinical Psychologist	Clinical Psychology		CD&T	29/09/2020	Yes			7545090589	Yes
Low	Ian	Williams	Paediatric Clinical Nurse Specialist	Children's Centre, St David's Hospital		Children & Women	08/10/2020	Yes	No	St David's Hospital	2920536789	Not Ticked
Low	Lynda	Jenkins	Nursing Informatics Lead	Corporate Nursing		Corporate Nursing	09/10/2020	Yes	No	UHL		Yes
Low	Alex	Speakman	PN Pharmacist	Pharmacy		CD&T	09/10/2020	Yes	No	UHW	02920 748109	Yes
Low	Claire	Main	Interim General Manager of Criticare Care and Major Trauma	Critical Care and Major Trauma		Specialist Services	09/10/2020	Yes	No	UHW	ext 45069	Yes
Low	Tanya	Burton	Myeloma Clinical Nurse Specialist	Haematology		Specialist Services	12/10/2020	Yes	No	UHW	7989168352	Yes
Low	Julie	Highfield	Consultant Clinical Psychologist /Associate Director	Critical Care		Specialist Services	12/10/2020	Yes	Yes	UHW	45114	Yes
Low	Kim	Atkinson	Strategic Lead Occupational Therapist	Therapies / Occupational Therapy		CD&T	12/10/2020	Yes	No	UHL	Ext 24893	Yes
Low	Michael	Pruski	Healthcare Scienctist (Evaluation)	Medical Physics and Clinical Engin	6	CD&T	12/10/2020	Yes	No	Medicentre	02921 848676	Yes
Low	Natalie	Robertson	Principal Physiotherapist in Mental Health	Physiotherapy		CD&T	13/10/2020	Yes	Yes	UHL	02921 824652	Yes
Low	Laura	Gwyther	CART Clinical Nurse Specialist	Haematology		Specialist Services	13/10/2020	Yes	No	UHW	Ext 48494	Yes
Low	Jessica	Hodges	Physiotherapist	Frailty	5		13/10/2020	Yes	No	UHW		Yes
Low	Laura	Price	Assistant Psychologist	Neuroscience		Specialist Services	13/10/2020	Yes		Rookwood Hospital	02920 313713	Yes
Low	Richard	Whitson	Consultant Vascular Surgeon	General Surgery		Surgery	14/10/2020	Yes	No	UHW	Ext 43356	Not Ticked
Low	Jill	Lubienski	Family Therapist	SHED	8a	Mental Health	14/10/2020	Yes	No	Global Link	2921 832200	Yes
Low	Debbie	Roberts	Health Visitor	Flying Start	7	Children & Women	15/10/2020	Yes	No	Eastmoors Road	029 2035 1375	
Low	Nicola-Xan	Hutchinson	Consultant in Acute Respiratory Medicine	Medicine/Respiratory		Medicine	15/10/2020	Yes	No	UHL	2920716847	Yes
Low	Andy	Lodwick	Lead Clinician Psychological Therapy Hub	Psychology		Mental Health	19/10/2020	Yes	Yes	UHL	2183 22249	Yes
Low	Ieuan	Davies	Consultant Paediatric Gastroenterologist	Child Health		Children & Women	26/10/2020	Yes	Yes	UHW	029 2074 8789	Not Ticked
Low	Jonathon	Gray	Interim Director of Transformation and Informatics	Executive	Executive	Executive	04.02.20	Yes	Yes	UHW		Not Ticked
Low	Ceris	Devereux	Public Health Dietitian	Nutrition and Dietetics		Community Dietetics	10.09.20	Yes		UHW	2920907698	Yes
Low	Kate	Littler	Principal Clincal Psychologist	Haematology		CD&T	11.03.2020	Yes	No	UHW	45558	Yes
Low	Mary	Hart	Consultant Radiologist	Radiology, Medical Physics, Clinical Engineering		CD&T	12.11.20	Yes	No	UHW	2920743538	Yes
Medium	Scott	Gable	Cellular Pathology Service Manager / lead Biomedical Scientist	Cellular Pathology and Mortuary Service, Laboratory Medicine	8b	CD&T	12.11.20	Yes	No	UHW		Yes
Low	Paul	Davis	Consultant Paediatrician	Child Health	Consultant	Children & Women	12.11.20	Yes	No	St David's Hospital	2920536825	Yes
Low	Kenneth	May	Consultant Cellular Pathology	Cellular Pathology and Mortuary Service, Laboratory Medicine	Consultant	CD&T	12.11.20	Yes	No	UHW	48040	Yes
Low	Declan	Coleman	Clinical Scientist	Medical Physics	8b	CD&T	12.11.20	Yes	No	UHW	42015	Yes
Low	Anna	Kuczynska	Clinical Board Director	PCIC	8+	PCIC	12.11.20	Yes	No	Woodland House		Yes
Low	Justyna	Witczak	Consultant Physician	Medicine	Consultant	Medicine	12.11.20	Yes	No	UHW	42341	Yes
Low	Rhys	Hewett	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	12.11.20	Yes	No	UHW	44687	Yes
Medium	Jared	Torkington	Consultant	General Surgery	Consultant	Surgery	12.11.20	Yes	Yes	UHW	44158	Yes
Low	Andrew	Wood	Consultant	Radiology	Consultant	CD&T	12.11.20	Yes	Yes	UHW	3955	Yes
Low	Stefan	Schwarz	Consultant Radiologist	CD&T	Consultant	CD&T	16.11.20	Yes	No	UHW	43042	Yes
Low	Robert	Kidd	Consultant Psychologist	Mental Health	Consultant	Mental Health	16.11.20	Yes	Yes	UHL		Yes
Low	Ulrich	Von Oppell	Consultant Cardiac Surgeon	Cardiac Services	Consultant	Specialist Services	16.11.20	Yes	No	UHW	45078	Yes
Low	Matthew	Boyd-Anderson	Physiotherapy Technical Instructor	Therapies		CD&T	19.05.2020	Yes	No	UHW		Yes
Low	Robert	Bauld	Principle Clinical Engineer / Design & Manufacture Team Leader / Health and Safety Coordinator	Artificial Limb and Appliance Service		Specialist Services	22.09.20	Yes	No	Treforest	01443 661799	Yes
Medium	Stuart	Walker	Executive Medical Director	Executive	VSM	Executive	30.09.20	Yes	Yes	UHW	2921836001	Yes
Low	Andrew	Vidgen	Consultant Psychologist	Mental Health	8c	Mental Health	15.04.20	Yes	No	Whitchurch Hospital	2921832610	Yes
Low	Thomas	Pembroke	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	12.11.20	Yes	No	UHW	45608	
Low	Richard	Hughes	Consultant Anaesthetist	Peri-Operative Care	Consultant	Surgery	12.11.20	Yes	No	UHW	44139	Yes
Low	Matthew	Morgan	Consultant in ICU	Critical Care	Consultant	Specialist Services	12.11.20	Yes	Yes	UHW	7760220095	
Low	Simon	White	Consultant Orthopaedic Surgeon	Trauma and Orthopaedics	Consultant	Surgery	12.11.20	Yes	No	UHW	48044	Yes
Low	Ryan	Trickett	Consultant Head Surgeon	T&O	Consultant	Surgery	12.11.20	Yes	Yes	UHL	25234	
Low	Daniel	Morris	Consultant Ophthalmologist	Opthalmology	Consultant	Surgery	13.11.20	Yes	Yes	UHW	42083	Yes
Low	Jamie	Hayes	Pharmacist	AWTTC	8d	CD&T	13.11.20	Yes	Yes	UHL	26869	Yes
Low	Catherine	Donan	Director of Health and Social Services Integration	Health and Social Services	9	Health and Social Services	12.11.20	Yes	No	Strategic Planning	07983 613875	Yes
Low	Natalie	Elliot	National AHP lead for Dementia	Mental Health	8D	Mental Health	13.11.20	Yes	Yes	Academic Centre UHL	7811020008	Yes
Low	Joon	Wong	Specialty Doctor in Paediatric Cardiology	Child Health	8+	Children & Women	13.11.20	Yes	No	Childrens Hospital for wales	02920 744743	Yes
Low	Sarah	Hale	Consultant Opthalmologist	Ophthalmmology	Consultant	Surgery	8.04.20	Yes	No	UHW	02920 748249	Yes
Low	Peter	O'Callaghan	Medical Consultant	Cardiothoracic	Consultant	Specialist Services	13.11.20	Yes	No	UHW		Not Ticked
Low	Claire	Ganderton	Senior Pharmacist	AWTTC	8b	CD&T	13.11.20	Yes	Yes	UHL	2921 826900	Yes
Low	Libby	Erin	Consultant Clinical Psychologist	Child Psychology	8c	Children & Women	13.11.20	Yes	No	Global Link		Yes
Low	Abraham David	Theron	Consultant Anaesthetist, CD Perioperative Care	Anaesthetics	Consultant	Surgery	13.11.20	Yes	No	UHW	43256	Not Ticked
Low	Philip	Smith	Consultant Neurologist	Neuroscience	Consultant	Specialist Services	13.11.20	Yes	No	UHW	0292074 2834	Yes
Low	Christopher	Hingston	Consultant Critical Care	Critical Care	Consultant	Specialist Services	13.11.20	Yes	Yes	UHW		Yes
Low	Richard	Cousins	Consultant in Immunology	Immunology	Consultant	Specialist Services	13.11.20	Yes	No	UHW	02920 748338	Not Ticked
Low	Ruth	Walker	Executive Nurse Director	Executive	VSM	Executive	13.11.20	Yes	No	Woodland House	36006	Not Ticked
Low	Andrew	Goringe	Consultant in Haematology	Haematology Laboratory	Consultant	CD&T	13.11.20	Yes	No	UHW	42033	Yes
Awaiting updated form	Gareth	Thomas	Consultant in Gastroenterology	Gastroenterology	Consultant	Medicine		Yes	No	UHW		Yes
Low	George	Eralil	Consultant Neurosurgeon	Neuroscience	Consultant	Specialist Services	13.11.20	Yes	No	UHW	46851	Yes
Low	Kenneth	Lim	Consultant Obs & Gynae	Obs & Gynae	Consultant	Children & Women	13.11.20	Yes	No	UHW	41249	Yes
Low	Katie	Pink	Respiratory Consultant	Medicine	Consultant	Medicine	13.11.20	Yes	No	UHL	25088	Yes
Low	Joanne	May	Locum Consultant Paediatric Rheumatologist	Child Health	Consultant	Children & Women	13.11.20	Yes	No	UHW	43400	Not Ticked
Low	Lena	Thia	Consultant in Paediatric Respiratory Medicine	Child Health	Consultant	Children & Women	13.11.20	Yes	No	UHW	43530	Yes
Low	Aleksander	Marin	Consultant Radiologist	Radiology	Consultant	CD&T	14.11.20	Yes	No	UHL	25563	Yes
Low	Timothy	Sheppard	Locum Consultant O&G	Obs & Gynae	Consultant	Children & Women	16.11.20	Yes	No	UHW		Not Ticked
Low	Peter	Groves	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	15.11.20	Yes	Yes	UHW	43533 / 42354	Yes
Low	Angela	Miser	Associate Specialist, Paediatric Haematology / Oncology	Acute Child Health	Consultant	Children & Women	15.11.20	Yes	Yes	UHW	48805	Yes
Low	Stuart Ashley	Roberts	Consultant Radiologist	Radiology	Consultant	CD&T	15.11.20	Yes	No	UHW	45207	Not Ticked
Low	Sarah	Hunt	Consultant Anaesthetist	Anaesthetics and Critical Care	Consultant	Specialist Services	15.11.20	Yes	No	UHW		Yes
Low	Jessica	Quirke	Consultant Clinical Neuropsychologist	Neuroscience	8c	Specialist Services	16.11.20	Yes	No	Rookwood Hospital	02920 313748	Yes
Low	Mark	Stacey	Consultant Anaesthetist	Anaesthetics	Consultant	Surgery	16.11.20	Yes	No	UHL	2920716860	Yes
Low	Mathew	Hoskins	Locum Consultant Psychiatrist	Adult Psychiatry	Consultant	Mental Health	16.11.20	Yes	No	Barry Hospital	1446 454300	Yes
Low	Roger	Maggs	Laboratory Manager	Dental	8c	Surgery	16.11.20	Yes	No	UHW	42411	Yes
Low	Christopher	Lewis	Interim Executive Director of Finance	Finance	VSM	Executive	13.11.20	Yes	Yes	Woodland House	41507	Yes
Low	Peter	Lindsay	Locum Consultant	Obs & Gynae	Consultant	Children & Women	13.11.20	Yes	No	UHL	21841268	Yes
Low	Nicholas	Drage	Consultant in Dental and Maxillofacial Radiology	Dental	Consultant	Surgery	12.10.20	Yes	No	UHW		Not Ticked
Low	Paul	Hodgson	Consultant Trauma and Orthopaedic Surgeon	Trauma and Orthopaedics	Consultant	Surgery	16.11.20	Yes	No	UHL	2071 5677	Yes
Low	Ramsey	Sabit	Consultant Physician in General and Respiratory Medicine	Medicine	Consultant	Medicine	16.11.20	Yes	No	UHL		Yes
Low	Kathryn	Allen	Community Pharmacy Advisor	Pharmacy	8a	PCIC	16.11.20	Yes	No	Woodland House	36156	Yes
Low	Rhiannon Meleri	Morgan	Consultant in Cellular Pathology	Cellular Pathology	Consultant	CD&T	16.11.20	Yes	No	UHW	41988	Yes
Low	Dennis Llewellyn	Cochlin	Locum Consultant Radiologist	Radiology	Consultant	CD&T	16.11.20	Yes	No	UHW	43572	Yes

First Name	Surname	a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies	Start - End Date	Financial / Other Benefits	b) Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the UHB	Start - End Date	Financial / Other Benefits	c) A personal or departmental interest in any part of the pharmaceutical/healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Start - End Date	Financial / Other Benefits	d) Sponsorship or funding from a known NHS supplier or associated company/subsidiary	Start - End Date	Financial / Other Benefits
Anna	Burgess	N/A	N/A	N/A	N/A	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.	2018 - Ongoing	Sponsorship to NPPG	Annual attendance at Neonatal and Paediatric Pharmacists Group (NPPG) Conference - this is an event sponsored by multiple pharmaceutical companies.	Nov 12 Ongoing	Delegate fees are reduced thanks to the sponsorship received
Adam Joshua	Cann	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ian	Williams	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Lynda	Jenkins	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Alex	Speakman	N/A	N/A	N/A	N/A	N/A	N/A	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
Claire	Main	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tanya	Burton	N/A	N/A	N/A	N/A	N/A	N/A	We use some of the pharma drugs in our health board	N/A	N/A	N/A	N/A	N/A
Julie	Highfield	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kim	Atkinson	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Michael	Pruski	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Natalie	Robertson	N/A	N/A	N/A	N/A	N/A	N/A	Husband is Director of Operations for CD&T - Matthew Temby	01/12/2014 - Ongoing	Salary	N/A	N/A	N/A
Laura	Gwyther	N/A	N/A	N	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jessica	Hodges	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Laura	Price	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Richard	Whitson	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jill	Lubienski	N/A	N/A	N//A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Debbie	Roberts	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nicola-Xan	Hutchinson	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsorship for European Respiraotry Conference attendence fees by Boehringer Ingelheim	7-9/10/20	Financial
Andy	Lodwick	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ieuan	Davies	N/A	N/A	N/A	N/A	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		Yes	N/A	N/A	N/A
Jonathon	Gray	Previous role as CEO of SWAHSN - a company Limited by guarantee Wife owns private company delivering mindfulness / training resilience training Brother-in-law Director of Ernst Young	0/11/17 - 0/11/19	N/A	Works one day a week as Clinical Director at Life Sceinces Hub through partnerhsip with C&VUHB. Also work 2 months a year in Singapore - contracted to delivery innovation work. I stop my contract with C&VUHB when I do this work	2020 - ongoing	Financial	Note links to Singapore Life Sciences Hub. I am a global ambassador for Hillary Institute - non profit leadership group in New Zealand. Visiting Fellow Green Templeton College, Oxford Spouse works for (Mindfulness and Resilience) for Cardiff Met and Education Centre	2016 - present	N/A	N/A	N/A	N/A
Ceris	Devereux	N/A	N/A	N/A	N/A	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.	16th October 2019 and 10/8/20	one off payment	N/A	N/A	N/A
Kate	Littler	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mary	Hart	Director Hart-Jones Consultancy LTD	Apr-19	Salary	N/A	N/A	Salary	N/A	N/A	N/A	N/A	N/A	N/A
Scott	Gable	Director - Labxcell Ltd	Jul-19	Retainer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paul	Davis	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kenneth	May	STTC Limited	Jul-19		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Declan	Coleman	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Anna	Kuczynska	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Justyna	Witczak	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes. I received travel grants and honoraria for talks from the following companies: Napp, Boehringer-Ingelheim, Novo-Nordisk	Nov 19 - Ongoing	Travel grants/honoraria for talks/lectures
Rhys	Hewett	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsored by Fresnus Kabi to attend BAPEN conference Nov 2019.		Paid for conference, hotel and flights.
Jared	Torkington	Director - Moondance Cancer Initiative Wife is a director of Cardiff Medical Events Ltd- a company that organises meeetings and conferences	2020 - 2019 -	N/A	N/A	N/A	N/A	Shareholding in Alessi Surgical Instruments - spinout from Cardiff University. Also act as a chair of medical advisory board.	2015 -	N/A	Consultancy to a trial management team from Medtronic Ltd for scientific study	2020	Consultancy
Andrew	Wood	N/A	N/A	N/A	Wife has a private garden design business (Eileen Garden Landscapes): currently working on the 'Orchard' project at Llandough	2008	Ongoing	N/A	N/A	N/A	Occassional Lecturing Honoraria	Last date 2016	Fees
Stefan	Schwarz	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Robert	Kidd	N/A	N/A	N/A	N/A	N/A	N/A	Partner is a Consultant Psychologist within Child Health at the Health Board.	Current	Salary	N/A	N/A	N/A
Ulrich	Von Oppell	Director - U & C Von Uppell Ltd	Mar-10	Private Practice	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Matthew	Boyd-Anderson	N/A	N/A	N/A	N//A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Robert	Bauld	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Stuart	Walker	Sister - Gilead employee, Father ILC CEO (both healthcare companies we may have relationships	N/A	risk of direct influence				see above re. sister/father - Gilead and ILC are pharma companies	N/A	N/A	N/A	N/A	N/A
Andrew	Vidgen	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Thomas	Pembroke	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Richard	Hughes	Director of R H Health Ltd (to manage private medical anaesthetic activities undertaken outside my NHS contract)	08/01/2013	Annual Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Matthew	Morgan	Matt PG Morgan Ltd, Director - Author/Writing Business for a book publishing about ICU Spouse - Matt PG Morgan Ltd, Director - Author/Writing Business	01/11/2017 - present 01/11/2017 - present	Dividends Dividends and salary	N/A	N/A	N/A						
Simon	White	Director, Simon P White Ltd	2008 - Present	Nil	N/A	N/A	N/A	Educational contract with Zimmer Biomet	2018 - present	Paid to lecture in annual leave	N/A	N/A	N/A
Ryan	Trickett	Director: Vale Hand Surgery (Private Practice) & Dragon Locums Spouse - Director: Vale Hand Surgery & Cardiff NHS GP Partner		salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Daniel	Morris	Dan Morris Ltd Spouse: Director	2003 - present	Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jamie	Hayes	Director of JMH Collaborations	March 2017 - ongoing	Salary, Dividends and Consultancy fees	Director of JMH Collaborations Ltd	March 2017 - ongoing	Salary, Dividends and Consultancy fees	Honorary Senior Lecturer appointments with Cardiff University School of Medicine and School of Pharmacy and Pharmaceutical Sciences	2006 - ongoing	Honoraria	N/A	N/A	N/A
Catherine	Donan	No	N/A	Nil	No	N/A	N/A						
Natalie	Elliot	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A
Joon	Wong	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A
Sarah	Hale	N/A	N/A	N/A	Nominated member of Cardiff Eye Surgeons LLP. Company that carries out ophthlamic work	2006 - current	Paid for any work carried out	N/A	N/A	N/A	N/A	N/A	N/A
Peter	O'Callaghan	Dr Peter O'Callaghan Ltd	2012 - ongoing	Private practice income	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Claire	Ganderton	Director Spouse / Partner - Director	12.09.17 - ongoing 12.09.17 - ongoing	Annual Dividend Annual Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Libby	Erin	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Abraham David	Theron	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Philip	Smith	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Christopher	Hingston	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Richard	Cousins	N/A	N/A	N/A	N/A	N/A	N/A	I have shares in AstraZeneca.	ongoing	Dividends	I have received sponsorship for travel and attendance at educational meetings from Novartis and Grifols.	Ongoing	Accommodation, travel and conference fees.
Ruth	Walker	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Andrew	Goringe	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Gareth	Thomas	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
George	Eralil	Director of my own PLC	Mar-20		Director of my own PLC	Mar-20		N/A	N/A	N/A	N/A	N/A	N/A
Kenneth	Lim	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Katie	Pink	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	nclear if this needs to be declared here but only potential declaration would be I have received speaker fees from drug companies and have been provided with (virtual) access to the European Respiratory Society Congress (Sept 2020) funded through a drug company (Chiesi). I have also been payed an Honoraria for attending a meeting to develop referral pathways for severe asthma management (Astra Zeneca)		Speaker Fees / Honoraria
Joanne	May	N/A	N/A	N/A	N/A	N/A	N/A	Medical advisor to treat to target panel for systemic J	Nov 2020 - Nov 2021	Honoraria	N/A	N/A	N/A
Lena	Thia	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Honorarium for speaking to nurses on asthma sponsored by AstraZeneca. Honorarium for speaking at two webinars sponsored by Vertex	13.02.20 - 1.10.20	Honorarium
Aleksander	Marin	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Timothy	Sheppard	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Peter	Groves	Director of Groves Cardiology Services Ltd (Wife - Dr Andra Helen Groves) Director and Shareholder in Groves Caridology Services Ltd	3.07.11 - current 3.07.11 - current	nil Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Angela	Miser	N/A	N/A	N/A	N/A	N/A	N/A	Chief Medical Officer, Lixte Biotechnology Holdings, Inc., East Setauket, New York 11733, USA	2020 - Present	Salary	N/A	N/A	N/A
Stuart Ashley	Roberts	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sarah	Hunt	Vale Anesthetics Ltd	2014 - ongoing	I do not draw a salary or dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jessica	Quirke	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mark	Stacey	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mathew	Hoskins	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Roger	Maggs	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Christopher	Lewis	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Peter	Lindsay	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nicholas	Drage	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paul	Hodgson	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ramsey	Sabit	Director of Ramsey Sabit Ltd. This is a PLC for earnings from private practice Spouse is a fellow share holder and director for "Ramsey Sabit ltd"	23.05.18 - ongoing	share dividends in 2019 but not 2020	N/A	N/A	N/A	N/A	N/A	N/A	Sponsorship for attendance at European Respiratory Society meeting by Chiesi (drug company) from 5/9/20 to 9/9/2020. Speaker fee meetings from Chiesi, TEVA and GSK (drug companies) for educational meetings for primary		Payment for online registration at meeting
Kathryn	Allen	Davies Homes Ltd	2010 - current	none	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rhiannon Meleri	Morgan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dennis Llewellyn	Cochlin	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

First Name	Surname	e) A position of authority in a charity or voluntary body in the field of health and social care	Start - End Date	Financial / Other Benefits	f) Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Start - End Date	Financial / Other Benefits	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	Start - End Date	Financial / Other Benefits	h) I undertake to notify the UHB of any changes which may occur within four weeks from the date of the change, in writing to the Corporate Risk and Governance Office. Please return completed forms to cav.declarations@wales.nhs.uk	i) I confirm that the information accurately reflects my interests and those of my family and understand that relevant information will be included in the Register which is available for public inspection	Signed	Date	Escalation/Other details:
Anna	Burgess	Member of the Neonatal and Paediatric Pharmacists Group (NPPG) executive committee and their Information Officer.	Nov 11 - ongoing	SLA in place with WMC to fund this position which is done as a team role. Personal expenses paid for	N/A	N/A	N/A	Presented healthcare professional educational sessions on excipients in medicines for children at events sponsored by Desitin Pharma Ltd and Proveca Ltd.	July 20 - Nov 20	Honoraria received		Yes	Anna Burgess	29.09.20	
Adam Joshua	Cann	N/A	N/A	N/A	N/A	N/A	N/A	Self employment as CBT therapist working with Efficacy Ltd	16/06/20 - ongoing	Yes	Yes	Yes	Adam Joshua Cann	15/10/2020	
Ian	Williams	N/A	N/A	N/A	N/A	N/A	N/A	Tutoring with the Open University - Nursing	01/10/2020	Salary	Yes	Yes	Ian Williams	01/10/2020	
Lynda	Jenkins	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	N/A	N	Yes	Yes	Lynda Jenkins	08/10/2020	
Alex	Speakman	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Alex Speakman	09/10/2020	
Claire	Main	N/A	N/A	N/A	Executive member of Association of Nephrology Nurses UK representing nursing on various UK renal projects	29.05.2018 - ongoing	No	N/A	N/A	N/A	Yes	Yes	Claire Main	09/10/2020	
Tanya	Burton	N/A	N/A	N/A	N/A	N/A	N/A	Janssen/Takeda/Celgene Sanofi	2017 - Ongoing 2020 - Ongoing	One off payment	Yes	Yes	Tanya Burton	12/10/2020	
Julie	Highfield	National Director of Wellbeing Intensive Care Society	15/06/20 - Ongoing	secondment from NHS 0.4WTE at 8c	N/A	N/A	N/A	Occasional private practice	Ongoing	adhoc salary	Yes	Yes	Julie Highfield	12/10/2020	
Kim	Atkinson	Vice Chair of Royal College of Ocuppational Therapists	2018 - 2021	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Kim Atkinson	12/10/2020	
Michael	Pruski	Council Member of the catholic Medical Association Club	15/04/2018 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Michal Pruski	12/10/2020	
Natalie	Robertson	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N	Yes	Yes	Natalie Robertson	13/10/2020	
Laura	Gwyther	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.	19/10/2020	£140	Yes	Yes	Laura Gwyther	13/10/2020	
Jessica	Hodges	N/A	N/A	N/A	N/A	N/A	N/A	Private Work as a Physiotherapist for Cardiff City Ladies Football Club.	9/10/20 - ongoing	paid	Yes	Yes	Jessica Hodges	13/10/2020	
Laura	Price	N/A	N/A	N/A	N/A	N/A	N/A	Private healthcare work within ithe community	9/09/20 - ongoing	paid hourly	Yes	Yes	Laura Price	13/10/2020	
Richard	Whitson	Trustee of Haven Homecare	2010 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Richard Whiston	14/10/2020	
Jill	Lubienski	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.	13/10/20 - ongoing	Yes I have some income from my self employed work.	Yes	Yes	Jill Lubienski	14/10/2020	
Debbie	Roberts	N/A	N/A	N/A	Volunteer with Breastfeeding Network and Volunteer on the National Breastfeeding helpline	2004 - ongoing	Reduced study costs	N/A	N/A	/A	Yes	Yes	Debbie Roberts	15/10/2020	
Nicola-Xan	Hutchinson	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Nicola-Xan Hutchinson	15/10/2020	
Andy	Lodwick	N/A	N/A	N/A	N/A	N/A	N/A	Andy Lodwick	2014 - ongoing	Self employed as a sole trader as Dr Neil Kitchiner. Personal website cbt cardiff attracts individuals seeking Private out-pt psychological therapy.	Yes	Yes	Andy Lodwick	19/10/2020	
Ieuan	Davies	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.	2016	N/A	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	N/A	N/A	N/A	N/A	Yes	Yes	Ieuan Davies	26/10/2020	
Jonathon	Gray	Member of Maggies Clinical Board, Fellow at Better Value Healthcare, Visiting Chairs - Wellington (New Zealand), Exeter, Singapore. Adjunct Profressor at the Health Services Research Centre, Faculty of Health at Victoria University of Wellington. Honarary Clinical Professor, University of Exeter Medical School. Spouse works as Clinical Psychologist for Maggies Cancer Charity - Velindre	01/06/19 - 31/05/2022 01/08/18 - 31/07/21	N/A	Global Ambassador for Hillary Leadership Institute (New Zealand) Health Foundation / IHI Fellow Member Insitute of Directors. Fellow of Better Value Healthcare - Led by Professor Sir Muir Gray (Not a relative) Deputy Lead	2004 2015 2012 2020	Present Present	Employed by Singapore as previous - arranged through C&VUHB but clear arrangement - I stop C&VUHB pay during 2 months Spouse: Maggies Centre and private work as previously mentioned			Blank	N/A	Jonathon Gray	04/02/2020	
Ceris	Devereux	N/A	N/A	N/A	N/A	N/A	N/A	I have undertaken some activities as part of my private practice.	Ongoing	N/A	Blank	Yes	Ceris Devereux	16.09.20	
Kate	Littler	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice	01/07/2020 - Ongoing	Salary	Yes	Yes	Kate Littler	03.08.2020	
Mary	Hart	N/A	N/A	N/A	N/A	N/A	NA	Self employment: Hart-Jones Consultancy LTD	Apr-19	Salary					
Scott	Gable	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Scott Gable	12.11.20	Secondary Form sent 26.01.21
Paul	Davis	N/A	N/A	N/A	Scientific Advisor to The Lullaby Trust	N/A	N/A	Private clinic at Cyncoed Consulting Rooms. Medicolegal practice in relation to child safeguarding cases (Category 2 work).				Yes	Paul Davis	12.11.20	
Kenneth	May	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice Histopathology reporting for backlogs Ltd				Yes	Kenneth May	12.11.20	
Declan	Coleman	N/A	N/A	N/A	N/A	N/A	N/A	I do some practice ultrasound scans for a private hospital in Newport	current	Honoraria	Yes	Yes	Declan Coleman	12.11.20	
Anna	Kuczynska	N/A	N/A	N/A	N/A	N/A	N/A	GP partner, Highlight Park Medical Practice , Lakin Drive, Barry CF628GP		Yes	Yes	Yes	Anna Kuczynska	12.11.20	
Justyna	Witczak	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Justyna Witczak	12.11.20	
Rhys	Hewett	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Rhys Hewett	12.11.20	
Jared	Torkington	Medical Advisory Board Bowel Cancer UK Charity	2017 -	N/A	N/A	N/A	N/A	Private Practice at Spire	current	Salary	Yes	Yes	Jared Torkington	12.11.20	Secondary Form sent 26.01.21
Andrew	Wood	Treasurer - Heart Research Fund Wales	2000 -	N/A	N/A	N/A	N/A	Private Medico-Legal Cases	Current	Fees	Yes	Yes	D Andrew M Wood	12.11.20	
Stefan	Schwarz	N/A	N/A	N/A	N/A	N/A	N/A	Practising privileges at SPIRE Hospital Cardiff, I also hold a honorary position at the University of Nottingham as a 'Clinical Associate Professor' since May 2016 for which I receive honoraria.	Current	Honoraria	Yes	Yes	Stefan Schwarz	16.11.20	
Robert	Kidd	N/A	N/A	N/A	Declarant is a member of the All Wales Approval Panel for Approved Clinicians in Wales, which sits within BCUHB and carries out its functions on behalf of the other LHBs. Declarant is also an external examiner at Birmingham University & an honorary lecturer at Cardiff University & an honorary (consultant) assistant professor to the school of medicine at nottingham university .	Current	Salary	Declarant occasionally undertakes direct (private) instructions for Crown Court reports, but does not make recommendations for hospital bed disposals	Ongoing	Fees	Yes	Yes	Robert Kidd	16.11.20	Secondary Employment form completed. Manager content with external work.
Ulrich	Von Oppell	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ulrich Von Oppell	16.11.20	
Matthew	Boyd-Anderson	N/A	N/A	N/A	N/A	N/A	N/A	Support Worker - Prospero Health and Social Care - Casual Flexi Hours	13/05/2020	Salary	Yes	Yes	Matthew Boyd-Anderson	19/05/2020	
Robert	Bauld	N/A	N/A	N/A	N/A	N/A	N/A	Rehabilitation Engineer Associate Lecturer	21/09/2020 - 31/08/21	Yes	Yes	Yes	Robert Bauld	22.09.20	
Stuart	Walker	N/A	N/A	N/A	N/A	N/A	N	N/A	N/A	N	Yes	Yes	Stuart Walker	30.09.20	
Andrew	Vidgen	N/A	N/A	N/A	N/A	N/A	N/A	private medico-legal work. Approximately 1.5 sessions / month outside normal working hours. Undertaken in Gwent area	Apr-17		Yes	Yes	Andrew Vidgen	12.11.20	
Thomas	Pembroke	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff University Employee			Yes	Yes	Thomas Pembroke	12.11.20	
Richard	Hughes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Richard Hughes	12.11.20	
Matthew	Morgan				I have donated £5000 to the 2 Wish Upon a Star charity and £200 to the C&V Health Charity.	2020		Writer for BMJ and BMJ Learning	2005 - present	Salary	Yes	Yes	Matt Morgan	12.11.20	
Simon	White	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Simon Paul White	12.11.20	
Ryan	Trickett	N/A	N/A	N/A	Member BSSH, BOA, BMA Spouse: Member BMA, RCGP	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ryan Trickett	12.11.20	
Daniel	Morris	Sambury Trust, Vale 4 Africa Keeler Trust (Trustee)	Ongoing	Nil	N/A	N/A	N/A	Work at Spire & Nuffield Paid via DM Ltd			Yes	Yes	Daniel Morris	13.11.20	
Jamie	Hayes	Elected Board member of the Royal Pharmaceutical Society and member of the Royal Pharmaceutical Society Assembly. Wife is Medical Director at Marie Curie, Cardiff and Vale Hospice, Penarth	June 2016 - ongoing	Honoraria, expenses	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jamie Hayes	13.11.20	
Catherine	Donan	Trustee for Llamau (Homelessness Charity)	Jan 20 - ongoing	Nil	No	N/A	N/A	No	N/A	N/A	Yes	Yes	Cath Doman	12.11.20	
Natalie	Elliot	Spouse: Executive Director of People & Places at Taff Housing	2017-ongoing	Spouse Salary	No	N/A	N/A	Annual Teaching Session (outside of NHS Working Hours) for Cardiff University	2017-ongoing	Paid and hourly rate.	Yes	Yes	Natalie Elliot	13.11.20	
Joon	Wong	No	N/A	N/A	No	N/A	N/A	Employed by Independent General Practice Cardiff on ad hoc basis (no more than 6 to 8 times per year) to do Children Heart Screening Day on behalf of the Welsh charity organisaion Welsh Hearts	Oct 2017 - ongoing (but haven't done a session since October 2019	Fees	Yes	Yes	Joon Wong	13.11.20	
Sarah	Hale	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Sarah Hale	8.04.20	Secondary Work Form sent 24.11.20
Peter	O'Callaghan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Peter O'Callaghan	13.11.20	Secondary Work Form sent 24.11.20
Claire	Ganderton	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Claire Ganderston	13.11.20	Secondary Work Form sent 24.11.20
Libby	Erin	N/A	N/A	N/A	N/A	N/A	N/A	I work privately seeing families where children are struggling with their mental health	2018 - ongoing	N/A	Yes	Yes	Libby Erin	13.11.20	Secondary Work Form sent 24.11.20
Abraham David	Theron	As Chair of the Royal College of Anaesthetist Welsh Advisory Board I am a co-opted member of college council. I am also Vice Chair of the Academy of Medical Royal Colleges of Wales.	N/A	N/A	Executive Member of the Welsh Medical Committee. Part od the clinical reference group of the National Clinical Framework.	N/A	N/A	I have co-edited the Oxford Handbook of Obstetric Anaesthetsia for Oxford University Press. Royalties for this book is to be donated to SAFE Africa.	N/A	N/A	Yes	Yes	Abrie Theron	13.11.20	
Philip	Smith	Co-Editor of BMJ journal, Practical Neurology (2011–present)	2011 - present	Honorarium	1. Chair of NICE Guidelines Panel on Heart Valve Disease 2. Member of NICE Guidelines Panel on Epilepsy	2019 - 2021	Nil	Member of GMC Tests of Competence Panel	2018 - present	ad hoc payment for specific tasks	Yes	Yes	Philip Smith	13.11.20	Secondary Work Form sent 25.11.20
Christopher	Hingston	Spouse: Director and Trustee of Latch Childrens Charity	2014 - current	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Chris Hingston	13.11.20	
Richard	Cousins	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Richard Cousins	13.11.20	Sponsorship Form sent 25.11.20
Ruth	Walker	Council Member of the Nursing and Midwifery Council	2016 - ongoing	salary	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ruth Walker	13.11.20	Secondary Work Form sent 25.11.20
Andrew	Goringe	N/A	N/A	N/A	N/A	N/A	N/A	I help supervise the haematology laboratory at the Spire hospital in Cardiff including reporting occasional blood films and chairing their Blood Transfusion Committee	June 18 - ongoing		Yes	Yes	Andrew Goringe	13.11.20	Secondary Work Form sent 25.11.20
Gareth	Thomas	N/A	N/A	N/A	N/A	N/A	N/A	Underake 1 session private work per week in uncontracted time	2001 - current		Yes	Yes	Gareth Thomas		Secondary Work Form sent 25.11.20
George	Eralil	N/A	N/A	N/A	N/A	N/A	N/A	Director of my own PLC	Mar-20	Private Practice	Yes	Yes	George Eralil	13.11.20	Secondary Work Form sent 25.11.20
Kenneth	Lim	Chair of South Wales Gynae Cancer Fund - registered chairty	2009 - ongoing	nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Kenneth Lim	13.11.20	
Katie	Pink	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Katie Pink	13.11.20	Sponsorship Form sent 25.11.20
Joanne	May	N/A	N/A	N/A	The department is supported by Versus Arthritis family workers. We have a project (currently on hold) with ballet cymru and the Arts Council for Wales to provide patient support.	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Joanne May	13.11.20	Secondary Work Form sent 26.11.20
Lena	Thia	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Lena Thia	13.11.20	Secondary Work Form sent 26.11.20
Aleksander	Marin	N/A	N/A	N/A	N/A	N/A	N/A	Medica Teleradiology Speciality Advisor in Thoracic Radiology, Spire Hospital Cardiff Reporting Radiologist	20.06.16	Monthly p0ayable fees for service	Yes	Yes	Aleksander Marin	14.11.20	Secondary Work Form sent 26.11.20
Timothy	Sheppard	N/A	N/A	N/A	Discussion and offer of employment in BPAS (not yet accepted, pending job planning)	2020	Sessional	203 Field Hospital, Army Reserve	1998 - Ongoing	Sessional / Daily Rate	Yes	Yes	Timothy Sheppard	14.11.20	Secondary Work Form sent 26.11.20
Peter	Groves	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private practice at Spire Hospital Cardiff. The income from this is received by Groves Cardiology Services Ltd My wife is a Director and Shareholder in Groves Cardiology Services Ltd	June 96 - current	Income and Dividends	Yes	Yes	Peter Groves	15.11.20	Secondary Work Form sent 26.11.20
Angela	Miser	1. Chairman of Board, Christian Salvation Service, Taipei, Taiwan (USA Office), 2. Chairman of Board, Desi Geestman Foundation (supports children with cancer), Los Angeles, USA	20+	No	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Angela Miser	15.11.20	
Stuart Ashley	Roberts	N/A	N/A	N/A	Whilst not a Trustee of the Intubation Box Charitable Trust, I was involved developing this protective device for COVID-19 staff protection. Charity Ref ZD07662	21.04.20 - ongoing	Nil	Private Practice at Spire	1997 - Present	Fee per case payment	Yes	Yes	Stuart Ashley Roberts	15.11.20	Secondary Work Form sent 26.11.20
Sarah	Hunt	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private practice at Spire Hospital Cardiff. The income from this is received by Groves Cardiology Services Ltd I undertake private practice in Spire Hospital. They do not employ me. See Ltd co	2014 - ongoing	I do not draw a salary or dividends	Yes	Yes	Jayne Sara Hunt	15.11.20	Secondary Work Form sent 26.11.20
Jessica	Quirke	N/A	N/A	N/A	N/A	N/A	N/A	Self employed in private practice	2008	Salary	Yes	Yes	Jessica Quirke	16.11.20	Secondary Work Form sent 26.11.20
Mark	Stacey	Board member of the Association of Anaesthetics	Oct 20 - Oct 24	Nil	N/A	N/A	N/A	I run a course called Medtrim - I occasionally run private courses	2017 - current	Yes	Yes	Yes	Mark Stacey	16.11.20	Secondary Work form sent 26.11.20
Mathew	Hoskins	N/A	N/A	N/A	sponsored by the Multidisciplinary Association for Psychedelic Studies (MAPS, USA), which will take place in partnership with Cardiff Uni and Cardiff and Vale UHB in 2021. I have recevied training funded by MAPS.			I have done part time agency locum consultant work for Powys Health board. Finished in July 2020. No more planned as I'm no longer part time.		Yes	Yes	Yes	Mathew Hoskins	16.11.20	Secondary Work Form sent 26.11.20
Roger	Maggs	N/A	N/A	N/A	N/A	N/A	N/A	Managing Director of a company for private work Wife - Director of same company	01/04/2015 - current 01/04/2015	salary	Yes	Yes	Roger Maggs	16.11.20	Secondary Work Form sent 26.11.20
Christopher	Lewis	President of Wales Branch of the Healthcare Financial Management Association(HFMA). HFMA is a registered charity.	Oct 09 - Preesent	None anticipated	My wife is Samantha Lewis, Assistant/Deputy Director of Finance, Swansea Bay University Health Board	2011 - Present		N/A	N/A	N/A	Yes	Yes	Christopher Lewis	13.11.20	
Peter	Lindsay	Treasurer - South Wales Gynaecological Cancer Fund	1997 - current	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Peter Lindsay	13.11.20	
Nicholas	Drage	N/A	N/A	N/A	N/A	N/A	N/A	Lecturing to dentists on all aspects of dental radiology	ongoing	Lecturing: personal payment	Yes	Yes	Nicholas Drage	12.10.20	Secondary Work Form sent 26.11.20
Paul	Hodgson	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice (company name PDH Ortho Ltd)	Feb 2013 - ongoing	payment per case	Yes	Yes	Paul Hodgson	16.11.20	Secondary Work Form sent 26.11.20
Ramsey	Sabit	N/A	N/A	N/A	N/A	N/A	N/A	Outpatient private practice at Spire Hospital and Nuffield hospital	Aug 2014 - ongoing	Private Practice earnings are paid	Yes	Yes	Ramsey Sabit	16.11.20	Secondary Work Form sent 26.11.20
Kathryn	Allen	N/A	N/A	N/A	N/A	N/A	N/A	Policy and planning manager Company Chemists' Association	2015 - to date	Yes salaried 7.5 hours per week	Yes	Yes	Kathryn Allen	16.11.20	Secondary Work Form sent 26.11.20
Rhiannon Meleri	Morgan	N/A	N/A	N/A	Board Member of Manon Jones Foundation - not yet established as a charity	01.01.20	None	Coronial post mortem work for South Wales Central Coroner's Office	2004	£96 per individual PM	Yes	Yes	Meleri Morgan	16.11.20	Secondary Work Form sent 26.11.20
Dennis Llewellyn	Cochlin	N/A	N/A	N/A	N/A	N/A	N/A	Medical and scientific advisor to Intelligent Ultrasound (formally MedaPho (Simulations and artificial intelligence in ultrasound)	2010	Consultancy Fees	Yes	Yes	Dennis Cochlin	16.11.20	Secondary Work Form sent 26.11.20

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

Low	Elijah	Ablorsu	Consultant Transplant and General Surgeon	Nephrology and Transplant	Consultant	Specialist Services	16.11.20	Yes	Yes	UHW	46647	Yes	Medlap Ltd, E&G Senior Care Ltd Spouse: Medlap Ltd, E&G Senior Care Ltd	MedLap 20/01/2012; E&G SC ltd: 22/1/2016 MedLap 20/01/2012; E&G SC ltd: 22/1/2016		E&G Senior Care Ltd E&G Senior Care Ltd			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PP - Spire Cardiff		Yes	Yes	Yes	Elijah Ablorsu	16.11.20	Secondary Work Form sent 26.11.20
Low	Pippa	Mundy	Consultant Clinical Psychologist	Child Health	Consultant	Children & Women	16.11.20	Yes		Global Link	07976 702638	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Orbis Education & Care	2014	Payment for clinical services	Independent practice as psychologist	2014	Payment for clinical services	Yes	Yes	Pippa Mundy	16.11.20	Secondary Work Form sent 26.11.20
Low	Thomas	Hockey	Consultant Histopathologist	Cellular Pathology	Consultant	CD&T	16.11.20	Yes	Yes	UHW	41986	Not Ticked	Director Director / Secretary	Dividend Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Thomas Hockey	16.11.20	Secondary Work Form sent 26.11.20
Low	Rona	Aldridge	Clinical Psychologist / Clinical Lead of the Integrated Autism Service	Psychology and Psychological Therapies / Autism	8b	Mental Health	12.11.20	Yes	No	Avon House	2921824240	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I do some private work in my capacity as a psychologist - autism assessments, sometimes interventions and court reports. I do not assess anyone for autism in CAV UHB in a private capacity.	2012 - current	Financial	Yes	Yes	Rona Eldridge	12.11.20	Secondary Work Form sent 30.11.20 Completed secondary work form received 25.01.21
Low	Peter	Welsh	Senior Hospital General Manager Llandough/Barry	Executives / Corporate	VSM	Executive	17.11.20	Yes	Yes	UHL	20715698	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Magistrate - Cardiff Bench	1989 - ongoing	N/A	N/A	N/A	N/A	Wife - Optician for Roberts Opticians Whitchurch Road, Cardiff Son has own web design business	1985 - ongoing 2014 - ongoing		Yes	Yes	Peter Welsh	17.11.20	
Low	Naushad Ali	Junglee	Consultant in Acute Medicine and Nephrology	Acute Medicine	Consultant	Medicine	17.11.20	Yes	No	UHL	46645	Yes	NAJ Clinical Services PLC. A PLC set up by me for the purposes of private medical practice	2018 - current	private practice earnings	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Nephrologist at Spire Hospital Cardiff	2017 - current	Private Practice earnings are paid	Yes	Yes	Naushad Ali Junglee	17.11.20	Secondary Work Form sent 30.11.20
Low	Menna	Jones	Clinical Lead	Mental Health	8c	Mental Health	16.11.20	Yes	No	Global Link	02921 832200	Yes	Director of Vegan International Ltd	24.12.19 - ongoing	none	Self employed as complementary therapist	2018 - ongoing	sessional payments		N/A	N/A	N/A	N/A	N/A	Director of British Eating Disorders Society	10.01.18 - ongoing	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Menna Jones	16.11.20	Secondary Work Form sent 30.11.20
Low	Sarah	Bailey	Senior Specialist Speech & Language Therapist	Neuropsychiatry Service	7	Mental Health	17.11.20	Yes	No	Hafan y Coed	24853	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I occasionally provide independent speech and language therapy assessment for case managers in brain injury litigation. The patients seen are always outside of the geographical and clinical remit of my cardiff and vale caseload.	current		Yes	Yes	Sarah Louise Bailey	17.11.20	Secondary Work Form sent 30.11.20
Low	Patrick	Fielding	Consultant Radiologist	Radiology	Consultant	CD&T	17.11.20	Yes	No	UHW	46959	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	received travelling expenses and a lecturing fee for a GE molecular imaging smyposium	Aug-18	Lecturing fee and travel	N/A	N/A	N/A	N/A	N/A	N/A	I undertake a small amount of private practice during my work at the UHB both in NM and via PETIC . I do not consider that these constitute a conflict of	Sept 2010 - ongoing	fee per patient basis	Yes	Yes	Patrick Fielding	17.11.20	Secondary Work Form sent 30.11.20
Low	Robert	Bleehen	Medical Consultant	Consultant Radiologist	Consultant	CD&T	17.11.20	Yes	Yes	UHL	26583	Yes	Cardiff Medical Consultant Ltd (Director) Partner: Cardiff Medical Consultant Ltd (Director)			Cardiff Medical Consulting Ltd Partner: North Cardiff Medical Centre (Partner) and Cardiff Medical Consultant Ltd			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff Medical Consultant Ltd (Director) Partner: Cardiff Medical Consultant Ltd (Director)			Yes	Yes	Robert Bleehen	17.11.20	Secondary Work Form sent 30.11.20
Low	Carwyn	Bridges	Physiotherapist	Specialty Medicine	7	Medicine	16.11.20	Yes	No	UHL	2071 6841	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Limited Consultancy Chiesi Ltd	June 20 - Oct 20	Honrarium	Yes	Yes	Carwyn Bridges	17.11.20	Secondary Work Form sent 30.11.20
Low	Robyn	Davies	Head of Innovation	Improvement and Implementation	8c	Corporate	16.11.20	Yes	No	Woodland House	7810636358	Not Ticked	Chairman - Culturvate Ltd	1.09.17	None	Chairman - Culturvate Ltd (existing UHB customer)	1.09.17	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Visiting Professor - University of South Wles; Hon Innovation Fellow - Cardiff University	1.07.20 - 1.07.23 16.11.20 - 1.01.25	None	N/A	N/A	N/A	Yes	Yes	Robyn Davies	17.11.20	
Low	Ann Marie	Procter	Consultant in Medical Genetics & Clinical Board Director	AWMGS	Consultant	Mental Health	17.11.20	Yes	No	UHL	24995	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of Kaleidoscope Addictions Charity	2018	Voluntary	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ann Procter	17.11.20	Secondary Work Form sent 01.12.20
Low	David Mark	Howells	Consultant Psychiatrist	Mental Health for Older People	Consultant	Mental Health	18.11.20	Yes	No	UHL	02921 711711	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of Resec (Research in Specialist and Elderly Care - Charity / Study Group)	2014 - current	None	N/A	N/A	N/A	Health Inspectorate Wales - Second Opinion Appointed Doctor (CAVUHB) Cwm Taf UHB, ABUHB Section 12 Dr Work	May 2019 - Current Oct 2017 - Current	Fees Fees	Yes	Yes	Dr David Howells	18.11.20	Secondary Work Form sent 01.12.20
Low	Alexander	Kennedy	Consultant Anaesthetist	Perioperative Care / Anaesthetics	Consultant	Surgery	12.11.20	Yes	No		7413908743	Yes	Director South East Wales Hang Gliding and Paragliding Club Ltd	16.03.17 - ongoing	No benefits	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Alexander Kennedy	12.11.20	
Low	Tristan	Groves	Lead Cardiology and Anticoagulation Pharmacist	Adult Cardiology	8a	Specialist Services	18.11.20	Yes	No	UHW	20746826	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Receiving Honoraria for providing educational sessions from Pharmaceutical companies related to anticoagulation. Honoraria received from BMS/Pfizer alliance and Bayer. Sponsored attendance of educational meetings also supplied by the above companies	2016 - current	Honoraria and meeting travel expenses	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Tristan Groves	18.11.20	Sponsorship Form sent 1.12.20
Low	Zaheer	Yousef	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	18.11.20	Yes	No	UHW	42972	Yes	ZY Consultant Ltd - Director	31.07.19 - ongoing	Shareholder: ad hoc dividend payments (nil to date)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chairman: Heart Research Wales and Medical Director Pace4Life	2015 - ongoing	N/A	N/A	N/A	N/A	In receipt of honoraria, lecture fees and research funding from Astra Zeneca, Pfizer, Servier, Beoringer Ingelheim, Bristol Meyers Squibb, Lilly, Novartis, Abbott, Medtronic . Undertake private practice at Spire Hospital and Nuffield Healthcare and provide sports cardiology screening services to elite athletes (e.g. Cardiff City football club, Swansea Football club, Football Association of Wales, Welsh Rugby Union, Glamorgan cricket)	2005 - ongoing		Yes	Yes	Zaheer Yousef	18.11.20	Secondary Work Form sent 01.12.20
Low	Alana	Adams	Principal Pharmacist	Pharmacy	8c	CD&T	18.11.20	Yes	No	UHW	43880	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	Attended two meetings as a Specialist Pharmacist in a consultancy role for Pharmaceutical Industry and Marketing company.	07.09.20 - 10.09.20	Honorarium received	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Participated in a podcast for Cardiff University	13.11.20 - 13.11.20	Payment received	Yes	Yes	Alana Adams	18.11.20	Secondary Work Form sent 01.12.20
Low	Vakeaparamabil	Biju	Consultant	Elderly Care Medicine	Consultant	Medicine	12.11.20	Yes	No	UHW		Not Ticked	Medic Training Limited - private work from publication of articles, attending ad - board	1.03.17 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Vakeaparamabil Biju	12.11.20	Secondary Work Form sent 01.12.20
Low	Charles	Janczewski	UHB Chair	Executives / Corporate	VSM	Executive	12.11.20	Yes	No	Woodland House		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Swansea University - Chair of Governance Board for Health & Wellbeing Academy	May 2018 - ongoing	Unpaid	N/A	N/A	N/A	Yes	Yes	Charles Jancewski	12.11.20	
Low	David	Tuthill	Consultant Paediatrician	Child Health	Consultant	Children & Women	12.11.20	Yes		UHW	46725	Not Ticked	Director Cardiff Paediatrics Partner: Director Cardiff Paediatrics	ongoing ongoing		N/A	N/A	N/A	I do occasional lectures for pharmaceutical and infant feed companies			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	David Tuthill	12.11.20	Secondary Work Form sent 01.12.20
Low	Annette	McLean	Dietetic Lead Mental Health	Dietetics	8a	CD&T	12.11.20	Yes		UHL	2071 5281	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ad hoc private dietetic work: Orbis education, plus dietetic consultation/training ad hoc on request, eg: cardiff uni/somek/knights-absorb.	2005 - ongoing		Yes	Yes	Annette McLean	12.11.20	Secondary Work Form sent 01.12.20
Low	Andrew	Beamish	ST8 General Surgery	General Surgery	ST8	Surgery	19.11.20	Yes	No	UHW		Yes	Director and Trustee of Limited Company "ASiT Events"	2014 - ongoing	Nil (Voluntary)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director and Trustee ofAssociation of Surgeons in Training - Currently applying for its Limited	2014 - ongoing	Nil (voluntary)	N/A	N/A	N/A	N/A	N/A	N/A	Yes	yes	Andrew Beamish	19.11.20	Secondary Work Form sent 01.12.20
Low	Richard	Hain	Consultant and Clinical Lead, Paediatric Palliative Care	Child Health (Community)	Consultant	Children & Women	19.11.20	Yes		UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CVUHB Office space within Ty Hafan Children's Hospice	2018		Office space, coffee			Yes	Yes	Richard Hain	19.11.20	
Low	Aled	Roberts	Clinical Board Director	Medical Consultant	Consultant	Medicine	19.11.20	Yes	Yes	UHW	42344	Yes	Co-Director SAGE Roberts PLC Co-Director SAGE Roberts PLC	2018 - ongoing 2018 - ongoing	dividend only (not taken this financial year) "	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Aled Roberts	19.11.20	
Low	Mary	Lawrence	Associate Specialist in Psychiatry	Mental Health	Consultant	Mental Health	20.11.20	Yes	No	Hamadryad CMHT	2046 3488	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Occasional private work in the form of reports for solicitors, DVLA, CPS, CICB, Child Services, Benefits Appeals, Immigration Applications, Occupational Health, Police etc. plus Mental Health Act Assessments. These are conducted in my own time (if undertaken during my normal working hours time slipping utilised with equivalent amount of NHS work undertaken in my own time)	Ongoing		Yes	Yes	Mary Lawrence	20.11.20	Secondary Work Form sent 01.12.20
Low	Frauke	Pelz	Associate Specialist in Clinical Genetics	All Wales Medical Genomics Service	Associate Specialist	All Wales Medical Genomics Service	20.11.20	Yes	Yes	UHW	48921	Not Ticked	Director of limited company	Since May 2016 - ongoing	Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I hold a very small private psychotherapy practice, limited to very few monthly hours, well outside my job planned hours in NHS post			Yes	Yes	Frauke Pelz	20.11.20	Secondary Work Form sent 01.12.20
Low	Mari	Lea-Davies	Lead Pharmacist - Respiratory	Pharmacy	8a	CD&T	20.11.20	Yes	No	UHL	2071 5261	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff University MSc in clinical pharmacy. Provide 2 hour teaching session every 12 or 24 months. Annual leave taken, therefore undertaken during my	March 11 - present	Hourly rate for delivering presentation	Yes	Yes	Mari Lea-Davies	20.11.20	Secondary Work Form sent 01.12.20
Low	Joy	Whitlock	Head of Quality and Safety Improvement	Patient Safety and Quality Improvem	8b	Corporate Nursing	23.11.20	Yes	No	Woodland House	36311	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sole trader of Joy Whitlock Coaching and Business Development www.joywhitlock.co.uk . Since I work part time for the UHB there will not be conflict with NHS duties. I'm declaring this, however, in the name of transparency.	2016 - ongoing	Hourly fee as work arises. Mostly pro bono	Yes	Yes	Joy Whitlock	23.11.20	Secondary Work Form sent 01.12.20
Low	Gary	Howell	Macmillan AHP Cancer Lead	Therapies	8a	CD&T	13.11.20	Yes	No	UHW	44294	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private dietetic practice	2008 - ongoing	Salary	Yes	Yes	Gary Howell	13.11.20	Secondary Work Form sent 03.12.20
Low	Julie	Loxton	Clinical Lead Nurse	Vale Locality Office / Daytime Servi	7	PCIC	24.11.20	Yes	No	Barry Hospital	7989223435	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	There is a call handler who is now related via Marriage to my son, they have now separated, she is band 2, I have nothing to do with managing her she is managed by Tracey Stafford my deputy. My cousin also works for the C&V UHB band 2 admin	2016 - ongoing	none	Yes	Yes	Julie Loxton	13.11.20	
Low	Sheelagh	Rogers	Dental Consultant	Orthodontics		Surgery	24.11.20	Yes	No	UHW	42448	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Specialist Practitioner; Cathedral Orthodontics; Cathedral Road; Cardiff	N/A	N/A	Yes	Yes	Sheelagh Rogers	24.11.20	Secondary Work Form sent 3.12.20
Low	Michael	Stechman	Consultant Surgeon	General Surgery	Consultant	Surgery	13.11.20	Yes	Yes	UHW		Yes	Director of KVMS Medical, Private Medical Practice Company Director of KVMS Medical, Private Medical Practice Company	June 2019 - present June 2019 - present	Dividends Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of the British Association of Endocrine and Thyroid Surgeons	October 2018 - Present	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Michael Stechman	23.11.20	
Low	Gail	Clayton	Lead Clinical Nurse Specialist in MS	Neurosciences	8a	Specialist Services	25.11.20	Yes	No	UHW	45018	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of UKMSSNA Committee		Sponsorship for overnight	N/A	N/A	N/A	Yes	Yes	Gail Clayton	26.11.20	Sponsorship Form sent 3.12.20
Low	Dev	Detta	Consultant in Metabolic Medicine	Haematology/ Immunology / Metabolic Medicine	Consultant	Specialist Services	26.11.20	Yes	No	UHL	26844	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Honoria received for expert advice and speaker fees from Amgen, Sanofi, Ackea, Amryt, Kyowa Kirin, Novartis	2011 - ongoing	Financial	N/A	N/A	N/A	Trustee, HEART UK	2018	None	N/A	N/A	N/A	Private Practice- Metabolic Clinic Ltd	2011	Financial	Yes	Yes	Dev Datta	26.11.20	Secondary Work Form sent 3.12.20
Low	Amy	Jones	Consultant Geriatrician	Clinical Gerontology	Consultant	Medicine	24.11.20	Yes	No	UHL	25653	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	On the committee for the British Geriatrics Society cardiovascular special interest group	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Amy Jones	26.11.20	
Low	Somashekara	Shivashankar	Consultant Psychiatrist	Adult Mental Health	Consultant	Mental Health	26.11.20	Yes	No	CRI	20335555	Yes	Director of a Limited company but have no actual or perceived conflict with the Health Board Spouse is also a Director of a Limited company but have no actual or perceived conflict with the Health Board	01/04/2019 April 2019		Part ownership of a limited company but have no actual or perceived conflict with the Health Board Spouse is also a part owner of a Limited company but have no actual or perceived conflict with the Health Board	01/04/2019 April 2019			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ad hoc work as SOAD for HIW but have no actual or perceived conflict with the Health Board	Jan-19		Ad hoc work as SOAD for HIW but have no actual or perceived conflict with the Health Board	Jan-19		Yes	Yes	Somashekara Shivashankar	26.11.20	
Low	Ceri Hopcyn	Jones	Consultant Haematologist (BMT & CAR T)	Consultant Haematologist	Haematology	Specialist Services	1.02.20	Yes	No	UHW	41976	Yes	I received sponsorship to attend various conferences including European Haematology Asssociation General meeting (EHA) 2019 and American Society of Hematolgy (ASH) 2019 from Abbvie, and EHA 2020, British Society of Haematology Annual General Meeting 2020 and ASH 2020 from Kite Gilead and Novartis	May 2019 - ongoing	Travel and registration costs only	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ceri H Jones	1.12.20	Sponsorship Form sent 3.12.20
Low	David Hywel	Thomas	Consultant Histopathologist	Histopathology	Consultant	CD&T	01.12.20	Yes	No	UHW	45316	Yes	Co-director of company to provide autopsy service for HM Coroner My wife is a co-director of the company	March 20 - ongoing March 20 - ongoing	payment from HM Coroner per autopsy salary from company	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	David Thomas	1.12.20	Secondary Work Form sent 3.12.20
Low	Matthew	Thomas	Consultant Restorative Dentistry	Dental	Consultant	Surgery	26.11.20	Yes	No	UHW	42519	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	West Coast Dental Care - Self employed private practice	ongoing		Yes	Yes	Matthew Thomas	26.11.20`	Secondary Work form sent 4.12.20
Low	Mark	Jones	Team Lead for the Young Onset Dementia Service	MHSOP	7	Mental Health	30.11.20	Yes	Yes		1446 454200	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chair of Trustees for Re-Live (Registered Charity Number: 1162546) Spouse is a Board Member with the charity 'Wish Upon a Star'.(Registered Charity Number 1168140).	01/07/2015 01/07/2015	None None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mark Jones	30.11.20	
Low	Sarah	Spencer	Deputy Head of Midwifery	Obs & Gynae	8b	Children & Women	4.12.20	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Huntleigh Healthcare	2014 - ongoing	£1,000	N/A	N/A	N/A	N/A	N/A	N/A	Huntleigh Healthcare	2014 - ongoing	£1,000	Huntleigh Healthcare	2-14 - ongoing	£1,000	Yes	Yes	Sarah Spencer	4.12.20	Secondary form sent 2.12.20
Low	Megumi	Baba	Consultant Paediatric Palliative Care	Child Health	Consultant	Children & Women	4.12.20	Yes	No	UHW	2920532200	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have an honorary cotract with Ty Hafan Children's Hospice as their consultant	21.06.16 - ongoing	CAVUHB invoices part of my salary (4 sessions per week)	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Megumi Baba	4.12.20	
Low	Paul	Bracegirdle	Senior Projects & Deputy Directorate Manager	Dental/Ophthalmology	8a	Surgery	6.12.20	Yes	No	UHW	44846	Yes	Active Director at Tre-Oda Court Management Ltd, Companies House Reference Number 08945509	5.10.17	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Paul Bracegirdle	6.12.20	
Low	Fiona	Jenkins	Executive Director of Therapies and Health Science	Executive	Executive	Executive	26.11.20	Yes	No	UHW		Yes	Interim Executive Director Therapies and Health Science, Cwm Taf Morganngw UHB	Nov 20 - tbc	Shared role with C&V UHB	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Fiona Jenkins	26.11.20	
Low	Balarao	Oruganti	Consultant in Psychiatry	Psychiatry	Consultant	Mental Health	18.11.20	Yes	No	UHL	47747	Not Ticked	Director of limited company but cannot see any conflict as not doing or seeking any business with UHB Spouse - Director of a limited company but cannot see any conflict as not seeking or doing any business with UHB			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Works for HIW and Judicial Appointment Committee for MHRT on ad hoc basis			Yes	Yes	Balarao Oruganti	18.11.20	Secondary form sent 21.12.20
Low	Carly	Jackson	Clinical Psychologist	Child Health	8a	Children and Women	14.12.20	Yes	No	St David's Hospital	2920536733	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical Psychologist with Sport Wales (employeed by Sport Wales) and Clinical Psychologist for Mindful Mindset (Self-Employeed)	Sports Wales (1.09.19) both ongoing	Sports Wales Salary	Yes	Yes	Carly Jackson	14.12.20	Secondary form sent 5.1.20
Low	Peter	Sharp	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	14.12.20	Yes	No	UHW	2921847089	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Consultant: Medtronic, Philips, Recor Medical, Penumbra	1.07.20 - ongoing	Speaker's and/or consultancy compensation for time	Research funding, Boston Scientific	1.10.20 - 2025	Executive committee recompense for time running study	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Andrew Sharp	14.12.20	Secondary form sent 5.1.20
Low	Karen	Visser	Professional UHB Lead for Speech & Language	Community Child Health	8c	Children and Women	17.11.20	Yes	No	Riverside Health Centre	029 2183 6585	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of Community Music Wales	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Karen Visser	17.11.20	Secondary form sent 5.1.20
Low	Peter	Mullaney	Consultant Radiologist	Radiology	Consultant	CD&T	11.12.20	Yes	No	UHW	43956	Yes	Yes	2019		Yes	2019	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Peter Mullaney	11.12.20	Secondary form sent 5.1.20
Low	Mary Annette	Thomas	Director Weqas	Weqas	8d	CD&T	17.12.20	Yes	No	Llanishen	48332	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Becton Dickinson - European Advisory Board member for Point of Care. Provided Advice and attended meetings. Invited Speaker at Siemens Healthineers meeting in Bangkok in 2019 and Brussels Oct 2018. Invited speaker at Nova Biomedical User Group meetings in Manchester and London November 2018.	Aug 18 - current	Received travel expenses to attend meeting in London 2018, Aberdeen in 2020	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mary Thomas	17.12.20	Secondary form sent 6.1.20
Low	William Jonathan	Kell	Consultant Haematologist	Haematology	Consultant	Specialist Services	22.12.20	Yes	No	UHW	42654	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Occasional requests from Pharmaceutical companies to give education (non-promotional) talks, or to sit on paid advisory boards	2002 - ongoing	Less than £2k	Treasure of UK MDS forum	2010 - ongoing	none	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jonathan Kell	22.12.20	Secondary form sent 6.1.20
Low	Sumit	Goyal	Consultant Surgeon	Surgery	Consultant	Surgery	23.12.20	Yes	No	UHW			Director of limited company Dr Goyal Ltd Spouse - secretary of company	Oct 2014 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of Breast Centre Charity	2009 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Sumit Goyal	23.12.20	Secondary form sent 6.1.20
Low	Sian	Moynihan	Consultant Paediatrician	Child Health	Consultant	Children and Women	4.02.21	Yes	No	St David's Hospital	2920536789	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am welfare Officer (Safegarding Officer) which is voluntary and unpaid for the Maindy Youth Cycling club- Im on the committee supporting decision making for the club that involves child welfare. It is recognised by British Cycling Authority and Welsh Cycling Authority and done necessary Safeguarding training. I do not believe there is any conflict of interest as this is done in outside work hours.		None	N/A	N/A	N/A	Yes	Yes	Sian Moynihan	4.01.21	
Low	Adam	Jones	Consultant Dental Surgeon	Dental	Consultant	Surgery	8.01.21	Yes	No	UHW	44365	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Merck Sharp & Dohme Ltd. funded travel / hotel and course expenses for training on 'PD-L1 testing (22C3) Professional Expert Course Head and Neck Advanced Training'.	13.01.21 - 14.01.21	Course, travel and hotel expenses	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Adam Jones	8.01.21	Secondary form sent 11.01.21
Low	Darren	Robinson	Registered Nurse	Addictions	7	Mental Health	8.01.21	Yes	No	UHW	2920744901	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trusteeship with Recovery Cymru	Jan-11	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Darren Robinson	8.01.21	
Low	David	Hanna	Consultant Paediatrician	Emergency Medicine	Consultant	Medicine	11.01.21	Yes	Yes	UHW	48008	Yes	N/A	N/A	N/A	My wife, Dr Alison Whyte is a partner in Clark Avenue Surgery, a GP Practice in Cwmbran, within the Aneurin Bevan UHB area. This practice does not currently do business or is it seeking to do business with Cardiff and Vale UHB.	2019		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	David Hanna	11.01.21	
Low	Louise	Ingleton	Avanced Paediatric Clinical Nurse Specialist	Community Child Health Deurodevelopmental	8a	Children and Women	13.01.21	Yes	No	St David's Hospital		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Member of UK Nurse Advisory Board-ADHD sponsored by Takeda Pharmaceuticals	March 20 - ongoing	honoria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Louise Ingleton	13.01.21	Secondary form sent 13.01.21
Low	Mirander	Barber	Consultant Clinical Psychologist	MHSOP	8+	Mental Health	13.01.21	Yes	No	UHL	20715782	Yes	I am the Director of a Ltd company which has not traded for 18 months	2015 - current	none	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Miranda Barber	13.01.21	
Low	Helen	Griffiths	Occupational Therapist	Community Resource Team	7	PCIC	14.10.20	Yes	No	Whitchurch Hospital	32501	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Work as occupational therapist for Stroke case management on ad hoc basis	Sept 2016 - ongoing	zero hour contract	Yes	Yes	Helen Griffiths	14.10.20	Secondary form sent 20.01.21
Low	Claire	Main	Interim Manager of Critical Care and Major Trauma	Specialist Services	8	Specialist Services	24.01.21	Yes	No	UHW	02921 845069	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	Yes - Executive member of the Association of Nephrology Nurses	Oct 20 - Present	No	No	N/A	N/A	No	N/A	N/A	Yes	Yes	Claire Main	25.01.21	
Low	Abigail	Harris	Executive Director of Strategic Planning	Strategic Planning	Director	Corporate	27.01.21	Yes	Yes	Woodland House		Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	My husband is an Independent Board member of the Wales Council for Voluntary Action. My uncle is a Trustee of the Teenage Cancer Trust.	Ongoing	No	I am an Independnet Board member of Social Care Wales.	Ongoing	No	Husband works for Competition and Markets Authority which on occasions rules in matters of fair competition in the NHS and healthcare.	Ongoing	Husband's salary.	Yes	Yes		27.01.21	
Low	Benny	Thomas	Consultant Neurophysiologist	Neuroscience	Consultant	CD&T	27.01.21	Yes	No		46690	Yes	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Private Practice	2002 - Present	Reimbursement of fees	Yes	Yes		25.01.21	Secondary Employment Form and Policy sent 28.01.21
Low	Iqroop	Chopra	Consultant Trauma and Orthopaedic Surgeon	Trauma and Orthopaedics, Spines	Consultant	Surgery	3.12.20	Yes	Yes	UHW	2920715289	Yes	Director 1. Tanman Consultancy Ltd 2. Tanman Investments Ltd Spouse Director 1. Tanman Consultancy Ltd 2. Tanman Investments Ltd	2008 - ongoing 2015 - ongoing 2008 - ongoing 2015 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Spinaid Ltd, Director	Dec-19	N/A	N/A	N/A	N/A	Practice privileges at Nuffield Vale Hospial and Spire Cardiff Hospital	2008		Yes	Yes	Iqroop Chopra	3.12.20	Secondary Employment Form and Policy sent 1.02.21
Low	Lauren	Whittington	Clinical Psychologist	CAMHS	8+	Children and Women	3.12.20	Yes	No	St David's Hospital	36730	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I currently work 1 session a week for Oxford Health NHS Foundation Trust as a clinical psychologist	27.11.20 - current	Salary as sessional worker	Yes	Yes	Laura Whittington	3.12.20	Secondary Employmet Form and Policy sent 3.02.21
Low	Jane	Maddison	Paediatric Physiotherapy	Acute Child Health	8a	Children and Women	13.11.20	Yes	No	Woodland House	365578	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Member of Chartered Society of Physiotherapy Welsh Board	N/A	N/A		N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jane Maddison	13.11.20	
Low	Gwenda	Phillips	Clinical Psychologist	Psychology Therapies	8d	Mental Health	25.01.21	Yes	No	UHL	24850	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director in Carers Trust South East Wales	2018 - ongoing	none	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Gwenda Phillips	25.01.21	
Low	Argiris	Asderakis	Consultant Transplant Surgeon	Nephrology and Transplant	Consultant	Specialist Services	25.01.21	Yes	No	UHW		Yes	N/A	N/A	N/A	Small number of shares in Pfizer	1.10.19 - ongoing	£500 shares as part of portfolio	Sanofi Frances, Novartis	01/10/2013 - 01.10.2015	30k provided for departmental research	Sanofi Frances, Novartis	01/10/2013 - 01.10.2015	Funding for an MD research project	Kidney Wales Trustee	01.02.2007 - ongoing	Board of Trustees and its HR	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Argiris Asderakis	25.01.21	
Low	Sharon	Irving	Senior Nurse ENT	ENT	8a	Surgery	07.02.21	Yes	No	UHW	02920 742783	Yes	No	N/A	N/A	No	N/A	N/A	A position with HIW as a nurse peer reviewer.	2019-Present	No	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	Yes	Yes	Sharon Irving	07.02.21	
Low	Hamsaraj	Shetty	Consultant Physician	Medicine Stroke	Consultant	Medicine	25.01.21	Yes	No	UHW	43837	Yes	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have received honoraria for GP lectures sponsored by Bayer on 7th October, 2020 and 28th January 2021) & from Portola/Alexion Pharmaceuticals for being a member of Delphi panel	6.10.20 - 19.10.2	Honorarium	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Hamsaraj Shetty	25.01.21	Secondary Form sent 9.02.21
Low	Jeffrey	Morris	Head of Electronic Assitive Technology Service for Wales	ALAS	8a	Specialist Services	12.11.20	Yes	No	Rookwood Hospital	02920 313852	Not Ticked	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Organising Committee and Scientific Committee member of the European Seating Symposium (ESS), based in Ireland.	Jun-11	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jeffrey Morris	12.11.20	
Low	Lawrence	Sunder Raj	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	25.01.21	Yes	Yes	UHW	44879	Yes	Yes Spouse Yes	6.01.19 - 18.02.20 18.02.20	Directors salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at Cardiff Bay Hospital	N/A	N/A	Yes	Yes	Lawrence Sunder Raj	25.01.21	Secondary Form sent 10.02.21
Low	Nimish	Shah	GP MHSOP	MHSOP	GP	Mental Health	25.01.21	Yes	No	UHL		Yes	Director Dr Nimish Shah Ltd	2016 - ongoing	Salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Nimish Shah	25.01.21	Secondary Form sent 10.02.21
Low	Vinod	Varghese	Consultant Clinical Geneticist	AWMGS	Consultant	AWMGS	7.12.20	Yes	Yes	UHW	43976	Yes	One of the directors of a ltd complany - Apps4Medics Ltd. Not linked to NHS or Cardiff & Vale UHB	11.01.2011 - ongoing Spouse - 11.01.21	Both have shares	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Vinod Varghese	7.12.20	
Low	Richard	Anderson	Consultant Cardiologist	Cardiothoracic	Consultant	Specialist Services	25.01.21	Yes	No	UHW	43786	Yes	Shareholder of Richard Anthony Anderson Ltd	1.08.15 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Committee member of the Wales Heart research Fund	01/01/2010 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Richard Anderson	25.01.21	
Low	Sharon	Jones	Consultant Rheumatologist	Specialised Medicine	Consultant	Medicine	25.01.21	Yes	No	UHW	42886	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Educational funding from Lily for EULAR conference (virtual) in June 2021			Have been an advisor to NASS - National Ankylosing Spondylitis Society and received an award in 2018		N/A	N/A	N/A	N/A	Private rheumatology practice at Spire funded (self employment) since 2001	N/A	N/A	Yes	Yes	Sharon Jones	25.01.21	Secondary and sponsorship form sent 10.02.21
Low	Mark	Jones	Team Lead for Young Onset Dementia Service	MHSOP	7	Mental Health	30.11.20	Yes	Yes	UHW	47747	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chair of Trustees for the Charity Re-Live (Registered Charity Number: 1162546) Spouse: Board Member with the Charity Wish Upon a Star (Registered Charity Number 1168140)	July 2015 Jan 2016	None None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mark Jones	30.11.20	
Low	Christopher	Thomas	Consultant Physician	Clinical Gerontology	Consultant	Medicine	25.01.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Previous sponsorship to attend international conferences and honoraria for teaching from pharmaceutical agencies (BIAL, GSK, Abbvie, Britannia) on various occasions between 2009 and 2019. I also sat on expert advisory panel for GSK	2009 - 2019	Honori & Sponsorship	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Christopher Thomas	25.01.21	
Low	Prabhu	Sekaran	Consultant Paediatrician Surgeon	Child Health	Consultant	Children and Women	25.01.21	Yes	Yes	UHW		Not Ticked	Director - Novel Surgery	2019 - current	nil	N/A	N/A	N/A	Spouse shares in GlaxoSmithKine			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertaken private practrice in the Spire, Cardiff	N/A	N/A	Yes	Yes	Prabhu Sekaran	25.01.21	Secondary Form sent 10.02.21
Low	Mark	Drury-Smith	Consulant Cardiologist	Cardiothoracis and Medicine	Consultant	Specialist Services	26.01.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I gave a talk to GPs on heart failure that was sponsored by AstraZenza.	13.07.20	Honoraria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mark Drury-Smith	26.01.21	Sponsorship form sent 10.02.21
Low	Ian	Bowler	Consultant Anaesthetist	Anaesthetics	Consultant	Surgery	18.12.20	Yes	No	UHL	26860	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chairman of MEDSERVE Wales, an Immediate Care Charity based in South Wales			Medical Advisor to the Myotonic Dystrophy Support Group			Private Practice with admitting rights at Spire Cardiff Hospital and Vale Hospital Hensol	N/A	N/A	Yes	Yes	Ian Bowler	18.12.20	Secondary form sent 10.02.21
Low	Robert	Beattie	Consultant Obs & Gynae	Fetal Medicine	Consultant	Children and Women	26.01.21	Yes	No	UHW		Yes	Founding Director of Innermost Secrets Ltd trading as Innermost Healthcare Spouse: ""	15+ years - current 15+ years - current	financial financial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Founding Chairman of Innermost Learning Registered Charity Trustee of Innermost Learning			Shareholder in Time for Medicine			N/A	N/A	N/A	Yes	Yes	Robert Beattie	26.01.21	Secondary form sent 10.02.21
Low	Sian	Griffin	Consultant Nephrology & Transplantation	Nephrology and Transplant	Consultant	Specialist Services	26.01.21	Yes	No	UHW	48451	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Advisory Board attendance - Roche, Novartis, Retrophin, Astra, Zeneca	17.08.20 - 16.11.20	Honoraria	N/A	N/A	N/A	General Secretary British Transplantation Society	01.03.18 - 01.03.21	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Sian Griffin	26.01.21	Secondary form sent 10.02.21
Low	Jan	Melichar	Consultant Psychiatrist	Addictions	Consultant	Mental Health	26.01.21	Yes	No	CRI	2920461788	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Consultancy & training for all UK pharmaceutical companies in this area	1995 - ongoing	Honoraria	Consultancy at third sector organisation (DHI) in Bath and Bristol	2011 - ongoing	Honoraria	Consultancy to LearnitOnline - online health education and training	2016 - ongoing	Honoraria	Self employed in private practice primarily Spire	2011 - ongoing	Fees	Yes	Yes	Jan Melichar	26.01.21	Secondary & Sponsorship form 10.02.21
Low	Khalid	Hamandi	Consultant Neurologist	Epilepsy Unit	Consultant	Specialist Services	26.01.21	Yes		UHW	46662	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Secretary, International League Against Epilepsy Britich Chapter. Chair Epilepsy Action Cymru National Advisory Council.	2019 - present	none	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Khalid Hamandi	26.01.21	
Low	Amar	Wahid	Consultant Paeds Gastroenterology	Paediatric Gastroenterology	Consultant	Children and Women	26.01.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private Practice Secretary for Private Practice	November - ongoing November - ongoing	Salary Salary	Yes	Yes	Anwar Wahid	26.01.21	Secondary form sent 11.02.21
Low	Ne-on	Loh	Consultant Paediatrician	Child Health	Consultant	Children and Women	26.01.21	Yes	No	UHW	44291	Not Ticked	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Consultant Paeditricin in Royal United Hospital Bath	February 2010 -	2PA	Yes	Yes	Bne-ron Loh	26.02.21	Secondary form sent 11.02.21
Low	Kate	Skone	Consultant Community Paediatrician	Child Health	Consultant	Children and Women	26.01.21	Yes	No	UHW	20536782	Not Ticked	Director of Dr Skone Ltd	01.07.19 - ongoing Spouse - 01.07.19 - ongoing	Dividend Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Kate Skone	26.01.21	
Low	Nagah	Elmusharaf	Consultant Haenatlogist	Haematology	Consultant	Specialist Services	26.01.21	Yes		UHW		Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Roche, Abbvie, AstraZenca		Fees for organising talks and to attend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Nagah Elmusharaf	26.01.21	Sponsorship form sent 21.01.21
Low	Craig	Parry	Consultant Radiologist	Radiology	Consultant	CD&T	26.01.21	Yes	No	UHW	43966	Yes	Craig Parry Diagnositics Ltd Co	Jul-17		Craig Parry Diagnostics Ltd Co	Jul-17	Salary	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice - Spire Hospital Cardiff		Salary	Yes	Yes	Craig Parry	26.01.21	Secondary form sent 11.02.21
Low	Richard	Penketh	Consultant Obs & Gynae	Obs & Gynae	Consultant	Children and Women	26.01.21	Yes	Yes	UHW	44390	Not Ticked	Director RPSF Ltd Director RPSF Ltd	April 2019 April 2019	Yes Yes	Director RPSF Ltd Director RPSF Ltd	April 2019 April 2019	Yes Yes	N/A	N/A	N/A	N/A	N/A	N/A	Trustee Welsh Institue for Women's Health Trustee Welsh Institue for Women's Health			N/A	N/A	N/A	Private practice at Spire all the income goes into RPSF Ltd			Yes	Yes	Richard Penketh	26.01.21	Secondary form sent 11.02.21
Low	Syeda	Zatman	Consultant Anaesthetist	Anaesthetics	Consultant	Surgery	25.01.21	Yes	No	UHW	43106	Yes	Brockweir Clinic Ltd	Apr-19	Nil	Brockweir Clinic Ltd	Apr-19	Nil	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	Yes	Yes	Tahsin Zatman	25.01.21	
Low	Paul	Morgan	Consultant Critical Care	Critical Care	Consultant	Specialist Services	26.01.21	Yes	No	UHW	43064	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A		N/A	N/A	N/A	N/A	Lead volunteer, the UK Sepsis Trust	2013		Lecturer for Doctors Academy	Apr-19		Yes	Yes	Paul Morgan	26.01.21	Secondary form sent 11.02.21
Low	Shibendra	Datta	Consultant Urologist	Urology	Consultant	Surgery	26.01.21	Yes	No	UHW	45115	Yes	Director of Urology Solutions Cardiff Ltd Spouse: Director of Urology Solutions Cardiff Ltd	01.02.18 - current 01.02.18 - current	Dividents ad hoc Dividents ad hoc	N/A	N/A	N/A	N/A		N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at Spire Hospital	Sept 2001 - ongoing		Yes	Yes	Shibendra Datta	28.01.21	Secondary form sent 11.02.21
Low	Anju	Sinha	Consultant Obs & Gynae	Obs & Gynae	Consultant	Children and Women	26.01.21	Yes	No	UHW	43238	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Private practice at Spire Cardiff Hospital	Ongoing	consultant fees charged	Yes	Yes	Anju Sinha	26.01.21	Secondary form sent 11.02.21
Low	Caroline	Evans	Consultant Anaesthetist	Periopertive Care	Consultant	Children and Women	27.01.21	Yes	No	UHW/UHL	43106	Yes	N/A	N/A	N/A	N/A	N/A	N/A	I do occasional consultancy work for Pfzer (Nov2020) and Pharmacosmos since 2016	Dec 2016 - ongoing	Honoraria for speaking role	I have recently secured sponsorship to run the WPOMS conference from Pharmacosmos	Dec-20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I do occasional private work at Spire Health - none this year but practicing privledges since 2011	Jan 11 - ongoing		Yes	Yes	Caroline Evans	26.01.21	Secondary and sponsorship form sent 11.02.21
Low	Sanjeev	Agarwal	Consultant Orthopaedic Surgeon	Orthopaedics	Consultant	Surgery	27.01.21	Yes	No	UHL		Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Institutional funding from Zimmer Biomet for funding of a knee fellow in orthopaedic surgery	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Sanjeev Agarwal	27.01.21	Sponsorship form sent 11.02.21
Low	Clare	Rowntree	Consulant Haematologist	Haematology	Consultant	Specialist Services	28.01.21	Yes	No	UHW	42033	Not Ticked	N/A		N/A	N/A	N/A	N/A	Members of previous advisory Boards for Novartis and Amgen in past 3 years		Yes	N/A	N/A	N/A	Advisory role to Leukaemia Care		No	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Clare Rowntree	28.01.21	Secondary form sent 11.02.21
Low	Stephen	Austin	Consultant Surgeon	Trauma and Orthopaedics	Consultant	Surgery	28.01.21	Yes	No	UHL	25239	Yes	Director - Austin Hip Solutions Ltd	24.06.2010 - ongoing	Dividends	N/A			N/A	N/A	N/A	N/A	N/A	N/A	Immediate past president of Brtish Hip Society						Consulting fees and/or design and / or royalties with orthopaedic companies * Deping - consulting fees education * Zimmer Bionet - consulting fees education * Smith & Nephew consulting fees - design & royalties * Orthofix - consulting fees, design & royalties * Lima - design & royalties * Adler - consulting fees, design & royalties * Private practice - Nuffield Hospitals		Yes	Yes	Yes	Stephen Jones	28.01.21	

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

Low	Andrea	Liu	Consultant Neuroradiologist	Radiology	Consultant	CD&T	28.01.21	Yes	No	UHW	44325	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4Ways Healthcare and Spire Cardiff	2012 and April 2010		Yes	Yes	Andrea Liu	28.01.21	
Low	Preetkiron	Bhal	Consultant Gynaecologist	Gynaecology	Consultant	Children and Women	28.01.21	Yes	No	UHW		Yes	Infiniti Healthcare Ltd Spouse	May 2013 - ongoing May 2013 - ongoing	Director Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A		N/A	N/A	N/A	N/A	Yes	Yes	Preetkiron Bhal	28.01.21	
Low	Aarti	Sharma	Consultant	Obs & Gynae	Consultant	Children and Women	28.01.21	Yes	No	UHW	43758	Yes	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Spire Hospital	Feb-18	Payment for seeing patients	Yes	Yes	Aarti Sharma	28.01.21	Secondary form sent 12.02.21
Low	Eileen	Brandreth	Independent Member of the Board	Executive / Corporate		Executive / Corporate	28.01.21	Yes	No	Woodland House		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Employee of Cardiff University	December 2008 ongoing		Yes	Yes	Eileen Brandreth	28.01.21	
Low	Haydn	Mayo	Assistant Clinical Board Director, PCIC	Community Director	8+	PCIC	28.01.21	Yes	No	Woodland House		Yes	Insync Healthcare Pharmacy, Insync Corporate Healthcare Ltd	2006 - 2007	Salary	Insync Healthcare Pharmacy, Insync Corporate Healthcare Ltd	2006 - 2007	Salary	Insync Healthcare Pharmacy, Insync Corporate Healthcare Ltd	2006 - 2007	Salary	N/A	N/A	N/A	Forget Me Not Chorus Charity Trustee			Penarth Civic Society Member / Chair - Friends of Victoria Square sub group			N/A	N/A	N/A	Yes	Yes	Haydn Guy Mayo	28.01.21	Secondary form sent 12.02.21
Low	Rhian	Thomas	Independent Member of the Board	Executive / Corporate		Executive / Corporate	28.01.21	Yes	No	Woodland House		Yes	N/A	N/A	N/A	Owner of consultancy business	01.03.19 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of Glas Cymru Cyf (Welsh Water) Co-opted Board Director of Cardiff & Vale Credit Union	01.10.19 - present 15.05.20 - present	Voluntary Voluntary	Senior Lecturer - University of South Wales	04.05.20 - ongoing		Yes	Yes	Rhian Thomas	28.01.21	
Low	Mohid	Khan	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	29.01.21	Yes	No	UHW	43443	Yes	Dr Mohid Khan Ltd	16.04.19	None	N/A	N/A	N/A	AAA	9.03.20	Speaker Fee	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mohid Khan	28.01.21	previous year 2019 - 2020
Low	Ioulia	Evangelou	Consultant Cellular Pathology	Cellular Pathology	Consultant	CD&T	29.01.21	Yes	Yes	UHW	41894	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	2018 - January 2021	Salary	Yes	Yes	Evangelou Ioulia	29.01.21	Secondary form sent 12.02.21
Low	Sridhar	Kamath	Consultant Radiologist	Radiology	Consultant	CD&T	29.01.21	Yes	No	UHW	44887	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have private practising privileges at Spire cardiff hospital, Nuffield hospital cardiff and St Josephs hospital Newport.			Yes	Yes	Sridhar Kamath	29.01.21	Secondary form sent 12.02.21
Low	Swaroop	Shanbhag	Consultant Spinal Rehabilitation	Neurosciences	Consultant	Sepcialist Services	30.01.21	Yes	No	UHW	33800	Not Ticked	Abergavenny Hand Surgery Ltd - Director Partner - Vasedev Shanbhag	Mar-17	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Swaroop Shanbhag	30.01.21	
Low	Meinolfus	Wulf	Consultant Anaethesia	Perioperative Care / Anaesthetics	Consultant	Surgery	1.02.21	Yes	No	UHL	26660	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Research Cooperation (History of Technology): Draeger Company, Luebeck, Germany & Wood Library Muesum, Schaumburg, ILL., USA	2001/2015 - ongoing	No	Occasional sponsorship of conference and travel expenses	2001 - ongoing	nil recent	N/A	N/A	N/A	Welsh Medical Committee (Member)	2018 - 2021	No	N/A	N/A	N/A	Yes	Yes	Meinofus Tratling	1.02.21	
Low	Ella	Rafferty	Consultant Clinical Psychologist	Welsh Gender Service	Consultant	Medicine	1.02.21	Yes	No	St David's Hospital		Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employed private practice	2012 - ongoing		Yes	Yes	Ella Rafferty	1.02.21	Secondary form sent 12.02.21
Low	Jamie	Duckers	Consultant Medicine	Specialised Medicine	Consultant	Medicine	1.02.21	Yes	Yes	UHL		Yes	N/A	N/A	N/A	Share holder in Time for Medicine company Wife is GP partner at Brynderwen and Minster Surgery	ongoing		CF service has previously received educational grant from Vertex	2015		Advisory Boards, lecturers and teching for pharmaceutical companies - Vertex, Merke, Chiesi, Insmed - intermittent	ongoing		N/A	N/A	N/A	Cardiff Chest Fed Secretary. Member of SE Wales Research Ethics Committee, member of organising committee of CF research events	ongoing		N/A	N/A	N/A	Yes	Yes	Jamie Duckers	1.02.21	Sponsorship form sent 12.02.21
Low	Simon	Wilkins	Associate Editor Pharmacist	Therapeutics & Toxicology	8b	CD&T	1.02.21	Yes	No	UHL	26868	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Secondment (0.4FTE) to, and employment (0.2FTE) by, Cardiff University School of Medicine as a Senior Lecturer and Programme Director of two MSc programmes.	2006	Salary	Yes	Yes	Simon Wilkins	1.02.21	Secondary form sent 12.02.21
Low	Seetal	Sall	POCT Lead	Laboratory Medcine	8a	CD&T	1.02.21	Yes	No	Ty Glas, Llanishen	45411	Yes	Yes	Jan 20 - Dec 20	None	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	S Sall	1.02.21	
	Annete	Schlaudrdaff	Consultant SRH	DoSH	Consultant	PCIC	3.02.21	Yes	No	CRI		Yes	N/A	N/A	N/A	N/A	N/A	N/A	DoSH ha sapplied fro for pharmaceutical funding for training and Waiting list reduction clinics from both Bayer plc and MSD succesfully. One such application that was apporved was filed by myself.			N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Annette Schuaudraff	3.02.21	Sponsorship form sent 12.02.21
Low	Paul	Williams	Principal Clinical Scientist	Therapies and Health Science	8b	CD&T	3.02.21	Yes	No	UHW	42010	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	25.10.20 - 31.10.20	One off payment	Yes	Yes	Paul Williams	3.02.21	Secondary form sent 12.02.21
Low	Mike	Bourne	Consultant Radiologist	Radiology	Consultant	CD&T	3.02.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	UKAS	Nov 16 - ongoing	Nil	Alliance Medical Ltd	Jan 18 - ongoing	Contractor	Yes	Yes	Mike Bourne	3.02.21	Secondary form sent 12.02.21
Low	Siobhan	Moore	Clinical Psychologists	Neurosciences	8+	Specialist Services	3.02.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	One off training session for a drug company (Biogen where I was paid during this financial year	Apr-20	Yes	N/A	N/A	N/A	Yes	Yes	Siobhan Moore	3.02.21	Secondary form sent 12.02.21
Low	Emma	Hingston	Consultant & Honorary Senior Lecturer Paediatric Dentistry	Paediatric Dentistry	Consultant	Surgery	5.02.21	Yes	No	UHW	42458	Yes	Director of LATCH cancer charity	2014 - ongoing	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee for LATCH - Children's Cancer Charity	2013 - ongoing	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Emma Hingston	5.02.21	
Low	Mark	Forster	Consultant Orthopaedic Surgeon	Trauma & Orthopaedics	Consultant	Surgery	8.02.21	Yes	Yes	UHW		Yes	Cardiff Knee Surgery Ltd (private practice0	2010 - ongoing		Partner: Cardiff Knee Surgery Ltd (private practice)	2010 - ongoing	Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mark Forster	8.02.21	Secondary form sent 12.02.21
Low	John	Union	Independent Member of the Board	Executives / Corporate	Executive	Executive	23.02.21	Yes	No	Woodland House		Yes	NED, Swansea Building Society Ignious Ltd (Subsidiary of Cadwyn Housing) Cardiff Business Club Ltd	1.11.17 - ongoing 1.1.20 - ongoing 1.1.20 - ongoing	Salary No salary No salary	John Union Ltd	1.4.16 - ongoing	No Salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Board Member/Vice Chair Cadwyn Housing Ltd Board member, Cambria Cudfuddiannol Ltd (Will step down shortly)	1.1.20 - ongoing 1.1.10 - ongoing	No salary No Salary	N/A	N/A	N/A	Yes	Yes	John Union	23.02.21	
Low	Emma	Kempshall	Consultant Haematologist	Haematology / BMT	Consultant	Specialist Services	10.02.21	Yes	Yes	UHW	47053	Yes	Director Gloucestershire Knee Surgery Ltd Spouse: Director Gloucestershire Knee Surgery Ltd	August - ongoing August - ongoing	No No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Emma Kempshall	10.02.21	
Low	Mohammed	Chowdhury	Consultant Dermatologist	Dermatology	Consultant	Medicine	11.02.21	Yes	No	UHW	43181	Yes	Director of Dr MMU Chhowdhury Ltd (private dermatology work)	2012 - ongoing	Dividends, no salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	President-Elect, British Association of Dermatologists, Executive Officer of Charitable organisation (unpaid role)	July 21 - July 22	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mmu Chowdhury	11.02.21	
Low	Philip	Atkin	Consultant in Oral Medicine	Dental	Consultant	Surgery	18.02.21	Yes	No	UHW	42463	Yes	1. Brynmill Ltd (orthodontics & (aesthetic medicine) 2. Nuform Medical Aesthetics Ltd (aesthetic medicine) 1. Spouse 2. Spouse and colleagues	2014 - current 2020 - current	expenses only	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Philip Atkin	18.02.21	
Low	Lisa	Jones	Clinical Psychology	Neuropsychology	8+	Sepcialist Services	21.02.21	Yes	No	UHW	43224	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I work as a self employed clinical neuropsychologist	2014 - ongoing	salary	Yes	Yes	Lisa Jones	21.02.21	Secondary form sent 25.02.21
Low	Susan	Elsmore	Independent Member of the Board	Executive / Corporate	Executive	Executive	24.02.21	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cabinet Member for Social Care, Health & Wellbeing Cardiff Council / Health & Social Care Spokesperson WLGA / C&V Regional Partnership Board Chair	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Susan Elsmore	24.02.21	
Low	Emyr	Stephens	Prescribing Advisor	Pharmacy	8a	PCIC	25.01.21	Yes	No	Woodland House	36176	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I attended a Health Service Journal (HSJ) award dinner in London in Feb '20, as a project that I (and other C&V colleagues) was involved with was shortlisted for an award. This was in the category of 'Partnership working with the Industry', and so the company (Lilly) paid for the dinner, accomodation	27.02.20 - 28.02.20	Attendance at awards event, accomodation and travel costs	N/A	N/A	N/A	I have taken part in an Advisory Board for various products over the last 10 years or so. These were all for 1 day only.	Various	Honoraria	N/A	N/A	N/A	Yes	Yes	Emyr Stephens	25.01.21	Secondary and Sponsorship forms sent 25.02.21
Low	Richard	Motley	Consultant Dermatologist	Dermatology	Consultant	Medicine	25.01.21	Yes	No	UHW	44629	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake Private Practice at the Spire Cardiff Hospital and in The Welsh Institute of Dermatology	1994 - ongoing		Yes	Yes	Richard Motley	25.01.21	Secondary form sent 25.02.21
Low	Alexandra	Murray	Consultant Medical Genetics	Genetics	Consultant	CD&T	26.11.20	Yes	No	UHW	44654	ESR	N/A	N/A	N/A	N/A	N/A	N/A	Paid a fee per patient to counsel them about private genetic test results purchased via Inntermost Healthcare	6.02.2017 - ongoing	Fee paid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am paid a month fee to provide a consultancy service to the National Pathology Manager about genetic tests	1.11.2017 - ongoing	monthly fee	Yes	Yes	Alexandra Murray	26.11.20	Secondary form sent 1.03.21
Low	Indu	Thakur	Consultant Paediatric Oncologist	Child Health	Consultant	Children and Women	2.11.20	Yes	No	UHW	7533167483	ESR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I was given a sponsorship place on a Haematology update conference by Novartis amounting to registration and stay costs of £268.20		Fee paid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Indu Thakur	2.11.20	Sponsorship form sent 1.03.21
Low	Andrew	Wood	Consultant Radiologist	Radiology	Consultant	CD&T	26.10.20	Yes	Yes	UHW		ESR	N/A	N/A	N/A	Spouse company - EGL Design				N/A	N/A	N/A	N/A	N/A	Treasurer Heart Research Wales		Voluntary	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Andrew Wood	26.10.20	
Low	Fiona	Walker	Head of Prescribing	Cardiff North and West Locality	8c	PCIC	12.11.20	Yes	No	Woodland House	7812554527	ESR	N/A	N/A	N/A	N/A	N/A	N/A	I am a NICE Medicines and Prescribing Associate. This is a role that does not attract a salary or any payment. I am standing down from this role at the end of 2020.		Nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	N/A	N/A	Yes	Yes	Fiona Walker	12.11.20	
Medium	Trevor	Pickersgill	Consultant Neurologist	Neurosciences	Consultant	Specialist Services	23.10.20	Yes	No	UHW	7971243314	ESR	N/A	N/A	N/A	N/A	N/A	N/A	I am a Chief Officer and Director of the BMA; and associated am a Director of BMA Charities and BMA Foundation for Research.			Over the last several years I have received travel bursaries/fees, conference registration sponsored by various pharmaceutical companies and occasional honoraria as follows: PHARMA REMUNERATION COI 2018: Novartis Chair symposium MS Trust - £1500 2017: Sanofi-Aventis ECTRIMS Paris travel/accom - £478.37 ECTRIMS registration - £536.36 Med Day Ad Board - £1000 Hilton Euston 2016: Roche Consultancy Cnicht climb project- £2,960; expenses £144 2015 - Teva Ad Board 2013 Biogen Ad Board Cardiff ECTRIMS 2018 Berlin no 2017 Paris yes Sanofi-Aventis 2016 London no 2015 Barcelona no 2014 Boston yes Novartis/Biogen 2013 Copenhagen no 2012 Lyon yes-Novartis 2011 Amsterdam yes - Novartis 2010 Gothenburg - no 2009 Dusseldorf yes - Biogen 2008 Montreal yes-Merck Serono 2007 Prague yes Merck Serono 2006 Madrid yes Serono 2005 Thessaloniki yes Serono 2004 Milan yes Serono AAN 2008 Chicago - Biogen	Nothing of note for 2019-20		I am a Chief Officer and Director of the BMA; and associated am a Director of BMA Charities and BMA Foundation for Research.			N/A	N/A	N/A	I perform Private medical Practice based in Cardiff			Yes	Yes	Trevor Pickersgill	26.10.20	Secondary Work form sent 1.03.21
Low	Howard	Kynaston	Consultant Urologist	Medicine	Consultant	Medicine	2.02.21	Yes	No	UHW	7834196104	ESR	Co Director of Bay Tree Wine Company - retiring from NHS 28.02.21 Spouse also co Director	2009 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Howard Kynaston	2.02.21	Retiring from NHS 28.02.21
Low	Angus	Robertson	Consultant in Trauma and Orthopaedics	Trauma and Orthopaedics	Consultant	Surgery	25.01.21	Yes	No	UHW	7809839881	ESR	N/A	N/A	N/A	Managing Partner Cardiff Sports Ortthopaedics LLP	N/A	N/A	Occasional paid lecturing for Arthrex (Equipment Supplier) No recent activity - none currently planned	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical Private Practice			Yes	Yes	Angus Robertson	25.01.21	Secondary work form sent 1.03.21
Low	Sara	Moseley	Independent Member of the Board	Executives / Corporate	Executive	Executive	2.03.21	Yes	No	Woodland House		Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director, Mind Cymru	01.11 - 04/ 21	Salary	Head of GMC Wales	04/21 - current	Salary	N/A	N/A	N/A	Yes	Yes	Sara Moseley	2.03.21	
Low	James	Galea	Consultant Neurosurgeon	Neurosciences	Consultant	Specialist Services	01.03.21	Yes	No	UHW	43762	Yes	Neurosurgery Services Ltd (Not seeking to do business with UHB)	30.11.17 - ongoing	Nil	N/A	N/A	N/A	Clinical Research involving but not funded by pharmaceutical companies 9SOBI Ab, Sweden)	2015 - ongoing	nil	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	James Galea	1.03.21	
Low	Nicola	Foreman	Director of Corporate Governance	Corporate / Executive	VSM	Corporate / Executive	02/03/2021	Yes	No	Woodland House	41506	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Company secretary for Safe Ventures Ltd			N/A	N/A	N/A	Yes	Yes	Nicola Foreman	2.03.21	
Low	Carys	Marshall	Principal Clinical Psychologist	Clinical Health & Neuropsychology	8a	Mental Health	25.01.21	Yes	No	Global Link	20832243	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employment - private practice	Mar-21	Ad hoc	Yes	Yes	Carys Marshall	2.03.21	Secondary work form sent 2.03.21
	Julie	Cornish	Consultant Surgeon	General Surgery	Consultant	Surgery	8.03.21	Yes	No	UHW		Yes	Cornish Healthcare Ltd Partner: Sniff Ltd	01/04/2019 January 2020	No Salary	N/A	N/A	N/A	N/A	N/A	N/A	I am the Secretary for the Pelvic Floor Society (professional association) and a Trustee for the MASIC foundation (charity). Both receive industry funding for educational events from mulitple industry partners. I have been paid honoraria by industry for participation in events which have been declared to CAVUHB and have been paid into Cornish Healthcare limited.	2018	None	Trustee and Exec Board Member of MASIC Foundation	2018	N/A	N/A	N/A	N/A	I work in Spire Cardiff in a session which has been agreed as part of my job plan	Apr-18		Yes	Yes	Julie Cornish	8.03.21	Secondary and Sponsorship forms sent 12.03.21
Low	Adul	Moideen	Consultant Spinal Surgeon	Trauma and Orthopaedics	Consultant	Surgery	12.03.21	Yes	Yes	UHL		Not Ticked	Director Private Practice Spouse: Director Private Practice	02.2022 02.2020	Salary Salary	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director - Private Practice Spouse - Director Private Practice		Salary Salary	Yes	Yes	Abdul Moideen	12.03.21	Secondary work form sent 12.03.21
Low	Gary	Baxter	Independent Member of the Board	Executives / Corporate	Executive	Executive	15.03.21	Yes	No	Woodland House		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Member, Governance Board ACCELERATE (Life Sciences Hub)	2019 - ongoing		N/A	N/A	N/A	British Heart Foundation research related work	1994 - ongoing		N/A	N/A	N/A	Cardiff University	2007 - ongoing	Salary	Yes	Yes	Gary Baxter	15.03.21	
Low	Neil	McCann	Consultant Anaesthetist	Anaesthetics	Consultant	Surgery	27.02.21	Yes		UHW	43105	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sponsorship by Medtronic UK to attend a day meeting in Leeds	4.12.19 - 5.12.19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Neil McCann	27.02.21	

Report Title:	**Legislative and Regulatory Tracker Report**								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	6th April 2021	
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 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 2019 the Risk and Regulation Team have been able to devote additional time 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 financial 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 don't 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 don't 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 3 entries have been noted on the register since February 2021's committee meeting. The additional were undertaken by Health Inspectorate Wales, the details of which are as follows:

1) A focused inspection of the Splott Mass Vaccination Centre was undertaken on the 1st March 2021.

   An immediate action plan was prepared and completed actions were submitted by the 12th March 2021. Feedback is awaited.

2) A virtual interview was undertaking on the 18th March 2021 with staff at the Hazel Ward at Hafan y Coed. Feedback is awaited.

3) A virtual interview was undertaking on the 10th March 2021 with staff at Ward E12, Hafan y Coed. A draft report has been received and an action plan is being developed.

Detailed below are inspections which are due to take place during the next quarter. As this would in many instances involve individuals coming onto site we do not believe that these inspections will take place.

1. Health Inspectorate Wales are scheduled to undertake an inspection of the Teenage Cancer Trust on the 31/03/2021.

2. UKAS are scheduled to undertake inspections at Haematology and Phlebotomy between the 20th and 22nd April 2021.

3. The Welsh Scientific Advisory Committee are scheduled to undertake inspections at Audiology on the 1st June 2021.

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 November 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.*

Saunders,Nathan 03/31/2021 15:03:3

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														
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. Update - Schedule B Requirement. New Style taps being trialled.	**C**
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			
COMMUNITY HEALTH COUNCIL														
Estates		Community Health Council	Disabled Car Park		Abigail Harris	Audit and Assurance	Geoff Walsh		21 and 25 November		10 recommendations			**NA**
FIRE AND RESCUE SERVICES														
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	20/01/2021	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.	Due to Covid access has been restricted to these areas to complete these works. In addition the fire service has suspended their audit inspections until the National emergency is stood down. Therefore all outstanding works will be completed this financial year	**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	26/01/2021	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.	Due to Covid access has been restricted to these areas to complete these works. In addition the fire service has suspended their audit inspections until the National emergency is stood down. Therefore all outstanding works will be completed this financial year	**PC**
Medicine	Capital and Asset Management	Fire and Rescue Services	Ward A6	Health and Safety at Work Act 1974	Len Richards	Health and Safety		365	19/02/2020	18/02/2021	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	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.	Due to Covid access has been restricted to these areas to complete these works. In addition the fire service has suspended their audit inspections until the National emergency is stood down. Therefore all outstanding works will be completed this financial year	**PC**
Specialist Services	Capital and Asset Management	Fire and Rescue Services	Rookwood Hospital, Artificial Limb Centre	Health and Safety at Work Act 1974	Len Richards	Health and Safety		365	10/02/2020	09/02/2021	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.	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.	Due to Covid access has been restricted to these areas to complete these works. In addition the fire service has suspended their audit inspections until the National emergency is stood down. Therefore all outstanding works will be completed this financial year	**PC**
Mental Health	Capital and Asset Management	Fire and Rescue Services	Vale Mental Health Services, Barry Hospital	Health and Safety at Work Act 1974	Len Richards	Health and Safety		365	27/01/2020	26/01/2021	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.	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.	Due to Covid access has been restricted to these areas to complete these works. In addition the fire service has suspended their audit inspections until the National emergency is stood down. Therefore all outstanding works will be completed this financial year	**PC**
HEALTH EDUCATION AND IMPROVEMENT WALES														

HEALTH INSPECTORATE WALES														
PCIC	**PCIC**	**HIW**	**MVC (Splott)**	**HIW**	Ruth Walker	QSE	**Director of Nursing, PCIC**				**1/3/21 Focused inspection undertken.Immediate action plan with completed actions submitted 12/3/21. Awaiting feedback**			**PC**
Mental Health	**Hafan Y Coed**	**HIW**	**Hazel Ward**	**HIW**	Ruth Walker	QSE	**Director of Nursing, MH**				**Virtual Interivew on 18/3/21**			**PC**
Mental Health	**MHSOP**	**HIW**	**E12**	**HIW**	Ruth Walker	QSE	**Director of Nursing, MH**				Virtual Interivew on 10/3/21**. 15th Draft report received. Action plan being developed**			**PC**
Children's & Women	Acute Child Health	HIW	Paediatric Surgical Ward		Ruth Walker	QSE	**Director of Nursing for C&W**				Quality Checks put on hold by HIW. Awaiting date			**NA**
PCIC	GP Practice	HIW	Radyr Medical centre	HIW	Ruth Walker	QSE	**Director of Nursing, PCIC**				Quaity Check cancelled. Awaiting further date			**NA**
PCIC	GP Practice	HIW	Porthceri Surgery, Barry.	HIW	Ruth Walker	QSE	**Director of Nursing, PCIC**				Planed for 1/12/20 HIW informed that this branch of the Vale Group Practice Surgery is no longer a GP surgery as USC hub therefor cancelled			**C**
Specialist	Haematology	HIW	Teenage Cancer Trust	HIW	Ruth Walker	QSE	**Director of Nursing, Specialist**				Virtual Inspection Interview 6/1/21 CNCELLED DUE TO COVID - AWAITNG NEW DATE : **New Date 31/3/21**			**NA**
Medicine	Medicine	HIW	MEAU, UHL	HIW	Ruth Walker	QSE	**Director of Nursing, Medicine**				Quality check to take place in MEAU , UHL on 08.12.20. via video call. Action plan and completed actions and Factual Accuracy submitted 7/1/20 and accepted.		**To be reported to QSE April 2021**	**PC**
Children & Women	W&C	HIW	Youth	HIW	Ruth Walker	QSE	**Director of Nursing, C&W**				In this thematic review of services across Wales 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.		**Reported to QSE in Sept 2019. Action plan / position submitted.**	**C**
Medicine	Medicine	HIW	E4, UHL	HIW	Ruth Walker	QSE	**Director of Nursing, Medicine**		23rd September 2020		**7/10/20 virtual interview & Evidence of completion accepted**		**Reported to Dec 2020 QSE Committee. Action plan submitted with actions completed and accepted.**	**C**
Specialist	Neuroscience	HIW	T4	HIW	Ruth Walker	QSE	**Director of Nursing Specialist Services**		30th September 2020		26.10.20 - Letter from HIW accepting comments. Findings report now finalised. Improvement plan accepted and will be published 28.10.20. Evidence submitted 4/1/2021 and accepted		**Reported to Dec 2020 QSE Committee. Action plan submitted with actions completed and accepted.**	**C**
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). **Letter recevied 13/1/21 from HIW Phase 2 on hold.**	Details of community maternity sites sent to HIW 17.07.20 and self assessement sent 24.07.20.		**PC**
Mental health	Hafan Y Coed	HIW	Elm and Maple Wards	HIW	Ruth Walker	QSE	Director of Nursing, Mental Health		10-12 February 2020		Immediate assurance letter issued . Extension requested. 04.03.20 - Immediate Assurance acceptance received from HIW.	**24.03.20** Improvement plan sent to 26.03.20. Final report published **21.07.20**	Reported at August 2020 QSE (delayed to September)	**C**
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.**			**NA**
PCIC	GP Practice	HIW (GP Announced visit)	Waterfront Medical Centre	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		Inspection due on March 23rd 2020		Cancelled no further date received			**NA**
PCIC	Community	HIW	Mental Health Team, Western Vale	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		04/12/2018		Action plan sent 5/2/19 and immediate actions completed.		Final report published 24/04/2019 Reported in April 2019 QSE	**C**
PCIC	Dental	HIW (Announced visit)	Penylan Dental Practice	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		28/11/2018		There were no areas of non compliance identified at this inspection.		Final report published 01/03/2019	**C**
HEALTH AND SAFETY EXECUTIVE														
CD&T	Medical Physics	HSE	Medical Physics	Control of Artificial Optical Radiation at Work Regulations 2010	Len Richards	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	Len Richards	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														
INFORMATION COMMISSIONERS OFFICE														

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 are captured within the controlled document framework plan which was presented at the DHIC meeting in February 2021.	**C**
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. A review of potential digital solutions will be carried out in early 2021/22	**PC**
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. HR input requested to ensure that specific JDs are updated approrpriately to include formal recognition of IG responsibilities wihtin those roles.	**PC**
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.	**C**
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. Discussions taking place with the Directorate Manager, CD&T who is responisble for med records, to asgree set of KPIs to be put in place by Q1 21/22	**PC**
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,	**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. IARs relating to 3rd parties/contracts have been completed.	**PC**
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				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.	**C**
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. As an additional control, the Concerns team will advise the IG team of any concerns relaing to privacy information.	**C**
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.	**C**
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.		contact made with NWIS regarding national e-learning module to understand whether training on fair processing can be incorporated. This will be added to the next IG training module by NWIS (no timescale provided)/ The IG dept will also add guidance to its internal webpage for staff engagin with patients.	**C**
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. A national procedure is now in place.	**C**
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. A national procedure is now in place. A national procedure is now in place.	**C**
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. A list of IAOs exists however there remain some gaps. a review is to be completed in early 2021/22	**PC**
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. This will be addressed by making the IAOs aware of the remit of the IG Group (April 2021)	**PC**
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**
MEDICAL GENETICS														
	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**	
	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			
	Medical Genetics	UKAS	Institute of Medical Genetics, UHW	!") 15189	Fiona Jenkins	QSE Committee	Lisa Grffiths		05/11/2020 - 10/11/2020	TBC	Mandatory findings x 49 Observations x 5 Extension to Scope (for new services) x 13	01/05/2021	**All Wales Medical Gneomics Service now part of the Executive Clinical Board, Directorate in thier own right.**	**PC**
MHRA														
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	Outstanding Estates issues to resolve to meet requirements of the regulator	**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	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/ Clinical Engineering	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														
OFFICE FOR NUCLEAR REGULATION														
QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES														

RESEARCH AND DEVELOPMENT														
	Haematology	Research and Development			Stuart Walker	QSE Committee								
UKAS														
CD&T	Lab Med/Haematology	UKAS	Haematology/ Blood Transfusion laboratory	ISO 15189	Fiona Jenkins	QSE Committee	Andy Goringe Alun Roderick Vicky Cummings Rachel Borrell	365	31/03/20 - 7/04/20	20/04/21 - 22/04/21				**C**
CD&T	Lab Med/ Haematology	UKAS	Phlebotomy (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Alun Roderick Vicky Cummings	365	31/03/20 - 7/04/20	20/04/21 - 22/04/21				**C**
CD&T	Biochemistry	UKAS	Biochemistry (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Carol Evans/Nigel Roberts	365	08/12/2020 to 11/12/2020		15 findings - closed. Accreditation maintained			**C**
CD&T	Specimen Reception (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Carol Evans/Nigel Roberts	365	08/12/2020 to 11/12/2020		Included in findings of Biochemistry UKAS					**C**
CD&T	Cellular Pathology (Mortuary UKAS)	UKAS	Cellular Pathology (Mortuary UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Adam Christian Scott Gable Sally Jones	365	02.03.21	Not scheduled yet	28 findings. Accreditation maintained subject to satsifactory closure of findings			**PC**
Specialist Services	ALAS	SGS/UKAS	ALAS (CAV)	ISO 9001:2015	Fiona Jenkins	QSE Committee	Paul Rogers	185 (Twice Yearly)	15-17/01/2020	01/01/2021	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		
WELSH WATER														
Estates		Welsh Water			Abigail Harris	Health and Safety								
WSAC														
Specialist Services	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		
Specialist Services	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		
Specialist Services	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														

Report Title:	**Internal Audit Recommendation Tracker Report**								
Meeting:	Audit Committee						**Meeting Date:**	6th April 2021	
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 shows progress made against recommendations from 17/18, 18/19, 19/20 and 2020/21.

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 110 individual recommendations to 106 during the period February 2021 to April 2021. Whilst the reduction is modest, this is reflective of the fact that a further 14 recommendations were added for the current financial year which counterbalanced the 18 that were recorded as completed in February (including one advisory recommendation).

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 (February 2021). 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 2020/21 (to date) and their overall assurance ratings.

	Substantial	Reasonabl	Limited	Rating	Total

	Assurance	e Assurance	Assurance	N/A	
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
Internal Audits 20/21 (to date)	1	5	1	1	8

Attached at Appendix 1 are summary tables which provide an update on the February 2021 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 regular 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.*

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	Operational Lead for Recommendation	Agreed Implementation Date	Committee Implementation Monitored by	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	Not Provided	01/06/2018	Finance	pc	WLI Policy drafted but review to ensure it aligns with the latest Welsh Consultant Contract delayed due to resources divrted to suport COVID. Aim is to complete review in February 2020.
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 have recently submitted a Programme Business Case for the redevlopment / replacement of UHW and the future of residence accommodation will need to form part of this project scope.	D Winstone		Strategy and Development	pc	All rental arrears are addressed with tennats and payments are agreed.
IA 1718	01/04/2018	University Hospital of Wales Neo Natal Development	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 Capital, Estates and Facilities	31/05/2018	Strategy and Development	c	Complete
IA 1718	01/04/2018	University Hospital of Wales Neo Natal Development	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 Request form should be brought into line with the requirements of the Scheme of Delegation. Approval signatures for all Single Tender Actions should be obtained in accordance with the requirements of SFIs.	Agreed	Director of Capital, Estates and Facilities	31/05/2018	Strategy and Development	c	Complete
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 Health Board, but at the time of fieldwork these plans do not cover all areas of the Health Board. Where plans have been supplied, these are not in the prescribed format set out by the templates within the BC guidance. Our review of the 3 sampled Clinical Boards identified that none had any documented BCPs in place. The audit has noted that whilst plans are not formally documented, that does not mean that there are not processes in place to manage business continuity in the event of some types of incidents. (Finding 2 – Not Actioned)	For last year, focus of the Emergency Preparedness Team (1.8 wte) has been the response to the pandemic, and all service areas have focused on business continunuity planning in the context of disruption caused by COVID. This work will be picked up with Clinical Boards once the pandemic is over.	Emergency Planning Manager	Not provided	Strategy and Development	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.	Quality & Safety manager/ Medical Director	01/06/2018	Quality, Safety and Experience	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 . The Medical Examiner was due to made statuatory by April 2021. This has been delayed becuase of COVID-19. The Medical Examiner is due to start on a pilot basis from the 18th Jan 2021 at the UHL site.
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.	Quality and Safety Improvement Manager	01/07/2018	Quality, Safety and Experience	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 same 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. The review group is piloting different Stage 2 forms in clinical areas. Once the lay out of the stage 2 forms are agreed it will be rolled out across the HB.
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. Whilst we will review and approve a local policy, the use of our limited resources will be directed primarily to influencing the development of the new waiting time rules and the requisite local implementation policy, procedures and training and awareness exercise.	Assistant Director of Informatics	01/09/2018	Strategy and Development	pc	The impact of the covid pandemic on RTT is significant. Throughout the pandemic treatment of patients has been based on clinical prioritisation rather than time based targets. Given the scale of the challenge of recovery, the indication is that there will be a national move away from RTT to a more risk based approach. It would not be prudent use of resource at this stage to update the local policy. This will be revisited in early 2021/22 once national guidance is finalised.
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.	Head of Cancer Services	01/11/2018	Strategy and Development	c	From December 2020, in line with the rest of Wales, the Health Board has moved to reporting of the new Single Cancer Pathway. This has also involved a move to a new cancer tracking system - Cancer Tracking Module - and strengthened validation. Suspensions can no longer be applied under the new SCP and rules.
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	Assistant Director of Informatics	01/05/2018	Strategy and Development	c	This action has been superseded. SCP is now live as of December 2020 and no longer in shadow reporting format. A new cancer tracking module is in place and validation of pathways has been strengthened
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.	Assistant Director of Informatics	01/06/2019	Strategy and Development	c	Treatment volumes are now included as standard

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IA 1819	12/02/2019	Performance Reporting Data Quality - Non RTT	Director of Transformation and Informatics	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.	Recommendation complete. Appropriate data source information now recorded.	Assistant Director - Information and Performance		IMT&G	c	Recommendation complete. Appropriate data source information now recorded.
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.	Corporate Strategic Planning Lead	01/07/2019	Strategy and Developement	c	Planning process in place to ensure CBs produce plans. COO performance process oversees delivery of plans.
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.	Business Manager	01/06/2019	Strategy and Delivery	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 authorised on individual timesheets	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.	Senior Manager (Performance and Compliance)	01/06/2019	Strategy and Delivery	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.	Head of Patient Safety	01/03/2019	Quality, Safety and Experience	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 Capital Estates and Facilities	22/05/2020	Strategy and Delivery	c	Included on the project risk register
IA 1819	15/02/2019	CRI Safeguarding Works	Director of Planning	Reasonable		R4/5	L	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**	Head of Outcomes Based Commissioning	01/05/2019	Strategy and Delivery	c	-
IA 1819	15/02/2019	CRI Safeguarding Works	Director of Planning	Reasonable		R5/5	L	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.	Head of Outcomes Based Commissioning	01/04/2020	Strategy and Delivery	c	
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.	Eleri Probert	01/04/2019	Strategy and Delivery	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 Capital, Estates & Facilities	30/06/2019	Health and Safety	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	Chair of Water Safety Group	30/07/2019	Health and Safety	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 Capital, Estates & Facilities	01/11/2019	Health and Safety	pc	Statutory inspections ongoing, information being entered into MiCad, live database
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. b) The Chair of the Water Safety Group should ensure that flushing guidance is re-issued to all clinical boards for full circulation to relevant staff (O).	Agreed	Director of Capital, Estates & Facilities	01/11/2019	Health and Safety	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	Richard Hurton	30/07/2019	Finance	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	Richard Hurton	31/10/2019	Finance	na	
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	Head of Health and Safety	01/02/2019	Audit and Assurance	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	Head of Health and Safety	30/06/2019	Health and Safety	na	This action if for the Fire Safety Manager to be followed up by end of June
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.	This scheme has now concluded. Surplus allowances were identifed and the UHB via procurement offered the surplus units for sale. Unfortunately there were no bidders therefore the units were not sold. The deadline to sell the credits has expired however the UHB will monitor the position and if the opportunity to sell the units arises again this will be investigated.	Head of Energy and Performance	16/08/2019	Strategy and	c	The surplus CRC allowances were advertised to be sold via procurement however there were no bids therefore no sale was made.

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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	Head of Corporate Governance	01/02/2019	Audit and Assurance	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	Directorate Managers for Adult and MHSOP	01/05/2019	Strategy and Development	c	This action if for the Fire Safety Manager to be followed up by end of June - Regular H&S meeting held in MH where the fire safety is a routine agenda item. Fire safety advisors and Directorate managers attand
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	1. Clinical Board Directors – Monitor compliance on a monthly basis through the Clinical Board Performance Reviews with joint		Audit and Assurance	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	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	1. Clinical Board Directors/Clinical Directors – one to three months. 2. Medical Director – Immediate.		Audit and Assurance	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		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.	1. Medical Director and AMD for Workforce and Revalidation - one month. 2. 15th June 2018 Medical Director/Director of		Audit and Assurance	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.	Clinical Board Directors action - Issues by Medical Director and AMD for Workforce and Revalidation - one month.		Audit and Assurance	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).	Assistant Medical Director Workforce Revalidation working with Medical Workforce Department/LED/Communications Team / Three months		Audit and Assurance	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.
IA1920	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.	1. Clinical Board Director/CD - 3 months. 2. Assistant Medical Director - Workforce - 3 months reviewpilot progress.		Audit and Assurance	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 EPRR (30.03.20); with aims to review local preparedness planning and enhance organisational resilience in case of disruption to the organisation's critical services. Business continuity also a standing agenda item on the MHCB Health and Safety meetings.	Ian Wile - Director of Operations June 20		Audit and Assurance	c	Complete - Brexit BC Stood Down
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 Department basis of staff whose nationality is blank on ESR. In addition, Workforce and Organisational Development have determined the email addresses of 2,148 of the 4,467 staff. Individual emails, with a step by step guide, have been sent to the 2,148 staff encouraging them to update their nationality on ESR.	Andrew Crook - Head of Workforce Governance. October 20		Audit and Assurance	c	Brexit Task and Finish Group Stood Down
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, deputies nominated, and the importance of regular representation emphasized again.	Abigail Harris – Executive Director of Planning. November 20		Audit and Assurance	c	Brexit Task and Finish Group Stood Down
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.	Abigail Harris – Executive Director of Planning. December 20		Audit and Assurance	c	Brexit Task and Finish Group Stood Down
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.	Information Governance Manager/ Q1 2020/21		Audit and Assurance	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. - monitoring and compliance arrangements including KPIs; and - reporting arrangements.	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.	Executive Director of Workforce and OD & Medical Director	01/07/2020	Audit and Assurance	pc	Not Completed due to COVID pressures
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 include the checking of core data on an annual or rolling basis	Comprehensive Review of local processes Directorate by Directorate will take place to ensure consistency of process with UHB Procedures and guidance	Executive Director of Workforce and OD & Medical Director	01/09/2020	Audit and Assurance	pc	Not Completed due to COVID pressures
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.	Executive Director of Workforce and OD & Medical Director	01/09/2020	Audit and Assurance	pc	Not Completed due to COVID pressures. Discussed at LNC, AE, RS, HS to Meet outside LNC, Date to be arranged

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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.	Executive Director of Workforce and OD & Medical Director	01/12/2020	Audit and Assurance	pc	Ejob Planning Live 13% currently on system. Work Ongoing.
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	Intrepid User Group will be refreshed with revised TOR and membership. Minutes of meetings and associated Action plans will be reviewed by the Medical	Assistant Medical Director (Workforce and Revalidation),	01/07/2020	Audit and Assurance	pc	Ongoing
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 2020 meeting. 12 months in from changes made we are now reporting 100% compliance on monthly reports	Health & Safety and Asbestos Manager	01/03/2020	Audit and Assurance	c	Completed
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. review completed in may 2020 contractors who have not be in active in the last 5 years have been removed from the contractor control database but not baktraq	Health & Safety and Asbestos Manager	01/10/2020	Audit and Assurance	C	Completed
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.	Health & Safety and Asbestos Manager	01/03/2020	Audit and Assurance	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. Different options will need to be reviewed to determine an appropriate direction of travel. A new app has been purchased and is due to goal live on remote sites on the 01/04/2021. The app is by a company called swiped on and is a web based app that uses smart phone technology	Head of Discretionary Capital & Compliance Health & Safety and Asbestos Manager	01/09/2020	Audit and Assurance	c	Completed
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 meeting. Due to Covid issues the H&S committee meetings were not held from March 2020 to January 2021. These meetings are not occuring. The permit to work procedure has been completed and will be presented at the next H&S committee meeting	Head of Discretionary Capital & Compliance Health & Safety and Asbestos Manager March 2020	01/03/2020	Audit and Assurance	pc	Work remains on going to develop the procedure.
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. No meetings have currently taken place due to the covid crisis	Head of Discretionary Capital & Compliance	01/09/2020	Audit and Assurance	pc	Work remains ongoing
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. As above	Head of Discretionary Capital & Compliance	01/09/2020	Audit and Assurance	pc	Work remains ongoing
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. In the February H&S committee meeting an annual audit was presented that included contractor control compliance including JRFs and permits to work	Health & Safety and Asbestos Manager	01/06/2020	Audit and Assurance	c	Completed
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.	Head of Risk and Regulation	07/2020 - 12/2020	Audit and Assurance	c	Complete and recognised in March 2021 Risk Management follow up.
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.	Head of Risk and Regulation	01/07/2020	Audit and Assurance	c	Complete and recognised in March 2021 Risk Management follow up.
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.	Head of Risk and Regulation	01/07/2020	Audit and Assurance	c	Complete and recognised in March 2021 Risk Management follow up.
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 Capital, Estates & Facilities	At Future Projects	Audit and Assurance	c	Scheme complete
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 Capital, Estates & Facilities	At Future Projects	Audit and Assurance	c	Scheme complete
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 Capital, Estates & Facilities	ongoing to end of project	Audit and Assurance	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 Capital, Estates & Facilities	01/05/2020	Audit and Assurance	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 Capital, Estates & Facilities	01/05/2020	Audit and Assurance	pc	Continuing monitoring of payments in accorance with the terms of the contract
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.	Head of Corporate Governance	01/12/2020	Audit and Assurance	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 recorded appropriately in the 'register'.	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 internet will fall to be monitored and maintained by the Corporate Governance team and plans will be put in place to correctly identify and collate those which are and those that will be monitored and maintained at a local level. 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.	Head of Corporate Governance	01/12/2020	Audit and Assurance	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.	Head of Corporate Governance	01/12/2020	Audit and Assurance	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.	Head of Corporate Governance	01/12/2020	Audit and Assurance	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.	Head of Corporate Governance	01/12/2020	Audit and Assurance	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:				Audit and Assurance	na	

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	Operational Lead for Recommendation	Agreed Implementation Date	Committee Implementation Monitored by	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update
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				Audit and Assurance	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.				Audit and Assurance	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.				Audit and Assurance	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.				Audit and Assurance	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.				Audit and Assurance	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.				Audit and Assurance	na	
IA 1920	27/09/2020	Strategic Planning - IMTP	Director of Planning	Reasonable	4	R4/4	L	Management should ensure the ToR are reviewed and updated as required.	NHS Wales Audit and Assurance Services Page 15 of 16 Finding 4 - BCAG Terms of Reference (Operating effectiveness) Risk The Business Case Approval Group is responsible for the scrutiny and management of revenue based business cases and ensuring they are robust. They have ToR which govern the Group. The BCAG ToR was last reviewed in March 2017. It was stated within the ToR that they would be reviewed on an annual basis to ensure they remain relevant and up to date. Inappropriate service changes / developments are implemented Recommendation 4 Priority level Management should ensure the ToR are reviewed and updated as required. Low Management Response Responsible Officer/ Deadline	Marie Davies	01/11/2020	Audit and Assurance	pc	BCAG will review ToR periodically going forward to ensure the role and function of group is updated if necessary.

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	Operational Lead for Recommendation	Agreed Implementation Date	Committee Implementation Monitored by	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	Not Provided	01/06/2018	Finance	pc	WLI Policy drafted but review to ensure it aligns with the latest Welsh Consultant Contract delayed due to resources divrted to suport COVID. Aim is to complete review in February 2020.
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 have recently submitted a Programme Business Case for the redevlopment / replacement of UHW and the future of residence accommodation will need to form part of this project scope.	D Winstone		Strategy and Development	pc	All rental arrears are addressed with tennats and payments are agreed.
IA 1718	01/04/2018	University Hospital of Wales Neo Natal Development	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 Capital, Estates and Facilities	31/05/2018	Strategy and Development	c	Complete
IA 1718	01/04/2018	University Hospital of Wales Neo Natal Development	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 Request form should be brought into line with the requirements of the Scheme of Delegation. Approval signatures for all Single Tender Actions should be obtained in accordance with the requirements of SFIs.	Agreed	Director of Capital, Estates and Facilities	31/05/2018	Strategy and Development	c	Complete
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 Health Board, but at the time of fieldwork these plans do not cover all areas of the Health Board. Where plans have been supplied, these are not in the prescribed format set out by the templates within the BC guidance. Our review of the 3 sampled Clinical Boards identified that none had any documented BCPs in place. The audit has noted that whilst plans are not formally documented, that does not mean that there are not processes in place to manage business continuity in the event of some types of incidents. (Finding 2 – Not Actioned)	For last year, focus of the Emergency Preparedness Team (1.8 wte) has been the response to the pandemic, and all service areas have focused on business continunuity planning in the context of disruption caused by COVID. This work will be picked up with Clinical Boards once the pandemic is over.	Emergency Planning Manager	Not provided	Strategy and Development	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.	Quality & Safety manager/ Medical Director	01/06/2018	Quality, Safety and Experience	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 . The Medical Examiner was due to made statuatory by April 2021. This has been delayed becuase of COVID-19. The Medical Examiner is due to start on a pilot basis from the 18th Jan 2021 at the UHL site.
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.	Quality and Safety Improvement Manager	01/07/2018	Quality, Safety and Experience	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 same 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. The review group is piloting different Stage 2 forms in clinical areas. Once the lay out of the stage 2 forms are agreed it will be rolled out across the HB.
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. Whilst we will review and approve a local policy, the use of our limited resources will be directed primarily to influencing the development of the new waiting time rules and the requisite local implementation policy, procedures and training and awareness exercise.	Assistant Director of Informatics	01/09/2018	Strategy and Development	pc	The impact of the covid pandemic on RTT is significant. Throughout the pandemic treatment of patients has been based on clinical prioritisation rather than time based targets. Given the scale of the challenge of recovery, the indication is that there will be a national move away from RTT to a more risk based approach. It would not be prudent use of resource at this stage to update the local policy. This will be revisited in early 2021/22 once national guidance is finalised.
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.	Head of Cancer Services	01/11/2018	Strategy and Development	c	From December 2020, in line with the rest of Wales, the Health Board has moved to reporting of the new Single Cancer Pathway. This has also involved a move to a new cancer tracking system - Cancer Tracking Module - and strengthened validation. Suspensions can no longer be applied under the new SCP and rules.
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	Assistant Director of Informatics	01/05/2018	Strategy and Development	c	This action has been superseded. SCP is now live as of December 2020 and no longer in shadow reporting format. A new cancer tracking module is in place and validation of pathways has been strengthened
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.	Assistant Director of Informatics	01/06/2019	Strategy and Development	c	Treatment volumes are now included as standard

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2017/18 (April 2021 Update)

	Update April 2021				Update April 2021				Update April 2021			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Overdue under 3 months												
Overdue over 6 months under 12 months												
Overdue more than 12 months	1		1		7	3	4		3	2	1	
Superseded												
Total	**1**		**1**		**7**	**3**	**4**		**3**	**2**	**1**	

Total number of recommendations outstanding as of 29th March 2021 for financial year 2017/18 is **11** (5 of which are complete) compared to the position in November 20 when a total number of outstanding recommendations of 13 were noted.

INTERNAL AUDIT REPORT RECOMMENDATION FOR 2018/19 (April 2021Update)

	Update April 2021				Update April 2021				Update April 2021			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached	3		1	2	5	1	1	3				
Overdue under 3 months												
Overdue by over 3 months under 6 months												
Overdue over 6 months under 12 months												
Overdue more than 12 months	3		1	2	3	1	1	1	3	3		
Superseded												
Total	**6**		2	4	**8**	**2**	**2**	**4**	**3**	**3**		

Total number of recommendations outstanding as of 29th March 2021 for financial year 2018/19 is **17** (5 of which are complete) compared to the position in November 20 when a total number of outstanding recommendations of 22 were noted.

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2019/20 (April 2021Update)

	Update April 2021				Update April 2021				Update April 2021			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Overdue under 3 months									1		1	
Overdue by over 3 months under 6 months	2			2	8		3	5	7	2		5
Overdue over 6 months under 12 months	5	1	4		16	8	7	1	5	2	2	1
Overdue more than 12 months					4	2	1	1				
Superseded												
Total	**7**	1	4	2	**28**	**10**	**11**	**7**	**13**	**4**	**3**	**6**

Total number of recommendations outstanding as of 29th March 2021 for financial year 2019/20 is 48 compared to the position in November 20 when a total number of outstanding recommendations of **55** were noted (NB – February's table suggested a total of 56 entries, the correct figure was in fact 55).

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2020/21 (April 2021Update)

	Update April 2021				Update April 2021				Update April 2021			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached												
Complete												
Overdue under 3 months	2	1	1	2	17	3	5	9	9	2		7
Overdue by over 3 months under 6 months												
Overdue over 6 months under 12 months												
Overdue more than 12 months												
Superseded												
Total	**4**	1	1	2	**17**	**3**	**5**	**9**	**9**	**2**		**7**

Total number of recommendations outstanding as of 29th March 2021 is 30 compared to the position in February 2021 when a total number of outstanding recommendations of **18** were noted. It should be noted that the additional Advisory recommendation noted in February's update has not been included in the above figures.

Report Title:	**Outstanding Audit Recommendations Update – 2017/18**								
Meeting:	Audit Committee						**Meeting Date:**	6th April 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Head of Risk and Regulation								

Background and current situation:

The purpose of this report is to provide Members of the Audit Committee with and update on outstanding Internal Audit Recommendations for the year 2017/18 and to put forward proposals for their management moving forward.

As of the 30th March 2021 the Health Board's Internal Audit Tracker records 11 recommendations for the financial year 2017/18, 5 of which are recorded as complete.

Details of outstanding recommendations for 2017/18, including those recorded as complete, are appended to this report.

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

Following February's committee meeting the Head of Risk and Regulation and his team have liaised with the executive leads for outstanding recommendations to understand whether their entries for 2017/18 should continue to be recorded on the Internal Audit Tracker and, if so, what plans are in place to ensure that the recommendations are proactively managed.

For the avoidance of doubt, recommendations would not continue to be recorded on the register if they were complete, superseded by subsequent audit recommendations or were no longer relevant/appropriate.

All 6 of the live recommendations for 2017/18 are recorded as partially complete. The present position for each of the recommendations and proposals for them are detailed below:

1) **AUDIT 1718 –WLI Payments Initiative – Executive Lead: Chief Operating Officer**

   - A WLI Policy has been drafted but review has been delayed due to resources diverted to support the Health Board's COVID-19 response. Aim is to complete review in February 2020. It is proposed that a revised implementation date of May 2020 is approved to either finalise the policy or to put the policy in a position to be approved so that the Audit Committee has assurance that the recommendation has been complied with and can be removed from the Internal Audit Tracker.

2) **AUDIT 1718 – Residences – Executive Lead: Executive Director of Strategic Planning**
   - The Health Board has recently submitted a Programme Business Case for the re-development /replacement of UHW of which the future of residence accommodation will

form part of the project scope. It is proposed that the recommendation be closed on the basis that Assurance can be taken that the re-development of UHW and the development of UHW2 will adequately address future plans for the provision and utilisation of residences.

3) **AUDIT 1718 –Business Continuity Planning – Executive Lead: Executive Director of Strategic Planning**
   - For the last 12 months the focus of the Emergency Preparedness Team has been the response to the Covid-19 pandemic, and all service areas have focused on business continuity planning in the context of disruption caused by COVID. As the Health Board has responded to new ways of working, alternative continuity plans and arrangements have developed and it is proposed that this Business Continuity Planning will be picked up and reviewed by Clinical Boards once the burden of the pandemic eases. It is proposed that this entry is closed and that a revised audit is undertaken of the Health Board's Business Continuity Plans once new plans have had the opportunity to take shape.
4) **AUDIT 1718 –Mortality Reviews (x2) – Executive Lead: Executive Medical Director**
   - A review of the Mortality Review process is due to commence in the new financial year. It is proposed that the Internal Audit Entries are closed and that a further review of the system is undertaken to reflect updated practice in the new financial year.

5) **AUDIT 1718 –Referral to Treatment (RTT) Performance Reporting – Executive Lead: Director of Digital and Health Intelligence**
   - The impact of the Covid pandemic on RTT has been significant. Throughout the pandemic treatment of patients has been based on clinical prioritisation rather than time based targets. Given the scale of the challenge of recovery, the indication is that there will be a national move away from RTT to a more risk based approach. It is proposed that local policy is updated in early 2021/22 once national guidance is finalised. Accordingly it is recommended that a further review of the system is undertaken to reflect updated practice in the new financial year and that the recommendation entry is closed.

To ensure that the recommendations are not closed and forgotten it is proposed that no entry is removed from the Internal Audit tracker until a formal agreement has been reached for the subsequent review of the recommendation subject matter in the new financial year.

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

There is a risk that continuing to record aged recommendations, which do not reflect current practice or impending changes to the Health Board's regulatory requirements, will divert energy and resource away from key service areas and impede the delivery of required change.

This risk will be mitigated by the closure of historic entries and the agreement of new, service specific reviews in the new financial year.

Recommendation:

The Audit Committee Members are asked to:

(a) **Note** the Outstanding Audit Recommendations Update – 2017/18
(b) **Approve** the proposals for the future recording and removal of historic recommendations Health Board's Internal Audit Tracker; and
(c) **Agree** that appropriate reviews will be arranged for those entries that are removed from the Health Board's Internal Audit 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	
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		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	x

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

Report Title:	**Audit Wales Recommendation Tracking Report and Regulatory Tracker Report**								
Meeting:	Audit Committee						**Meeting Date:**	6th April 2021	
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:

20 External Audit Recommendations were brought forward from February's Audit Committee and a further 5 recommendations have been added to the tracker which relate to the Follow-Up of the Operating Theatres Audit.

The External Audit tracker demonstrates that a further 4 recommendations have completed since November, however, there are also 17 (of 25) recommendations that are partially complete. 4 actions of 25 have had no recorded action taken since November's committee meeting.

Three recommendations are over 1 year old, eight are over 6 months old (of which two are complete) and 14 actions of the 25 are less than three months old (of which two are complete).

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

A review of all outstanding recommendations has been undertaken since February 2021 and this will continue and be reported at each Audit Committee to provide regular updates in the movement of recommendations.

The table at Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken in **18/19, 19/20 and 20/21** as at 29th March 2021.

This report and appendices will also be discussed at Management Executive and HSMB meetings so that the leadership teams of the Health Board have 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.*

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	Operational Lead for Recommendation	Agreed Implementation Date	Committee Implementation Monitored by	Updated Implementation Date	Recommendation Status [RAG Rating]	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update	Status	Status of Report Overall	Age	Age Group
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.	Head of Corporate Governance	Dec-19	Audit and Assurance Committee	Dec-19	Open over 6 months under 12 months	pc	an overall performance management framework document is being presented to S&D committee in Sept 2020	Open	pc	485	Over One Year
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	Head of Corporate Governance	Mar-19	Audit and Assurance Committee	Dec-19	Open over 6 months under 12 months	pc	Welsh Government model Standing Orders were adopted by the Board in Nov 2019, and in May 2020 the Board approved a temporary variation during COVID-19. The model SOs are being amended to appropriately reflect the requirements of the UHB. The SFIs are currently being reviewed by the all Wales NHS Directors of Finance Group, proposed changes will be considered at the Oct 2020 meeting and if agreed will be submitted to WG for reissue of model SFIs.	Open	pc	730	Over One Year
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	Head of Corporate Governance	Oct-19	Audit and Assurance Committee	Dec-19	Open over 6 months under 12 months	pc	The Policy is currently being reviewed as due for renewal in Nov 2020 so this work will cover off these requirements.	Open	pc	516	Over One Year
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 Digital and Health Intelligence	Sep-19	Audit and Assurance Committee	Dec-19	Open over 6 months under 12 months	c	An uppated perfromance management framework document was presented to and agreed in principle at the S&D committee in Sept 2020.	Open	pc	547	Over One Year
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 Digital and Health Intelligence	Mar-19	Audit and Assurance Committee	Dec-19	Open over 6 months under 12 months	c	The technical roadmap plan to support the Digital strategy has been developed to address DR and BC requirements. These will be presented to the D&HIC in 2021	Open	pc	730	Over One Year
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. **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.	James Webb		Digital & Health Intelligence Committee	Open over 12 months under 18 months	Open over 12 months under 18 months	pc	recruitment to additional Band 5 Assistant Coding Manager to take place Q4 2020/21	Open	pc	nodate	Date not Specified
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. **g)** Head of Coding to discuss with Medical Directors to establish the most appropriate platform	James Webb		Digital & Health Intelligence Committee	Open over 12 months under 18 months	Open over 12 months under 18 months	**a)** pc, **b)** pc, **g)** na	Head of Clinical Coding to discuss with the EMD the importance of training re good qualit medical records by Q4 2020/21	Open	na	nodate	Date not Specified
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	Chris Lewis, Interim Finance Director	Mar-20	Audit and Assurance		Open over 12 months under 18 months	pc	Phase 2 – all cases completed Phase 3 – 9 claims remain incomplete – all claims have been reviewed but these are not ready for completion yet due to requiring further meetings, negotiation, panels etc. Delays in finalising some claims during 20/21 due to the nurse assessors involved being redeployed to other areas during Covid crisis, and the inability to hold face-to-face meetings due to the pandemic.	Open	pc	394	Over one year
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Planning	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		Open over 6 months under 12 months	na		Open	na	nodate	over 6 Months
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Planning	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.		Dec-21	Strategy and Delivery		Open over 6 months under 12 months	pc	Programme of business cases in development with engagement of detail of services required to meet local needs taken forward as part of business case. First scheme (Maelfa) on track to be completed in Dec 21.	Open	pc	-246	Over 6 Months
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Planning	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		Open over 6 months under 12 months	na		Open	na	nodate	Over 6 Months

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.		Nov-21	Strategy and Delivery		Open under 3 months	na		Open	na	-216	Over 6 Months
WAO 20	2019-20	**Nov-19**	Implementing the Wellbeing of Future Generations Act	Director of Planning	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.		Oct-21	Strategy and Delivery		Open under 3 months	pc	The Right Sizing Community Services initiative has mapped out some of the intermediate care services, and where we have service capacity gaps. Third sector has mapped service provision. Work is progressing to look at how cluster, locality and intermediate care service models form single integrated out of hospital model of care.	Open	pc	-185	Over 6 Months
WAO 20	2019-20	**Nov-19**	Implementing the Wellbeing of Future Generations Act	Director of Planning	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.		Oct-21	Strategy and Delivery		Open under 3 months	pc	Work has commenced on the operating model of the hubs. The work is currently on pause as a result of the focus on C-19.	Open	pc	-185	Over 6 Months
WAO 20	2019-20	**Nov-19**	Implementing the Wellbeing of Future Generations Act	Director of Planning	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.		Oct-21	Strategy and Delivery		Open under 3 months	pc	For each scheme, there is an engagement plan with the local community to ensure the detailed plans have been informed by both service views and views of those who will use the services.	Open	pc	-185	Over 6 Months
WAO22	2019-20	**Aug-20**	Audit of Accounts Report Addendum - Recommendations	Director of Finance	3	R1	Some of the accounting processes and records need to be simplified, with far less use of manual adjustments to financial ledger outputs: The Health Board should reevaluate why so many manual adjustments are currently necessary and, in do so, liaise with us and consider engaging with a health boasrd that has the same finance system and avoids similar level of manual intervention	The Health Board agrees to review its manual adjustments and assistance from Audit Wales in identifying good practice would be very helpful.	Chris Lewis, Interim Finance Director	Apr-21	Audit and Assurance		Open under 3 months	pc	The UHB has met with Audit Wales on 4th November 2020 in order to progress this. The finance department has redeployed additional resource to support improvements. Action not due	Open	na	-2	under 3 months
WAO22	2019-20	**Aug-20**	Audit of Accounts Report Addendum - Recommendations	Director of Finance	3	R2	The quality of some of the Health Board's underlying working papers requires further improvement: The Health Board should review and simplufy its supporting records for certain areas of its annual financial statemnets, including the inappropriate use of manual data entry (rather than formulas) within spreadsheets. To aid the review the Health Board should liaise with us to understand hjow some of hte documentation affects our audit.	The Health Board will work with Audit Wales to review its supporting records with the aim of simplication to support the final accounts audit	Chris Lewis, Interim Finance Director	Apr-21	Audit and Assurance		Open under 3 months	pc	The UHB has met with Audit Wales on 4th November 2020 in order to progress this. The finance department has redeployed additional resource to support improvements. Action not due	Open	na	-2	under 3 months
WAO22	2019-20	**Aug-20**	Audit of Accounts Report Addendum - Recommendations	Director of Finance	3	R3	Related party declarations need to be signed and submitted after the end of each financial year: The Health Board shoud update it sannual related party declaration so that it specifies that the IM / SO must consider the whole financial year and therefore sign and submit it after 31 March, or on departure if that is relevant	The Health Baord will revrt to requesting returns after 31 March 2021. The Health Board will continue to obtain signed declarations from Ims and Sos at the time of departure. In addition,	Chris Lewis, Interim Finance Director	Apr-21	Audit and Assurance	Apr-21	Open under 3 months	na	Please note that this is an end of year action and will not be completed until after the end of year as agreed by the implementation date	Open	na	-2	under 3 months
WAO23	2020-21	**Aug-20**	Effectiveness of Counterfraud Arrangements	Director of Finance	2	R1	Counter-fraud training Implement mandatory counter-fraud training for some or all staff groups	As part of the Compliance & Competency section within the Heath Body's Electronic Staffing Record (ESR) Database, any such training, which is deemed as being mandatory, has to be agreed and by the Health Body's Workforce Department in conjunction with Staff Side Representation before it can be implemented.	Chris Lewis (Interim Finance Director) and Martin Driscoll (Director of Workforce &OD)	Ongoing with review date of 31st March 2021	Audit and Assurance		Open under 3 months	c	Recommendation not accepted. The siuation remains the same.	Open	na	nodate	Date not Specified
WAO23	2020-21	**Aug-20**	Effectiveness of Counterfraud Arrangements	Director of Finance	2	R2	Counter-fraud staff capacity Consider the Local Counter-Fraud Specialist capacity required to resource required levels of proactive and investigative work, including staff training, and build in resilience to the team.	Based on historical data, the Health Body is confident that the number of days in it's current work-plan meets the current requirements. In support of this, regular reviews of the ongoing CF work and resources used are carried out and reported to the A/C. However, should there be an increase in referrals, the need for any additional resource would be agreed with the Finance Director. The overall budget is reviewed in the annual budget setting exercise.	Craig Greenstock (LCFS) and Chris Lewis (Interim Director of Finance)	Ongoing with review date of 31st March 2021	Audit and Assurance		Open under 3 months	c	Recommendation not accepted. The siuation remains the same.	Open	na	nodate	Date not Specified
WAO24	2020-21	**Dec-20**	Follow-up of Operating Theatres	Chief Operating Officer	5	R1	Ensure that momentum is maintained to deliver the benefits of the theatre improvement project which relate to process improvement, such as Day of Surgery Admission and pre-operative assessment: • prioritise the expansion of the pre-operative assessment service across specialties where doing so will achieve maximum benefit in improving quality and safety of care.	THE WAO reported reported highlight that R! had been implemented. There is still work to do to expand POAC in order to cover the large increase in patients due to covid, and to provide a richer offer of support including for areas such as diabetes and frailty, but the report highlighted the good work done in this area.	Ceri Chinn	Mar-22	Strategy and Delivery	Oct-21	Open under 3 months	pc	Agreed implementation date not yet reached. Good progress being made	Open	na	-336	Due Date Not Reached
WAO24	2020-21	**Dec-20**	Follow-up of Operating Theatres	Chief Operating Officer	5	R2	Ensure that staff are engaged with the aims and success of the theatre improvement project. Where possible and beneficial, build change management capacity and leadership from within the service to ensure that service changes are properly embedded, and that operational leaders are involved in the design of their services.	The schemes of employee engagement continue and have been enhance through the pandemic. A workforce manager post is being implemented in order to drive staff engagement and workforce redesign. This post will be central to achieving the goals of this recommendation and a full project approach will be implemented to monitor progress during 21/22	Ceri Chinn	Mar-22	Strategy and Delivery	Oct-21	Open under 3 months	pc	Agreed implementation date not yet reached. Good progress being made	Open	na	-336	Due Date Not Reached
WAO24	2020-21	**Dec-20**	Follow-up of Operating Theatres	Chief Operating Officer	5	R3	Ensure sufficient time and resources are given for people management, including appraisals, sickness absence management, development and delivery of training.	A new starter training day have been introduced which has been extremely well received. The workforce programme manager post will support with the development of training days and as the pandemic reduces there will be an increase focus on PADRs.	Ceri Chinn	Mar-22	Strategy and Delivery	Oct-21	Open under 3 months	pc	Agreed implementation date not yet reached. Good progress being made	Open	na	-336	Due Date Not Reached
WAO24	2020-21	**Dec-20**	Follow-up of Operating Theatres	Chief Operating Officer	5	R4	Create standards for professional management and leadership and ensure that team leaders meet that standard.	A development booklet for clinical leaders has been developed which outlines the professional standards for our clinical leaders. A development plan will be developed by the workforce programme manager to supports clinical leaders to achieve these.	Ceri Chinn	Mar-22	Strategy and Delivery	Oct-21	Open under 3 months	pc	Agreed implementation date not yet reached. Good progress being made	Open	na	-336	Due Date Not Reached
WAO24	2020-21	**Dec-20**	Follow-up of Operating Theatres	Chief Operating Officer	5	R5	Ensure that quality and safety improvement initiatives are developed and led by service staff. These could focus on areas such as reducing surgical site infection, cleanliness, improving WHO checklist processes, applying lessons from incidents and improving patient experience.	The department has a strong history of incident management and reporting. Additional debriefing initatives are being initiatied post covid to help support staff who are involved in adverse incidents - led by the Lead Nurse and a Consultant Anaesthetist. There is a theatre estates group which is looking at the risk and saefty concerns due to the aging estates.	Ceri Chinn	Mar-22	Strategy and Delivery	Oct-21	Open under 3 months	pc	Agreed implementation date not yet reached. Good progress being made	Open	na	-336	Due Date Not Reached

External Audit (WAO) Recommendations 2018/19 – 2020/21 (April 2021)

External Audit	Complete	No action	Partially complete	< 3 mths	> 3 mths	+6 mths	+ 1 year	Grand Total
Structured Assessment 2018	2	-	3	-	-	5	-	5
Clinical Coding Follow Up	-	-	2	-	-	-	2	2
Audit of Financial Statements	-	-	1	-	-	-	1	1
Implementation of the Wellbeing of Future Generations Act	-	3	4	-	-	7	-	7
Audit of Accounts Report Addendum - Recommendations	-	1	2	3	-	-	-	3
Effectiveness of Counterfraud Arrangements	2	-	-	2	-	-	-	2
Follow Up of Operating Theatres	-	-	5	5	-	-	-	5
Total	**4**	**4**	**17**	**10**	**-**	**12**	**3**	**25**

From the above table it can be seen that since the last report to Committee in February 2021 4 of the 25 outstanding WAO recommendations from February 2021 have been completed. It can also be seen that there are a further 4 of 25 recommendations where there has been no action a further and 17 of 25 where the recommendation is partially completed. 3 actions of 25 are over 1 year old and 12 of 23 are over 6 months old.

Report Title:	**Counter Fraud Annual Plan for 2021-2022**								
Meeting:	**Audit and Assurance Committee**						**Meeting Date:**	**6th April 2021**	
Status:	**For Discussion**	**x**	**For Assurance**		**For Approval**	**X**	**For Information**	**x**	
Lead Executive:	**Executive Director of Finance**								
Report Author (Title):	**Nigel Price** **Local Counter Fraud Specialist**								

Background and current situation:

The Counter Fraud Annual Plan provides the Audit Committee with a plan for NHS Counter Fraud work for the period 1st April 2021 to the 31st March 2022. The plan sets out a self assessment against the new counter fraud standards and the resources required to deliver the workplan.

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

The plan maintains the current level of resources deployed for counter fraud, which is deemed to be adequate and appropriate. The main change in this year's plan is the adoption of the Government's new standards for Counter Fraud which comprises 12 components against which a self assessment has been made.

Approval and adoption of this plan is supported.

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

Fraud committed against the NHS has a financial and reputational impact. This work plan sets out the counter fraud work to be undertaken to combat and fraud. This includes cultural work in creating an anti fraud culture, together with planned prevention and detection activity.

Self assessment against the new standards provides assurance that the counter fraud service is currently meeting the key components of this standard. This plan aims to maintain this level of service and delivery.

Progress against this plan will be monitored via regular progress reports at all future Audit and Assurance Committees in 2021/22 and if required, changes can be made to the plan dependent upon circumstances.

Recommendation:

The Audit and Assurance Committee is asked to:

APPRVOVE the Counter Fraud Annual Plan for 2021-22

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								

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

NHS Counter Fraud Service

CARDIFF AND VALE UNIVERSITY HEALTH BOARD COUNTER FRAUD WORKPLAN 2021-2022

1 Background

1.1 This document draws up the counter fraud arrangements with the health board and should be reviewed annually. The work plan details the counter fraud standards of the Government Functional Standard GovS: 013: Counter Fraud which comes into effect on the 1st April 2021 and consists 12 'components'. It also recommends the resources which are outlined in NHS Counter Fraud Policy and Procedures. These recommendations are based on an annual Quality Assurance Programme which consists of two processes, assurance and assessment. Both are linked to the anti-fraud, corruption and bribery standards set out annually by NHS Counter Fraud Authority

1.2 The Quality Assurance process includes an annual self-review, conducted by the health board and compared with the standards. The results are sent to the NHS Counter Fraud Authority (CFA) with the health body's counter fraud annual report. The Quality Assurance process is reviewed by the CFA's Quality and Compliance team and the Health Board.

1.3 The Health Board formulates its work plan by taking a risk-based approach, and the guidance is used to help provide a framework on which such arrangements can be developed and organisations are encouraged to formulate tailor-made plans.

1.4 The Wales Audit Office had the following comments to make:

[the Template Work-plan] appears to be a comprehensive and demanding proactive programme of Counter fraud work. If the plan is delivered to a high standard across the NHS in Wales, [it] will make a significant impact in the prevention of fraud in the NHS.

It may be worth reminding LCFS' of the importance of liaison with External Auditors when planning local Counter fraud work in order to prevent duplication of effort. There are some elements of the Counter-Fraud Work-plan which External Auditors may review on a risk basis as part of their own reviews of Governance Arrangements, e.g. Whistle-Blowing arrangements, Declaration of Interests; Gifts and Hospitality. External Auditors will certainly be seeking to gain assurance that Counter fraud arrangements are robust, particularly in the light of NHS reorganisation in Wales."

The Wales Audit Office recognised that effective delivery of the plan does represent a substantial programme of work.

1.5 The total number of suggested **pro-active and reactive days** to be allocated in 2021-2022 for Cardiff and Vale University Health Board is **440 days**. This response has been allocated using data from organisations in both Primary and Secondary Care Sectors that have done well.

1.6 When planning the resources for counter fraud work, it is important that the health body accounts for reactive time and this should be reflected in the work plan.

1.7 Pro-Active work, e.g. strategic, culture, deterrence, prevention and detection, should not be absorbed by reactive activity or *vice versa* and to this end NHS Counter fraud Authority strongly encourages pro-active work to be 'ring-fenced'. Effective pro-active work must be undertaken or the health body may be at risk from fraud, corruption or bribery.

1.8 Organisations vary in size and following scale is used to calculate the number of days allocated to counter fraud:

Number of staff	Number of Pro-Active Counter fraud days
Less than 4,999	295
5,000 to 9,999	305
10,000 to 13,999	315
More than 14,000	325

1.9 It is important to note that, while this is a work-plan to ensure effective counter fraud arrangements, it is not a maximum requirement and Health Boards are strongly urged to consider further local requirements that might result in the recommended resource levels being exceeded. This work-plan gives guidance for considering Counter fraud arrangements, but it is important that tailor-made plans are carried out on a risk-based approach (see section 2).

1.10 Organisations that fall below standard should provide evidence why decisions on work planning have been taken and these should be shown to NHS CFA or NHS CFS (Wales).

1.11 The work-plan is a framework on which to build robust counter fraud arrangements and is comparable with the Annual Quality Assurance Programme and Self Risk Assessment that each Health Board is asked to submit at the end of the financial year.

2 Taking a risk-based approach to planning local counter fraud work

2.1 Locally investigators are in the best position to identify and understand the counter fraud requirements for their organisation. Successful implementation of counter fraud policy relies on the work of the Local Counter fraud Specialist (LCFS).

2.2 The counter fraud work-plan should be tailor-made for the NHS organisation, for example, utilising local annual staff survey results will identify areas on which to concentrate for raising awareness, while examination of referrals may show the need for more work on preventing fraud or highlight that awareness is needed in a particular department or staff group.

2.3 Meeting key personnel in the health board and using the information from staff surveys are important methods for forming action plans. The responses may also reveal areas of risk highlighting a need for pro-active prevention or detection work.

2.4 The LCFS will liaise with the individual in the health board who is responsible for managing risk. It is recommended that the LCFS is told about frauds which have occurred in the organisation to identify any risks and take action to prevent those happening again.

2.5 Any risks which are identified by the LCFS must be placed on the risk register to provide another level of assurance that the risk will be managed.

2.6 While every effort will be made to identify local risks, it is important that information from outside the organisation is taken into account; for example, NHS Counter fraud Authority fraud alerts which must also be included in risk-based planning.

2.7 Accurate records of counter fraud work is crucial to planning investigations, evaluating outcomes, risk register entries and audit reports. The end of year Quality Assurance Programme and Self Risk Assessment requires accurate record keeping and can help to identify strengths and weaknesses.

2.8 To help organisations take a risk-based approach to counter fraud work and planning, The NHS CFA has issued a risk assessment tool. That tool helps the LCFS when assessing the counter fraud arrangements at their own organisation. It is designed to complement the quality assurance process, and provides a process to review counter fraud arrangements prior to completing the end of year quality assurance programme.

3 Focusing on outcomes and not merely activity

3.1 Completed counter fraud work will show the results for each investigation or referral. Those outcomes may relate to successful investigations or progress being made in proactive areas, for example, staff feedback on how their knowledge of fraud in the NHS has improved due to attending presentations. For example, for the year 2020-2021, 187 members of staff attended fraud awareness sessions; out of which, 81% said they “Strongly agreed” and 18% said they “Agreed” that the session improved their knowledge of counter fraud work.

3.2 That feedback supports the progress in developing an anti-fraud culture. Another example would be reviewing an organisation’s policies to identify any potential areas which may be susceptible to fraud. A good example of this is the childcare funding for student nurses who are eligible for the award. A weakness in the process was identified and after taking action fraud referrals were considerably reduced. Clearly, the NHS must get value for the money it spends on counter fraud work and in planning for the year ahead consideration needs to be given to obtaining evidence to demonstrate this is happening.

4 Work-plan Components

Meets The Requirement	Partially Meets The Requirement	Does Not Meet The Requirement	Local Counter Fraud Service Position
1 Accountable individual There is a member of the executive board or equivalent body who has a clearly defined responsibility for the strategic management of, and support for, counter fraud, bribery and corruption work.	Not applicable to this component	There is no member of the executive board, or equivalent body, who has a clearly defined responsibility for the strategic management of, and support for, counter fraud, bribery and corruption work	The Director of Finance is the lead and accountable Executive Director.
2 Counter fraud bribery and corruption strategy The impact of the organisation's counter fraud, bribery and corruption strategy has been evaluated, and the counter fraud work plan or counter fraud resources has been updated as required as a result.	The organisation's counter fraud, bribery and corruption strategy is aligned to NHSCFA's strategy, and it has been approved at senior management or executive level.	The organisation does not have a counter fraud, bribery and corruption strategy.	The health board has a counter fraud policy which follows the NHSCFA strategy. An annual counter fraud plan for the health board is agreed by the Audit and Assurance Committee.
3 Fraud bribery and corruption risk assessment Resources to carry out the work are realistically assessed and suitable for addressing the risk identified within a reasonable timescale, in line with the	Risk assessments have been carried out to identify fraud, bribery and corruption risks at the organisation in line with GCFP fraud risk assessment methodology. These	There is no evidence of any local risk assessments carried out to identify fraud, bribery and corruption risks at the organisation	The health board's fraud policy has been reviewed and will be assessed against the risk register. Liaison with other departments such as procurement and internal audit is carried out to identify any areas which may be vulnerable to fraud.

organisational risk policy	risks are recorded in line with the organisational risk management policy.		Resources to carry out the work are reviewed annually and are deemed to be adequate.
4 Policy and response plan There are significant levels of staff knowledge and awareness of the existence of the policy and plan. Levels of awareness are routinely measured, and any resulting corrective or preventative action is implemented and evaluated.	The organisation's policy and plan are in line with the NHSCFA's strategy, and it has been approved at senior management or executive level, implemented and communicated across the organisation.	The organisation does not have a policy and plan, or where one exists, it is not publicised, or it is out of date	Fraud awareness sessions are regularly carried out and the staff complete feedback sheets. for the year 2020-2021, 187 members of staff attended fraud awareness sessions; out of which, 81% said they "Strongly agreed" and 18% said they "Agreed" that the session improved their knowledge of counter fraud work.
5: Annual action plan Risk-based objectives of the work plan are adequately resourced to carry out the work.	The annual work plan has been agreed by the audit committee (or equivalent body). Adequate resources have been assigned to specific areas of activity.	There is no evidence of the annual work plan being agreed by the audit committee (or equivalent body).	The health board's annual counter fraud plan is signed off by the Director of Finance and then approved by the Audit and Assurance Committee who then monitor progress on a quarterly basis.
6 Outcome-based metrics The organisation has agreed targets / outcomes and has metrics in place to monitor progress - these are regularly reviewed by the Audit Committee and revised where necessary. New metrics are appropriately implemented.	The organisation has agreed targets / outcomes but no evidence of tracking or monitoring to measure progress	No metrics are in place (or defined outcomes against counter fraud initiatives or investments).	The targets for the health board's counter fraud work is set out at the beginning of the financial year as part of the annual plan. Progress towards those targets for example: the days allocated for investigations, financial recoveries, the number of open and closed cases and the number of fraud awareness sessions is reported to the Audit and Assurance committee at each meeting.

7 Reporting routes for staff, contractors and members of the public The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption, including the NHSCFA's Fraud and Corruption Reporting Line and online reporting tool.	The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption, including the NHSCFA's Fraud and Corruption Reporting Line and online reporting tool.	The organisation does not have well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption, or where reporting routes exist, it is not publicised, or it is out of date.	Every fraud presentation covers ways in which staff can report any suspicions or concerns about fraud both internally and the external NHS Fraud Reporting Line. All referrals are recorded on the case management system
8 Report identified loss There is evidence to indicate that the completeness and timeliness of information recorded on the approved NHS fraud case management system is regularly and soundly evaluated and that, where appropriate, findings lead to improvements.	The organisation records all reports of suspected fraud, bribery and corruption, investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises, on the approved NHS fraud case management system in line with NHSCFA guidance.	The organisation does not use the approved NHS fraud case management system to record all reports of suspected fraud, bribery and corruption, investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises.	All progress and outcomes are recorded on the case management system. Part of the investigation is to identify weaknesses in policies or procedures which are recorded in the investigation report. Appropriate action is taken to prevent similar incidents happening again.
9 Access to trained investigators The organisation has notified any	Not applicable to this requirement	There is no accredited person (or persons) employed or contracted in to carry out the full	The health board has 2 accredited fraud investigators in full time employment

/ all changes to nominations to the NHSCFA as soon as reasonably practicable. There is an accredited, nominated and appropriately trained person(s) who is employed or contracted in and conducts the full range of counter fraud, bribery and corruption work on behalf of the organisation		range of counter fraud, bribery and corruption work on behalf of the organisation.	
10 Undertake detection activity Where anomalies are identified which may be indicative of fraud, bribery and corruption, the organisation carries out proactive exercises to address them. Resulting recommendations are actioned	The organisation can demonstrate that it uses relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption.	There is no evidence that the organisation uses relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption.	The CF service regularly reviews department policies to identify areas which may be vulnerable to fraud, bribery or corruption. In addition to that proactive work is undertaken by engaging with other departments, for example Accounts Payable, Procurement and Internal Audit
11 Access to and completion of training The organisation has an ongoing programme to raise awareness of fraud, bribery and corruption issues among all staff, using a range of methods that are appropriate to different staff groups. There is evidence that presentations and other	The organisation has an ongoing programme to raise awareness of fraud, bribery and corruption issues among all staff using a range of methods. This may include induction, presentations, newsletters, posters and other awareness	The organisation has not raised awareness of fraud, bribery and corruption issues among staff and has not attempted to create a counter fraud, bribery and corruption culture.	Fraud awareness sessions are regularly given to the health board's departments and new employees which is tailor-made to the audience to ensure it is relevant. A counter fraud newsletter is published every 4 months which gives details of contacts

awareness materials are targeted to specific staff groups	materials. The awareness work carried out is in line with NHSCFA's strategy		
12 Policies and registers for gifts and hospitality and Conflicts of Interest The organisation has a managing conflicts of interest policy and registers that include gifts and hospitality that is proactively communicated to all staff.	The organisation has a managing conflicts of interest policy and registers that include gifts and hospitality that is available to all staff and includes the appropriate references to fraud, bribery and corruption and the requirements of the Bribery Act 2010	The organisation does not have a managing conflicts of interest policy and registers that include gifts and hospitality or does not publicise it where one exists.	The UHB has policies that cover conflicts of interest and gifts and hospitality. The Director of Governance manages the Conflict of Interest register and liaises with counter fraud if appropriate.

Appendix 1

Number of Days agreed with Cardiff and Vale University Health Board Finance Director for the 2021- 2022 Financial Year is 440 days.

COUNTER FRAUD SUMMARY PLAN ANALYSIS 2021/22

AREA OF WORK	Annual Plan
Strategic Requirements	
Attendance at All Wales Meetings	8
Meetings/Training Courses	6
Preparation of Annual Reports etc.	10
Audit Committee Meetings/Reports	10
Quarterly Statistics Returns	5
Annual Activity	
Create an Anti-Fraud Culture (Inc PPV)	30
Awareness Presentations, Newsletters etc.	40
Other work to deter Fraud	10
Prevention	
Review of System Weaknesses etc.	20
Detection	
Local Pro-Active Work	10
NHS CFA Exercise (Procurement)	10
National Fraud Initiative (NFI)	20
Investigation, Sanctions and Redress	
Investigations/Enquiries	245

Court Hearings/Sanctions etc.	10
Civil Redress/Repayment	6
TOTAL DAYS	**440**

Agreed by and signed by

Signature: **Date:**

Catherine Phillips
Finance Director - Cardiff and Vale University Health Board

Signature: **Date:**

Nigel Price
Counter Fraud - Cardiff and Vale University Health Board

Saunders,Nathan
03/31/2021 15:03:39

Report Title:	**Clinical Audit Plan**								
Meeting:	**Clinical Audit Committee**					**Meeting Date:**			
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**x**	
Lead Executive:	**Executive Medical Director**								
Report Author (Title):	**Head of Patient Safety and Quality Assurance**								

Background and current situation:

Clinical audit is an integral component of the quality improvement process and is embedded within the Welsh Health and Care Standards. Participation is a central component of the suite of Delivery Plans developed for NHS Wales.

HQIP is responsible for several national healthcare quality improvement programmes, including managing and commissioning the National Clinical Audit and Patient Outcomes Programme (NCAPOP) on behalf of NHS England, the Welsh Government and in some cases other devolved authorities.

NCAPOP covers two main sub-programmes: the National Clinical Audit Programme (NCAP) and the Clinical Outcome Review Programmes (NCORP). HQIP have published a publication schedule for 2021 https://www.hqip.org.uk/ncapop-9-month-publication-schedule

Welsh Government have not yet published a National Clinical Audit and Outcome Review Plans (NCAORP) for 2021/22. However, it is not anticipated that any significant changes will be made from the previous rolling program National Clinical Audit and Outcome Review Plan (NCAORP) 2019/2020

National audit allows the UHB to compare performance with other organisations against nationally agreed best practice standards in England and Wales. These audits also deliver improved processes and outcomes for the population that the health board serves by informing and measuring the effectiveness of quality improvement initiatives. The extent of this data driven improvement program is wide reaching, incorporating services across all Clinical Boards.

For the past three years a formal process has been in place to ensure that all national audit publications are reviewed and the health board results are considered and where necessary the requisite improvements are put in place. The Health Board reports these results, and improvements to Welsh Government.

Cardiff and Vale University Health Board participate in 38 National Clinical Audits that are mandated by Welsh Government. A Clinical Audit Lead is identified for each audit, the majority of which are undertaken by those clinical leads. There are a further 13 audits that come under the clinical outcome review programme.

Local clinical audit functions best as part of a planned programme of quality improvement activity. The development of a clinical audit plan should be informed by local quality and safety priorities and should meet the priorities of each Clinical Board, as a result there is recognition that it should be a dynamic plan which will respond to changing priorities throughout the year.

Clinical Boards should have governance arrangements in place to ensure that clinical audits are planned, prioritised, undertaken and reported in a way that maximises the benefit of the audit to the organisation. Reporting arrangements should be determined to ensure results and improvement plans can discussed in the correct forum.

When deciding on clinical audit activity consideration should be given to recent:

- Serious Incident / Never Events
- Patient Safety themes
- Patient outcomes
- Release of new or revised best practice guidance.

In February 2018 the committee agreed an approach to categorise clinical audits into three tiers, to support a prudent and targeted approach.

- **Tier 1** Mandatory National Clinical Audits.
- **Tier 2** All other national audits and local clinical audits undertaken to address the patient safety and quality agenda.
- **Tier 3** Local clinical audits undertaken for any other reason including revalidation and

CPD purposes.

Tier 1 audits should take priority and Clinical Audit Leads, Directorates and Clinical Boards should prioritise the data collection, reporting and development of requisite improvements around these audits before agreeing the allocation of any resource to Tier 2 or Tier 3 audits.

Tier 2 audits should be developed to give assurance around patient safety issues that have been identified as a result of Serious Incidents, Regulation 28 and other existing patient safety incident themes etc. or to give assurance that care delivery is in line with NICE guidance or other recently published or updated best practice guidance.

Tier 3 audit proposals should be scrutinised by the Clinical Audit Lead and the Clinical Director to ensure they are prudent and offer a benefit to the Directorate and Clinical Board.

The Clinical Boards and Clinical Audit Leads have developed a 2021/22 Clinical Audit Plan incorporating all Tier 1 and anticipated Tier 2 audits (Appendix 1). There is not an expectation that Tier 3 audits will be included in the clinical audit plans, however the requirement to register and have approved all audits and to report and escalate the results remains imperative.

The current Clinical Audit Process has been in place for some years, and whilst this process has served well, there are areas for improvement that have been identified through a recent review of the Quality Assurance Processes in Patient Safety.

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

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

Many Steps have been taken in recent months to improve and monitor Clinical Effectiveness and Quality Assurance:

- A Clinical Effectiveness Committee has been established, the first meeting was held in December 2020 and is chaired by the Associate Medical Director, it aims to ensure clinical effectiveness throughout the Health Board by:

a) Monitoring the implementation of national and local evidence, guidelines and standards to ensure best practice across the Health Board.

b) Providing strategic direction for the UHB's national and local clinical audit programme.

c) Providing assurance to the QSE committee on the above points through the production of reports.

d) Receiving reports from the sub groups and following analysis either escalate issues or provide assurance to the QSE committee and Board.

e) Contribute to the production of the Annual Quality Statement to be presented to the Board of Directors.

- Investment in Team Structure. Bench marking against other Health Boards in Wales along with a review of current resource and team structure has identified that investment will be required to deliver the desired improvements. This forms part of a wider and much larger piece of work that is currently underway with regards to the Health Board Quality and Safety agenda.

- Capturing Clinical Audit and Improvement Activity. A demonstration is planned with a neighbouring Health Board in Wales for a system called AMaT. This is a system for tracking and monitoring Clinical Audit activity to give more control and to provide real-time insight and reporting for clinicians, wards, audit departments and the health boards. The system aims to support staff in all areas to improve patient care, by capturing the data around all Clinical Audit activity throughout the Health Board in one place helping to manage risk, and comply with reporting requirements.

The Clinical Boards and Clinical leads have faced significant challenges in developing the Clinical Audit Plan for 2021/2022 and their hard work and commitment in this exceptional and extremely difficult time is acknowledged. Due to the frequently changing landscape within the

health service currently some flexibility/fluidity may be required as the year progresses with the Clinical Audit Plan.

Progress against the plan will be reported to the QSE Committee in June 2022.

Recommendation:
The Clinical Audit Committee are asked to note the content of the report and the proposed Clinical Audit Plan for 2021/22.

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	
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		Integration	x	Collaboration	x	Involvement	

Equality and Health Impact Assessment Completed	Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Appendix 1- Cardiff and Vale University Health Board - Local Clinical Audit Plan 2021/2022			
Clinical Board	**Directorate**	**Tier 1 National Audit**	**Tier 2 Quality and Safety Priority (Local Audit)**
PCIC	Primary Care	National COPD Audit	Management of Asthma in Primary Care
PCIC	Primary Care		Acute Kidney Injury
PCIC	Primary Care	National Audit of Diabetes	
PCIC	Primary Care		NATROX
PCIC	Localities		National Audit of Intermediate Care
PCIC	Department of Sexual Health		Management of Patients diagnosed with Gonorrhea in Cardiff
PCIC	Department of Sexual Health		National Audit of HIV and Malignancy Services in Centers within South East Wales
PCIC	Prison service		Use of NEWS charts in prison
PCIC	Palliative Care Services		Is primary thromboprophylaxis of palliative care cancer inpatients compliant with NICE (NG89)?
PCIC	Palliative Care Services	National Audit of Care at the End of Life	
PCIC	Primary Care	Fracture Liaison Service Database	
W&C	Acute Child Health	National Paediatric Diabetes Audit	

W&C	Acute Child Health		RCPCH Quality in Diabetes Programme
W&C	Acute Child Health	MBRACE- UK perinatal mortality reporting (and contributing to Each Baby Counts)	
W&C	Acute Child Health		All Wales neonatal network: Neonatal Sepsis Risk calculator (SRC)
W&C	Acute Child Health		Annual service evaluation against All wales Neonatal Standards reporting to neonatal network
	Acute Child Health	Children and Young People Asthma	
W&C	Acute Child Health		Review of Necrotising Enterocolitis cases
W&C	Acute Child health	Epilepsy 12 : National Audit of Children and Young People	Review of Gentamycin Monitoring in Paediatric patients (Joint)
W&C	Acute Child health	Paediatric Intensive Care (PICaNET)	Management of Epstein Anomaly in patients at Noah's Ark
W&C	Acute Child Health		Review of Neonatal Term Admissions
W&C	Obstetrics and Gynaecology		Knowledge and understanding of Diathermy safety
W&C	Obstetrics and Gynaecology		BSGE national audit of complex endometriosis surgery outcomes and complications
W&C	Obstetrics and Gynaecology		Quality of image optimisation in gynaecology outpatients department
W&C	Obstetrics and Gynaecology		Use of TVT
W&C	Obstetrics and Gynaecology		Quality of image optimisation in gynaecology outpatients

			department after teaching intervention
W&C	Obstetrics and Gynaecology		Hysterectomy methods and complications
W&C	Obstetrics and Gynaecology		Antibiotic use in gynaecology
W&C	Obstetrics and Gynaecology		Consenting for fetal tissue
W&C	Obstetrics and Gynaecology		evaluation of mini touch
W&C	Obstetrics and Gynaecology		evaluation of Resect
W&C	Obstetrics and Gynaecology		Evaluation of Trans rectal ultrasound in outpatients
W&C	Obstetrics and Gynaecology		Management of Hyperemesis
W&C	Obstetrics and Gynaecology	National Maternity and Perinatal Audit	
W&C	Obstetrics and Gynaecology	MBRRACE - UK	
W&C	Obstetrics and Gynaecology		Antenatal routine enquiry audit
Surgery	Dental		An audit of compliance by UDH OMFS department to new MRONJ protocol guidelines (SDCEP) prior to extractions.
Surgery	Dental		Re-audit WHO checklist in oral and maxillofacial surgery
Surgery	General Surgery	National Oesophago-Gastric Cancer Audit	
Surgery	Urology		National Renal Colic
Surgery	general Surgery	National Audit of Breast Cancer in Older People	
Surgery	Urology		Monitoring of compliance with UAG guidance: Trans-ureteral

			resection of bladder tumour surgery
Surgery	Urology	National Prostate Cancer Audit	COVID stones
Surgery	Urology		Audit of Stress urinary Incontinence I Women
Surgery	Urology		Audit of Urethroplasty
Surgery	Urology		Audit of Cystectomy
Surgery	Urology		Audit of Nephrectomy
Surgery	Urology	Renal Registry (Renal replacement therapy)	
Surgery	Urology		Audit of Scrotal Pain Pathway Audit
Surgery	Urology		Audit of Consent for day of surgery admission patients
Surgery	Ophthalmology	National Ophthalmology Audit	
Surgery	Anesthetics		Obs Cymru
Surgery	Trauma and Orthopaedics		Fragility Fracture post-operative mobilisation.
Surgery	Trauma and Orthopaedics		Does the management of Pelvic Fractures in UHW adhere to BAST guidelines (joint T&O)
Surgery	Trauma and Orthopaedics		Re-audit of the spinal admissions pathway following the introduction of the Major Trauma Centre at UHW
Surgery	Trauma and Orthopaedics		The management of Fragility Fractures across Cardiff and Vale UHB (BOAS Standard)

Surgery	Trauma and Orthopaedics		Assessing the Quality of T&O operation notes (RCOS guidelines for documentation)
Surgery	Trauma and Orthopaedics		Spinal Venous Thromboembolism Audit - UHW Amber (NICE NG89)
Surgery	Trauma and Orthopaedics	National Joint Registry	Audit of Medical Record keeping on T&O (Joint with medical students
Surgery	Trauma and Orthopaedics	National Hip Fracture Database	
Surgery	Peri-operative services		WHO checklist
Surgery	General Surgery		National Audit of Pediatric Mastoiditis
Surgery	General Surgery		BAETS UK registry of endocrine and thyroid surgery
Surgery	General Surgery	National Oesophago Gastric Cancer Audit	PANC study (Pancreatitis: a National Cohort Study)
Surgery	General Surgery		PQUIP
Surgery	General Surgery	National gastrointestinal cancer audit	Audit of Appendicitis inflammatory response scoring
Surgery	General Surgery		SWORD pouch surgery database
Surgery	General Surgery		Pelvic floor national database (mesh rectopexy)
Surgery	General Surgery	National Vascular Registry	Peri-operative treatment of rectal cancer prior to and during COVID (NICE quality standard - 4)
Surgery	General Surgery	National Emergency Laparotomy Audit	Hepatobiliary Multi -disciplinary imaging review of colorectal cancer patients with intrahepatic metastases (NICE quality statement 6)

Medicine	Medicine	National Diabetes in Pregnancy Audit	COVID pathways
Medicine	Medicine	National Pulmonary rehabilitation Audit	Venous Thrombosis Prophylaxis (NICE NG89)
Medicine	Medicine	National Asthma Audit	Audit of Acute non-invasive ventilation
Medicine	Medicine	Diabetes Transition Audit	
Medicine	Medicine	National COPD Audit	
Medicine	Emergency Unit		Does the management of Pelvic Fractures in UHW adhere to BAST guidelines (joint T&O)
Medicine	Emergency Unit		Venous thromboembolism risk in lower limb mobilisation (NICE NG89)
Medicine	Emergency Unit		Management of Pain in Children
Medicine	Gastroenterology		
Medicine	Gastroenterology		Initial management of upper gastrointestinal bleeding
Medicine	Gastroenterology		Long term management of ulcerative colitis with first line biologics during COVID 19 (Joint with med students)
Medicine	Rheumatology	National Early Inflammatory Arthritis Audit	
Medicine	Medicine	National Diabetes Inpatient Audit	
Medicine	Medicine	National Stroke Audit (SSNAP)	
Medicine	Medicine	National Lung Cancer Audit	
CD&T	Pharmacy		Review of Gentamycin Monitoring in pediatric patients (Joint)

CD&T	Podiatry	National Diabetes Foot care Audit	
CD&T	Audiology	National Audiology Audit	
CD&T	Laboratory medicine		National Audit of the management of Encephalitis 2020 university of Liverpool brain infections group (ABN national guidance)
CD&T	Speech and Language Therapy		Dysphagia Audit & Neuropsychiatry IP-Audit against 5 good communication Standards.
CD&T	Radiology, Medical Physics and Clinical Engineering		Carotid Audit
CD&T	Radiology, Medical Physics and Clinical Engineering		Temporal Artery Audit
CD&T	Radiology, Medical Physics and Clinical Engineering		Ultrasound Audit
CD&T	Radiology, Medical Physics and Clinical Engineering		Anomaly Scan Audit
CD&T	Radiology, Medical Physics and Clinical Engineering		Combined Screening Scan Audit
CD&T	Radiology, Medical Physics and Clinical Engineering		DQASS (Nuchal Translucency audit)
Specialist	Cardiology	National Heart Failure Audit	Physiologist-led Valve clinic in a tertiary canter
Specialist	Cardiology	Cardiac Rhythm Audit	
Specialist	Cardiology	National Adult Cardiac Surgery Audit	
Specialist	Cardiology	National Audit of Percutaneous Coronary Interventions	
Specialist	Cardiology	National Congenital Heart Disease Audit	

Specialist	Cardiology	Myocardial Ischemia National Audit Project	
Specialist	Nephrology and Transplant		Valganciclovir prescribing for cytomegalovirus prophylaxis
Specialist	Neurosciences		Diagnosis and management of UTI's I inpatients at the Welsh spinal cord injury rehabilitation center
Specialist	Critical Care	Case Mix Program (CMT) (Mandatory	
Specialist	Critical Care	TARN	
Mental Health	Adult Mental Health	National Audit of Psychosis	
Mental Health	CAMHS		Physical Health Monitoring of Children and Adolescents Prescribed Antipsychotic Medication.
Mental Health	Adult and Older people's Mental Health		Care and Treatment Plan Audit
Mental health	Adult and Older people's Mental Health		Metrics Cymru Compliance with Psychological Therapies
Mental Health	Adult Mental Health		Patient Own Medication Audit

Report Title:	**Internal Audit Plan 2021/22**								
Meeting:	Audit & Assurance Committee						**Meeting Date:**	06/04/21	
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.

It is a requirement of the Public Sector Internal Audit Standards that an Internal Audit Plan and Charter is prepared on an annual basis and presented to the Audit Committee for approval.

The work undertaken by Internal Audit will be completed in accordance with the Plan, which has been prepared following a detailed planning process and is subject to Audit Committee approval. The plan sets out the programme of work for the year ahead, covering a broad range of organisational risks. The full document also describes how we deliver that work in accordance with professional standards. The plan has been prepared following consultation with the Management Executive.

The Internal Audit Charter has been updated as at April 2021 and sets out the purpose, authority and responsibility of the Internal Audit service along with the relationships with the Health Board, its officers and other assurance providers.

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

Following an extensive planning process and in accordance with the requirements of the Public Sector Internal Audit Standards, the Internal Audit Plan has been prepared which sets out our risk-based plan of work for the year 2021/22.

The plan covers the whole of the 2021/22 audit year but will be subject to regular on-going review and adjustment as required to ensure that the audits reflect the Health Boards evolving risks and changing priorities and therefore provide effective assurance.

In addition, the Plan also includes the Internal Audit Charter which has been prepared as at April 2021.

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

The Internal Audit Plan and Charter provide the Audit Committee with a level of assurance that the work of the Internal Audit department will be based around the key risks faced by the Health Board and will be sufficient to allow for delivery of the annual Internal Audit report and Head of Internal Audit Opinion.

Recommendation:

The Audit & Assurance Committee is asked to:

- **Approve** the Internal Audit Plan for 2021/22; and
- **Approve** the Internal Audit Charter for 2021/22.

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 Plan 2021/22

April 2021

NHS Wales Shared Services Partnership
Audit and Assurance Services

Contents

1. Introduction

This document sets out the Internal Audit Plan for 2021/22 (the Plan) detailing the audits to be undertaken at Cardiff and Vale University Health Board (the Health Board) and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

As a reminder, the Accountable Officer (the Health Board's Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (The Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2021/22. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Public Sector Internal Audit Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- quantification of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- the provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering the:

- organisation's risk assessment and maturity;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities, and is mindful of significant national changes that are taking place, in particular the ongoing impact of COVID-19. In addition, the plan aims to reflect the significant local changes occurring as identified through the Annual Plan and other

changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit & Assurance Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control require annual review, and some work is mandated by Welsh Government, our risk based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we are also aiming to agree a programme of work through both the Board Secretaries and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

1) Annual audit work: Areas where annual audit work will support the most efficient and effective delivery of an annual opinion. These cover the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

We recognise that there is a need to audit in a more agile way and to this end we have agreed with some organisations to plan this component of the work on a half-yearly rather than annual basis (the two half year elements making an annual plan). The Health Board has chosen to have a full annual programme of work identified at this stage recognising that some audits may change during the year.

3) Follow up: this is follow-up work on previous limited and no assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation

tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit & Assurance Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely PHW, HEIW, NWSSP, Digital Health and Care Wales, WHSSC and EASC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure the our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; thus we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the Corporate Risk Register;
- risks identified in papers to the Board and its Committees (in particular the Audit & Assurance Committee and Quality, Safety & Experience Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);

- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales, WHSSC and EASC;
- work undertaken by other supporting functions of the Audit & Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Health Inspection Wales (HIW); and
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Health Board Executives and Independent members to discuss current areas of risk and related assurance needs. Meetings have been held, and planning information shared, with the Health Board's executive team, the chair of the Audit & Assurance Committee and the Chair of the Board.

The draft Plan has been provided to the Health Board's Executive Management team to ensure that Internal Audit effort was best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and Corporate Risk Register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2020/21

The Plan is set out in Appendix A and identifies the audit assignment, lead executive officer, outline scope, and proposed timing. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic risks identified within the Corporate Risk Register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management and Audit Wales requirements if appropriate.

The Audit & Assurance Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit & Assurance Committee meeting.

Audit coverage in terms of capital audit and estates assurance will be delivered by our Specialist Services Unit, and work on Information Governance and IT Security will be delivered by our IM&T Team.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. We are particularly mindful of the level of uncertainty that currently exists with regards to the COVID-19 pandemic. At this stage, it is not clear how the pandemic will affect the delivery of the Plan over the coming year. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been

retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit & Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit & Assurance Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

Internal Audit has the necessary resources to deliver the agreed programme through both the local audit team and access to specialist resources.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need, and presented to the Audit & Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board/Trust/Other, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2021/22 and:

- Approve the Internal Audit Plan for 2021/22;
- Approve the Internal Audit Charter; and
- Note the associated internal audit resource requirements and key performance Indicators.

Ian Virgill
Head of Internal Audit (Cardiff and Vale University Health Board)
Audit & Assurance Services
NHS Wales Shared Services Partnership

Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing
1. Annual Audit Work				
Annual Governance Statement		To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Corporate Governance	Q4
Risk Management	BAF	Review the on-going development and implementation of the Risk Management Strategy and Procedure. Focus on risk assessment and management processes within Clinical Boards	Corporate Governance	Q4
IM&T Control & Risk Assessment	BAF Risk 6	Review and assess the control environment for the management of IM&T within the organisation.	Digital & Health Intelligence	Q3
UHB Core Financial Systems	BAF Risk 2	Review a selection of controls in place to manage key risk areas across the range of the main financial systems.	Finance	Q3
Claims Reimbursement		Review compliance with Welsh Risk Pool Standard requirements for claims reimbursement.	Nursing	Q3
2. Organisation Based Work				
Whistle Blowing Policy (Deferred from 20/21 plan)	BAF Risk 4	Review processes for UHB staff to raise concerns and on-going management.	Corporate Governance	Q2
Legislative / Regulatory Compliance	BAF Risk 6	Review the corporate arrangements for monitoring and managing compliance requirements. Include review of Patient Safety Alerts process, as agreed with Executive Director of Nursing.	Corporate Governance	Q1
Management of staff Sickness Absence (Deferred from 20/21 plan)	BAF Risk 1	Review compliance with the All Wales Managing Attendance Policy. Focus on poor performing areas.	Workforce & OD	Q2
Compliance with Welsh Language Act	BAF Risk 5	Review processes in place within the Health Board to ensure compliance with the requirements of the Act.	Workforce & OD	Q3

Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing
Retention of Staff	BAF Risk 1	Review the effectiveness of processes implemented to improve retention of staff. Include a review of leavers process to establish quality and use of data being collected.	Workforce & OD	Q2
Vaccination Programme (Flu / Covid)	BAF Risk 7	Review the processes in place for the planning and delivery of either the annual flu or on-going Covid vaccination programmes. The exact focus and scope of the audit to be agreed later in the year, depending on how the situation progresses.	Public Health	Q4
UHB Restaurant & Retail Standards		Review the processes in place for developing and implementing the standards and reporting performance against them. Provide advice around the audit process for monitoring compliance.	Public Health	Q1
Clinical Board's QS&E Governance (Deferred from 20/21 plan)	BAF Risk 4	Review the arrangements in place within the Clinical Boards for Quality, Safety and Experience Governance.	Nursing	Q2
Nurse Bank	BAF Risk 1	Review the effectiveness of the process and controls operating within the Health Board's Nurse Bank. Establish the level of efficiency and effectiveness of service provided to the Clinical Boards.	Nursing	Q3
Medical & Dental Staff Bank	BAF Risk 1	Review the effectiveness of the processes and controls operating within the Health Board's new Medical & Dental Staff Bank managed by MEDACS.	Medical	Q3
Clinical Audit	BAF Risk 4	Review the adequacy of the systems and controls in place for the planning, delivery and reporting of Clinical Audit work.	Medical	Q2
Five Steps to Safer Surgery Checklist	BAF Risk 4	Review the processes in place to ensure effective completion of the Checklist for all surgical procedures.	Medical	Q1
Consultant Job Planning Follow-up		*Potential further follow-up, dependent on outcome of 21/22 follow-up.*	Medical	*Q4*

Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing
Health & Safety		Review arrangements in place within the Health Board to ensure compliance with Health & Safety Regulations.	Chief Executive	Q2
IT Service Management (ITIL) (Deferred from 20/21 plan)	BAF Risk 6	Review processes in place for the management of IT Service delivery to ensure they are aligned with best practice and meet the needs of the organisation.	Digital & Health Intelligence	Q2
IT Strategy (Deferred from 20/21 plan)	BAF Risk 6	Review processes in place for the development and delivery of the IT strategy to ensure it meets the needs of the UHB.	Digital & Health Intelligence	Q4
Departmental IT System		Review controls in place to manage a local IT system. System to be agreed with management.	Digital & Health Intelligence	Q3
Security of Network and Information Systems (NIS) Directive Implementation	BAF Risk 6	Review process in place within the Health Board to ensure effective implementation of the Directive and compliance with the NIS Regulations.	Digital & Health Intelligence	Q3
Medicine CB - Bank & Agency Nurses Scrutiny Process (Deferred from 20/21 plan)	CB Risk Register	This audit was deferred from the 20/21 plan. The Clinical Board and COO will need to agree if this audit is still appropriate or should be replaced by a different audit.	Chief Operating Officer	Q2
PCIC CB - GP Access (Deferred from 20/21 plan)	CB Risk Register	This audit was deferred from the 20/21 plan. The Clinical Board and COO will need to agree if this audit is still appropriate or should be replaced by a different audit.	Chief Operating Officer	Q2
Surgery CB	CB Risk Register	Audit area to be agreed with COO and Director of Operations	Chief Operating Officer	Q3
Specialist Services CB	CB Risk Register	Audit area to be agreed with COO and Director of Operations	Chief Operating Officer	Q3
CD&T CB	CB Risk Register	Audit area to be agreed with COO and Director of Operations	Chief Operating Officer	Q3

Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing
Mental Health CB	CB Risk Register	Audit area to be agreed with COO and Director of Operations	Chief Operating Officer	Q4
Mental Health CB – Cancellation of Outpatient Clinics Follow-up	CB Risk Register	Follow-up of 19/20 Limited Assurance report.	Chief Operating Officer	Q2
Children & Women CB	CB Risk Register	Audit area to be agreed with COO and Director of Operations	Chief Operating Officer	Q4
Recovery of Non-COVID services / Delivery of Planned Care	*BAF Risk 8*	*Scope and timing of potential audit to be agreed with COO dependent on on-going COVID situation.*	Chief Operating Officer	*??*
Performance Reporting	*BAF Risk 8*	*Scope and timing of potential audit to be agreed with COO dependent on on-going COVID situation and reinstatement of WG reporting requirements.*	Chief Operating Officer/ Digital & Health Intelligence	*??*
Financial Plan / Reporting	BAF Risk 2	Review COVID and non-COVID financial planning and reporting to Welsh Government.	Finance	Q3
Post Contract Audit of DHH Costs		Carry out a detailed post contract audit of the costs related to the Dragons Heart Hospital, as per the Welsh Government recommendation following the independent assurance review undertaken by KPMG.	Finance	Q1
Medical Equipment and Devices	BAF Risk 6	Review arrangements in place for recording, monitoring and replacing medical equipment and devices.	Therapies & Health Science	Q2
ALNET Act	BAF Risk 6	Review the status of the Health Board's preparations for the implementation of the ALNET Act.	Therapies & Health Science	Q1

Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing
Delivery of 21/22 Annual Plan	BAF Risk 10	Review processes in place for monitoring and reporting delivery against the agreed Annual Plan for 21/22.	Strategic Planning	Q3
Estates Assurance – Waste Management	BAF Risk 6	Review the adequacy of the waste policy & strategy, organisation & management arrangement, management and monitoring of waste contracts, storage and transportation, financial issues etc.	Strategic Planning	Q3
Estates Assurance - Decarbonisation	BAF Risk 6	Review the adequacy of management arrangements to ensure compliance with the Welsh Government decarbonisation strategy.	Strategic Planning	Q3
Major Capital Scheme - UHW II	BAF Risk 6	The programme business case is currently being developed and the programme team/governance arrangements were to be established during 2020. Noting the same a small provision of time is included to provide an observer role, proactive input, and an overview of the progression through the period.	Strategic Planning	Ongoing
Capital Scheme - Genomics	BAF Risk 6	The focus of this initial review will be to consider the project initiation and business case development processes. The FBC to include the internal audit provisions through to project completion.	Strategic Planning	Q2
Shaping Future Wellbeing in the Community Scheme	BAF Risk 6	An annual provision is provided and will be allocated to appropriate schemes during the year (subject to separate risk assessment).	Strategic Planning	Q4
Capital Systems Management (Deferred from 20/21 plan)	BAF Risk 6	A review of the systems, policies and procedures in place to manage those projects not specifically identified within the audit plan.	Strategic Planning	Q4

Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing
3. Follow-up				
Follow-up		We will conduct follow-up work linked to the Health Board's recommendation tracker throughout the year to provide the Audit Committee with assurance regarding management's implementation of agreed actions.	Corporate Governance	Ongoing
4. Work Agreed with Board Secretaries/Directors of Finance/Other Executive Peer Groups				
To be determined.				
5. Audits Undertaken at Other Bodies				
Purchase to Pay		Audit undertaken at NWSSP of non-pay expenditure controls.	NWSSP Director of Finance	Q3/Q4
Payroll		Audit undertaken at NWSSP of pay expenditure controls.	NWSSP Director of Finance	Q3/Q4
Primary Care Contractor Payments (GMS, GOS, GDS, Pharmacy)		Audit undertaken at NWSSP of pay expenditure controls.	NWSSP Director of Finance	Q3/Q4
6. Integrated Audit and Assurance Plans				
Development of Integrated Audit Plans	BAF Risk 6	Integrated Audit Plans will be developed for inclusion within the respective business case submissions for relevant major projects/ programmes.	Strategic Planning	Ongoing (Subject to Business cases)

Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing
Other Activity				
Contingency & Assurance and Advisory		This element of the plan allows the flexibility to respond to management requests in order to meet specific Health Board needs throughout the course of the financial year.	Corporate Governance	
Planning, Management and Audit Committee		An allocation of time is required for the management of the service to the Health Board covering: • Planning, liaison and management – Incorporating preparation and attendance at Audit Committee; completion of risk assessment and planning; liaison with key contacts and organisation of the audit reviews; • Reporting and meetings – Key reports will be provided to support this, including preparation of the annual plan and progress reports to the Audit Committee; and • Liaison with External Audit and other stakeholders.	Corporate Governance	
Head of Internal Audit Annual Report and Opinion		Mandatory requirement to comply with the Public Sector Internal Audit Standards and Annual Governance Statement.	Corporate Governance	Q4

The KPIs reported monthly for Internal Audit are:

KPI	SLA required	Target 2020/21
Audit plan 2019/20 agreed / in draft by 30 April	✓	100%
Audit opinion 2018/19 delivered by 31 May	✓	100%
Audits reported vs. total planned audits	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [15 days]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

NHS WALES GIG CYMRU
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Cardiff and Vale University Health Board

INTERNAL AUDIT CHARTER

April 2021

Contents

1 Introduction

1.1 This Charter is produced and updated regularly to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Cardiff and Vale University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Cardiff and Vale University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Director of Corporate Governance with liaison with the Executive Director of Finance.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Cardiff and Vale University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

Audit work designed to deliver an audit opinion on the risk management, control, and governance arrangements is referred to in this Internal Audit Charter as Assurance Work because management use the audit opinion to derive assurance about the effectiveness of their controls

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective advisory service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such advisory work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards is the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit budget and resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

3.3 Whilst maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Public Sector Internal Audit Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly the Head of Internal Audit has a direct right of access to the Accountable Officer the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance e.g. Quality & Patient Safety Committee, and the Information Governance Committee.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance with Liaison with the Executive Director of Finance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance with Liaison with the Executive Director of Finance in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, internal audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

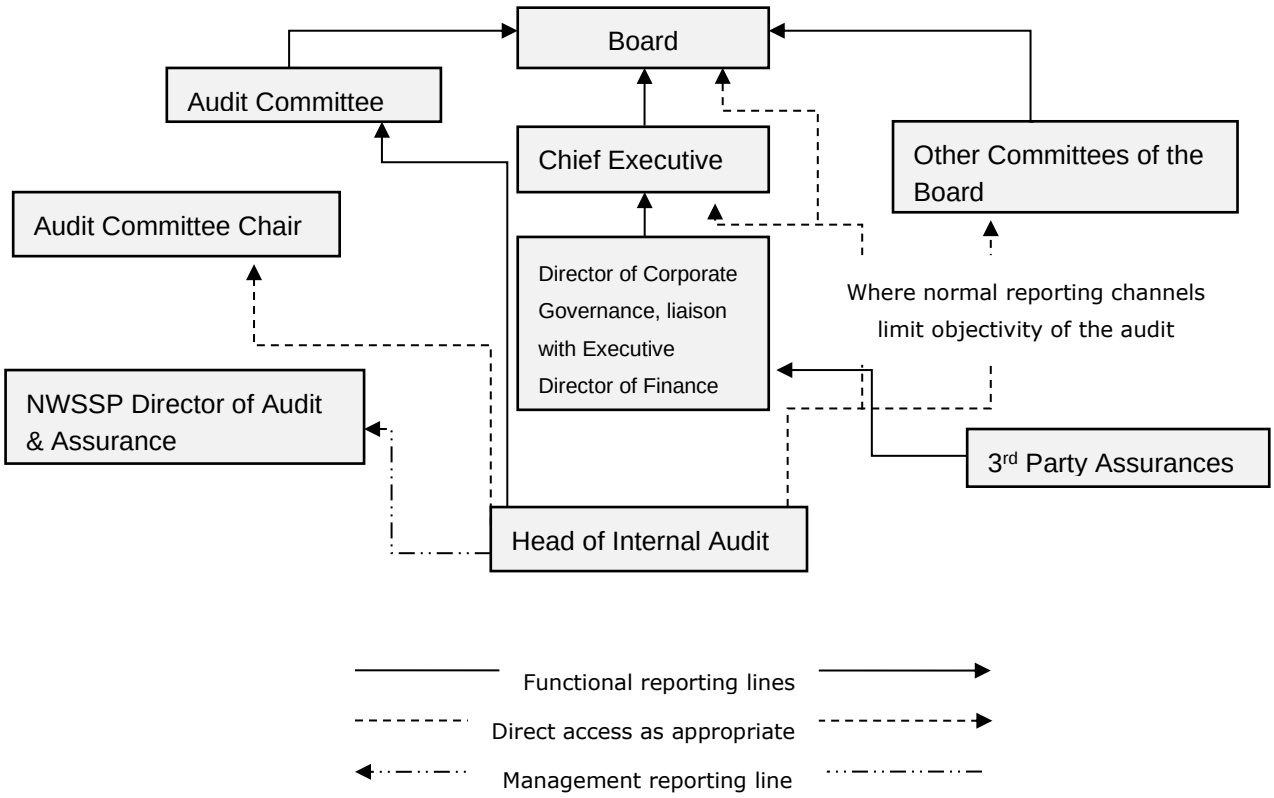
5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, e.g. the NHS Wales Shared Services Partnership, WHCCS, EASC and NWIS.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The key organisational reporting lines for Internal Audit are summarised in Figure 1 overleaf. As part of this, the Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all reports.

Figure 1 Audit reporting lines



6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2018) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- reviewing arrangements for demonstrating compliance with the Health and Care Standards.
- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Governance and Accountability modular assessment and the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit, or prejudice the ability of internal audit to deliver a services consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

7.4 The scope of the audit coverage will take into account and include any hosted body.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 2 overleaf

Figure 2 Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales to
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance

needs of the organisation will be met as required by the Public sector Internal Audit Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisations objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which "are appropriate, sufficient and effectively deployed to achieve the approved plan";
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information, and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead, and will also be copied to the Director of

Corporate Governance. The key stages in this risk based audit approach are illustrated in figure 3 below.

Figure 3 Risk based audit approach

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement. The process for arriving at the appropriate assurance level for each Head of Internal Audit opinion was subject to a review process during 2013/14, which led to the creation of a set of criteria for forming the judgement that was adopted and used for 2013/14 opinions onwards;

- The Head of Internal Audit opinion will:

a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes, with reference to compliance with the Health and Care Standards;

b) Disclose any qualification to that opinion, together with the reasons for the qualification;
c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and

- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below and presented in flowchart format in Appendix A:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage;
- Operational management will receive draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B. The draft report will also indicate priority ratings for individual report findings and recommendations;
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, stating their agreement or otherwise to the content of the report, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;

- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Director of Corporate Governance and Executive Director of Finance. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately;
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance and Executive Director of Finance. The Head of Internal Audit may present the draft report to the Audit Committee where no management response is forthcoming;
- Final reports inclusive of management comments will be issued by Internal Audit to the relevant Executive Director within 10 working days of management responses being received; and
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and Executive Director of Finance and placed on the agenda for the next available Audit Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition any

matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance - NHS Wales Shared Services Partnership
April 2021

Appendix A Audit Reporting Process

Audit fieldwork completed and debrief with management.	Following closure of audit fieldwork and management review audit findings are shared with operational management to check accuracy of understanding and help shape recommendations for improvement to address any control deficiencies identified.
A draft report is issued within 10 working days of fieldwork completion and the resolution of any queries.	Draft reports are issued with an assurance opinion and recommendations within 10 days of fieldwork completion to Operational Management Leads, and copied to the relevant Executive Leads.
Management responses are provided on behalf of the Executive Lead within 15 working days of receipt of the draft report.	A report clearance meeting may prove helpful in finalising the report between management and auditors. A response, including a fully populated action plan, with assigned management responsibility and timeframe is required within 15 days of receipt of the Draft report.
Outstanding responses are chased for 5 further days.	Where management responses are still awaited after the 15 day deadline, a reminder will be sent. Continued non-compliance will be escalated to Executive management after 5 further days.
Report finalised by Internal Audit within 10 days of management response.	Internal Audit issues a Final report to Executive Director, within 10 working days of receipt of complete management response. All Final reports are copied to the Chief Executive.
Individual audit reports received by Audit Committee.	Final reports are received by the Audit Committee at next available meeting and discussed if applicable. For reports with "green/ yellow" assurance ratings, Executive Summaries are received for noting. For those with "red/ amber" ratings, the full reports are received for discussion. The Audit Committee identifies their priority areas for Internal Audit to follow up.

Appendix B Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	 - + Green	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	 - + Yellow	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	 - + Amber	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	 - + Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

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UHW Surge Hospital - Lakeside Wing

Final Internal Audit Report

Cardiff & Vale University Health Board

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance

CONTENTS

Review reference:	SSU_CVU_2021_06
Report status:	Final
Fieldwork commencement:	19 November 2020
Fieldwork completion:	5 January 2021
Draft report issued:	11 January 2021
Draft report meeting:	13 January 2021
Management response received:	17 February 2021
Final report issued:	22 February 2021
Auditor/s:	NWSSP: Audit & Assurance – Specialist Services Unit
Executive sign off	Abigail Harris, Executive Director of Strategic Planning
Distribution	Geoff Walsh, Director of Capital, Estates & Facilities
Committee	Audit & Assurance Committee

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.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit 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 & Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Internal Auditors.

1. Introduction and Background

In response to the first phase of the Covid-19 pandemic, the University Health Board (the UHB) secured the Principality Stadium as a temporary field hospital (Dragon's Heart Hospital), accommodating up to 1,500 beds if required, to treat Covid-19 patients who did not require critical care.

Recognising the agreed expiry of the arrangement with the Welsh Rugby Union on 31st October 2020, there was a need to identify alternative arrangements to deliver circa 400 beds to ensure contingency arrangements in the face of a potential second Covid-19 surge; in addition to winter pressures.

Following a review of a number of options the UHB identified a modular building solution within the grounds of the University Hospital Wales (UHW) site as the preferred way forward – the 'Lakeside Wing'. The solution allows for 350 beds to be allocated as a step-down Covid-19 contingency with the remaining 50 beds to be utilised as a winter bed pressure unit.

Welsh Government approval was granted on 11th September 2020 in the sum of £33.230m.

At the time of reporting, Phase 1 (providing 166 beds) was handed over on schedule on 25th November 2020 (having commenced on site on 12th September 2020). Phase 2 was on target to deliver the remaining beds on time, with the final contractual handover of 5th February 2021.

2. Scope and Objectives

The review was undertaken to determine the adequacy of, and operational compliance with, the UHB's systems and procedures for the management of capital projects, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

Accordingly, the focus of the audit was directed to the following areas:

- **Approvals:**
  - Assurance that appropriate internal / external approval mechanisms were applied as the project progressed through key junctures including consideration/approval of option appraisals, revenue implications etc.
  - Assurance that planning approval requirements were monitored/delivered.
- **Governance arrangements:**
  - Assurance that adequate governance arrangements existed including management ownership, defined roles and

responsibilities, and clearly designed accountability and delegation arrangements.

- Assurance that generally accepted project management techniques were applied and reported.

- **Appointment and Contracting:**
  - Assurance that the process to appoint the preferred contractor and advisers complied with local and national requirements.
  - Assurance that appropriate contractual arrangements were implemented.
  - Assurance that appropriate Health and Safety standards were applied (recognising the modular build nature of the facility).

3. Associated Risks

The potential risks considered in the review were as follows:

- The project may be progressed outside of approved parameters.
- Poor governance arrangements may result in a loss of control of project objectives.
- Key appointments could fail to demonstrate adequate competition, impacting value for money;
- The contractual arrangements may not adequately protect the interests of the UHB.

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.

In response to the current pandemic situation, the Lakeside Wing was required to be delivered in a significantly shorter timeframe than typical projects of this size/complexity would normally be afforded.

Despite this significant time pressure, robust governance arrangements have been applied at the project with no evidence of reduced controls in key areas such as the establishment of a sound project structure, assignment and operation of responsibilities, reporting or project decision making. Project meetings have taken place on a weekly (or more frequent)

basis, with attendance from key parties at all times to enable the project to move forward at the required pace.

The project, managed by an in-house team, achieved handover of Phase 1 on schedule, with Phase 2 delivery on target at the date of this report.

In delivering the project within such a tight timescale, to provide the anticipated Covid-19 surge capacity, there were instances noted where the UHB operated outside of normal control parameters e.g.:

- As agreed with Welsh Government, the project was not progressed in line with the requirements of the Welsh Government Infrastructure Investment Guidance (including the development of a formal business case). Accordingly, formal identification and approval of revenue costs did not take place at the time of project scrutiny and approval; and
- Variation to the standard project governance protocols / guidance.

These items are reported as observations, rather than recommendations, noting the accepted divergence from standard UHB practices and noting that the divergence was deemed to be of limited risk to the UHB. See **Appendix A** for detail.

A small number of recommendations have been raised for management attention (see **Appendix B**)

Whilst acknowledging the unconventional approval and procurement arrangements applied, this accelerated project is forecast to be delivered within the key cost and delivery parameters. Accordingly, against this 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 development of the Lakeside Wing 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.

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	Approvals			✓	
2	Governance arrangements				✓
3	Appointments & Contracting			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review highlighted **no** issues that are classified as a weakness in the system control/design for managing the requirements of the Lakeside Wing project.

Operation of System/Controls

The findings from the review highlighted **6** issues that are classified as weaknesses in the operation of the designed system/control for managing the requirements of the Lakeside Wing project.

6. Summary of Audit Findings

In preparing this report, we have been cognisant of the recently published Welsh Government's Integrated Assurance Hub 'Critical Friend' report. Recognising some areas of potential cross-over between the two reviews, we have avoided duplication of coverage where possible. Recommendations made at the WG report are included at **Appendix C** of this report for reference.

Approvals

That appropriate internal and external approval mechanisms have been applied as the project progresses through key junctures. That planning approval requirements are monitored/delivered.

Recognising the pace at which this project needed to be delivered, in agreement with Welsh Government (WG), a formal business case development process was not undertaken. Funding was instead requested from WG via submission of cost forms, which, following scrutiny by NWSSP: SES, were approved on 11 September 2020, in the sum of £33.230m.

The preceding internal approval process involved a series of high-level decisions taken at Management Executive and Board level, during June and July 2020; informed by management activity in key areas such as bed capacity planning, options appraisals (including alternative sites and construction methods) and capital costings.

Board approval to the project was provided in July 2020 for the preferred modular build approach. It was noted that the supporting paper presented the capital cost of the project as £19.2m (an earlier cost estimate) rather than that of the preferred option as recommended by Management Executive (£28-£33m). Management were unclear why this lower cost was presented for Board approval. However it is evident from the decision-making audit trail available (and all subsequent reporting) that both the Chair and Chief Executive had been sighted on the more accurate, higher capital figure. Therefore, no recommendation has been made.

Whilst a range of capital costs had been considered during the above process, revenue costs had not similarly been identified, scrutinised and approved (**observation 1**). A full revenue model, setting out potential costs based on a range of bed-occupancy scenarios, was developed post project approval; and is now being used to inform the UHB's ongoing financial planning.

The modular build was progressed under the Town and Country Planning (General Permitted Development) (Amendment) (Wales) (No. 2) Order 2020. This was subject to conditions in Part 3A (Temporary Buildings and Changes of Use for Public Health Emergency Purposes), including removal

of the structure before expiry of a period of 12 months or planning permission to be sought for continuing use.

It is the UHB's intention to retain the facility for future use once the current emergency requirement ends, and management have confirmed plans will be implemented (January 2021 onwards) regarding work towards obtaining full planning permission. The planning risk has been included on the project risk register to ensure appropriate attention is received at Project Board. This accordingly also needs to feed through to the Corporate Risk register (as noted at the WG Critical Friend report).

Whilst the immediate purpose of the facility is to replace the Dragon's Heart Hospital, potential future use had not yet been determined although we acknowledge that opportunities post Covid-19 are starting to be considered. Potential costs associated with the future retention (e.g. ongoing building maintenance costs, operational costs etc.), or disposal of the facility had not been seen to be reported or approved at the time of review. These matters would typically have been considered during the business case process, and will therefore now need to be robustly scrutinised and approved (as appropriate) (**recommendation 1**).

Internal approvals arising during project delivery have been appropriately escalated from Project Board to Management Executive level for higher level scrutiny and approval, where appropriate.

Scrutiny and approval for this project was evident; however, consideration of revenue and other potential future costs had not been undertaken to the same extent as capital, noting the absence of the development of a full business case. Therefore, **reasonable assurance** has been determined.

Governance Arrangements

That adequate governance arrangements exist and that generally accepted project management techniques are applied and reported.

A comprehensive governance structure had been developed at the project, and was observed to be operating effectively at the time of review. Key project roles had been appropriately assigned (Senior Responsible Officer (SRO), two joint Project Directors and sub-group leads); with a Project Board supported by two key workstreams (construction and operational delivery) which in turn were supported by a number of sub-groups.

Whilst noting the pace of delivery may have necessitated a joint-Project Director approach, to ensure appropriate attendance / awareness of issues across the project, this is a deviation from standard project governance best practice - which sees one project director as a single point of responsibility for the project. It is recommended therefore that the UHB

assess the benefits or otherwise of this, and any innovative project governance / management arrangements applied, at the post-project evaluation. This should determine whether there may be benefits in applying similar arrangements at future capital projects undertaken at the UHB (**recommendation 2**).

The Project Board met on a weekly basis, with clear commitment demonstrated through regular attendance by key parties (including the SRO and Project Directors). Clear reporting channels were observed to ensure key issues were discussed at Project Board; and considered for onward escalation where applicable.

Whilst recognising the strength of the above arrangements, the supporting terms of reference required improvement to better reflect the agreed governance practices (including quorum, assigned responsibilities, Project Board membership etc.) (**observation 2**). Further, the project decision and action logs were not maintained effectively by the Programme Management Office (PMO), noting these were out of date at the time of review (**recommendation 3**).

Project and construction risk registers were in place, reviewed and updated regularly at workstream level, with the project risk register discussed as a standing agenda item at Project Board. The risks, however, had not been costed. Whilst acknowledging that project costs were monitored at the weekly Commercial meetings, and the positive contingency position at the time of the audit, the costing of project risks may aid the assessment/scrutiny and ultimately the sufficiency of available contingency funds (**recommendation 4**).

In the absence of a formal business case, defined performance and evaluation criteria for the delivery of the project were not evidenced. Whilst recognising the overall successful delivery of the project to date, a formal post project evaluation should be undertaken (as indicated previously), to incorporate a formal assessment of the benefits / disadvantages of the approach taken (particularly where varying from standard practice) (see **recommendation 2**).

In recognition of the robust governance arrangements that were implemented for the management of the Lakeside Wing, and the nature of the recommendations made, **substantial assurance** has been determined.

Appointments and Contracting

Assurance that the process to appoint the contractor and advisers complied with local and national requirements and that appropriate contractual arrangements were established. Also that appropriate health and safety standards are applied.

The project involved the appointment of two key contractors: one to deliver the modular build, and another to undertake the supporting mechanical and electrical infrastructure enabling works. An external cost adviser was also appointed to provide specialist support and advice to the UHB.

The modular build contractor was procured from the Shared Business Services (SBS) Modular Build Framework, via a mini-competition exercise. The approach taken followed advice received from NWSSP Procurement Services, ensuring compliance with national procurement guidelines.

The UHB received only two tender returns (from a potential ten parties invited). A benchmarking exercise, subsequently performed post-appointment of the contractor, confirmed that value for money was obtained from the winning bid (when compared with standard Framework rates). The timeliness of this assessment was raised at the WG Critical Friend Report (see **Appendix C**).

A robust tender evaluation and approval process was otherwise observed.

A Letter of Intent was utilised to instruct the commencement of works, following receipt of approval from WG. The main contract (JCT Design & Build) was executed six weeks later. Whilst recognising the urgency with which this project needed to progress, the use of a letter of intent would not normally be advocated.

However, the contractual arrangement with the enabling works contractor, appointed from the UHB's Local Framework, took longer to execute (**recommendation 5**).

It is also noted that there was an error in detail (in respect of the effective assignment dates) at the SBS Framework Service Level Agreement with the Cost Adviser (**recommendation 6**).

The appropriate risk assessment, and development of supporting site procedures by the main contractor and sub-contractors, was evidenced in respect of Covid-19 safe working practices and other project-specific risks. Furthermore, daily site visits were undertaken by the UHB's Health & Safety Manager to confirm compliance with relevant requirements.

Reasonable assurance has been determined in respect of appointments and contracting.

7. Summary of Observations / Recommendations

The audit observations are detailed in **Appendix A.**

The audit findings and recommendations are detailed in **Appendix B** together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Agreed recommendations	-	4	2	**6**
Actioned since fieldwork	-	1	-	**1**
Outstanding recommendations to be addressed	**-**	**3**	**2**	**5**
Additional audit observations (not for inclusion in UHB audit tracker)	*-*	*1*	*1*	***2***

Finding 1: Approvals – Revenue costs	Risk
The project was progressed through a number of internal approval stages, prior to final sign-off by the Board in July 2020. Key decisions/approvals were based on a range of information presented, including: • Costs associated with retention of the Dragon's Heart Hospital; • Bed capacity requirements; • Option appraisals assessing potential locations and construction methods; and • Associated capital costs related to the various options considered. However, associated revenue costs were not presented in any of the scrutiny / approval papers. Subsequent to Board approval and appointment of the main contractor, work commenced (October 2020) on developing the revenue financial model for the facility, to capture costs such as energy, security and workforce. At the time of audit fieldwork (mid-construction), the model had been prepared and was being used to guide financial planning for the remainder of the financial year. It is noted that workforce restrictions have been reported throughout as the key risk to the project. Whilst recognising the pace of delivery for this project has meant that key aspects such as the workforce model were being developed alongside construction (as opposed to having been fully considered at business case stage), it would be	The Board may not be able to take a fully informed decision based on the total potential costs of the new facility.

expected that the Board should have had sight of some estimated revenue costs, at the time of project approval, based on a range of potential bed-occupancy options. It is acknowledged that revenue costs would typically be incorporated into the normal business case process applied at capital projects progressed within the UHB.	
Observation 1	**Priority level**
In accordance with standard UHB practice, and Welsh Government requirements (NHS Wales Infrastructure Investment Guidance), revenue costs (or a range of potential costs, based e.g. on bed occupancy) should be presented within business case submissions to appropriate forums to enable a fully informed decision to be taken when granting approvals.	**Medium**
Management Response	
This project was progressed as an exception to normal practice, with revenue costs otherwise included in the business cases prepared and approved at other projects within the UHB.	

Finding 2: Project Terms of Reference	Risk
A robust governance structure was observed at the project: appropriately designed and operated to support the accelerated nature of the delivery programme. Noting the timescales and personnel involved, the terms of reference for the project was adapted from the one applied at the Dragon's Heart Hospital, and did not follow the typical format normally applied at Capital, Estates & Facilities-led projects. The resulting document lacked the clarity and level of detail expected at a major capital project. Issues noted include: • Inconsistent terminology used for the key project groups; • Insufficient clarity of key roles and responsibilities and accountability arrangements (e.g. project directors / project managers); • Absence of key information such as Project Board meeting frequency, quorum requirements and decision-making remits; and • Absence of narrative relating to the construction workstream. Whilst recognising that these omissions were not observed to adversely affect operational practice (as reviewed during the audit) the terms of reference is a key governance document and should align with best practice.	Insufficient clarity over the intended/ approved project governance arrangements.

Observation 2	Priority level
In accordance with standard UHB practice, appropriate terms of reference setting out project governance arrangements, should be applied at all major capital projects.	Low

Management Response
Terms of reference prepared by Capital, Estates & Facilities would apply standard best practice in this area. Noting the speed with which this project was initiated, coupled with the document in this case having been developed from that applied at Dragon's Heart Hospital, by a project management team outside CEF, it is accepted some key elements of clarity were omitted.

Finding 3: Approvals – Future Usage of Lakeside Wing	Risk
The potential costs associated with future retention (e.g. ongoing building maintenance costs, operational costs) or disposal of the facility had not been reported or approved. It is acknowledged that the opportunities for the Lakeside Wing, post Covid-19, are starting to be considered. However, these matters would typically have been considered during the business case process and therefore, now need to be formally scrutinised and approved (as appropriate). The conclusion of this work, to enable informed and effective decisions to be taken regarding the future use of the facility, will remain a priority until addressed.	The Board may not be able to take a fully informed decision based on proposals for use of the facility.
Recommendation 1	**Priority level**
The future use / case for change for the Lakeside Wing will be subject to the formal business case approval process (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Accepted. The Management Executive has agreed principles to guide potential future use of the facility, with a number of priorities identified. This has been shared with Welsh Government officials and further discussions are due to take place imminently. Business cases will be developed to secure the necessary support and investment for future use.	Executive Director of Planning Ongoing

Finding 4: Project Governance	Risk
Standard project governance best practice, as typically applied at the UHB, sees the role of Project Director assigned to a single individual, to oversee and coordinate project activities. The Project Director should be a single point of responsibility at the project, to ensure clear lines of communication and effective decision making. At this project, two Project Directors were assigned, to separately oversee the construction and operational workstreams – coming together at the Project Board to report directly to the SRO. The benefits, or otherwise, of this approach (together with any other deviation from standard UHB project governance arrangements) which contributed to the successful project delivery, should be reviewed at a post-project evaluation exercise.	Absence of a clear single point of decision making may delay project progression. Lack of central coordination may result in lack of clarity over project processes.
Recommendation 2	**Priority level**
A post project evaluation exercise should consider any innovative project governance / management arrangements applied and their potential application at future UHB capital projects (**O**)	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed. A post project evaluation will be undertaken to identify any areas of good practice which may be applied at future UHB projects.	Executive Director of Planning (Senior Responsible Officer) At the post-project evaluation

Finding 5: Governance – Project Management Logs	Risk
The project was supported by two dedicated Project Managers (see **finding 4**) operating a Programme Management Office (PMO) to *"ensure workstream connectivity and coordination of actions and decisions"*. Central Actions and Decisions Logs were maintained, to record and monitor activities across the workstreams. Action logs were also maintained from the daily construction workstream briefings, with records up to date at the time of audit review. However, the Project Manager confirmed that the central records were incomplete at the time of audit review, and required updating from the communication trail held within the Project Manager's email account / notes from meetings attended. Recognising the pace at which this project is moving, and the number of personnel involved, central record keeping should be managed in a timely manner. This would also facilitate handover of project management activities should this be required (i.e. status of activities should not be reliant on an individual's email communication trail or personal recollection of matters awaiting recording).	Potential failure to complete key activities to deadline – risking achievement of project objectives. Potential loss of key information if project management roles are transferred. Inability to provide accurate project status information. Incomplete audit trail of decisions taken.
Recommendation 3	**Priority level**
Recognising the near-completion of this project, the Actions and Decisions Logs should be updated to provide a clear audit trail of project decisions, for retrospective scrutiny where necessary (**O**)	**Medium**

Management Response	Responsible Officer/ Deadline
Actioned since fieldwork	Project Manager N/A

Finding 6: Governance – Risk Management	Risk
A project risk register had been prepared by the UHB, which was observed to be reviewed and updated as a standing agenda item at the weekly Project Board meetings. Management confirmed the register also received daily attention at the Construction workstream briefings. A construction risk register was also in place, prepared by the main contractor. However, neither the project or construction risks had been costed. Whilst recognising that at the time of the audit fieldwork, a positive forecast balance of contingency was reported (£462,461 remaining from total budgeted of £1,318,624, as at November 2020), the costing of appropriate project risks would aid assessment and scrutiny of the sufficiency of available contingency funds. It is acknowledged that the time pressures at this project did not allow for a detailed risk assessment workshop (including assignment of costs) to take place. However, management advised that key risks were discussed at the daily project meetings.	The potential financial impact of project risks may not be accurately determined. The potential financial impact of identified project risks may not be sufficiently taking into account when managing project contingency funds.
Recommendation 4	**Priority level**
The UHB's project and construction risk registers should be costed where appropriate (**O**).	**Medium**

Management Response	Responsible Officer/ Deadline
Accepted. Project and construction risk registers will be costed.	Director of Capital, Estates & Facilities At future schemes

Finding 7: Appointments & Contracting – Local Framework	Risk
The enabling works contractor was appointed from the UHB's Local Framework. A requisition request was raised prior to commencement of works on site, and appropriately signed by the UHB Chair and Directors in line with its value (£1.107m). However, the Framework call-off agreement was not fully executed until approximately three months later in mid-December 2020, by which time the works were complete. It is recognised that the UHB would be afforded some additional protections by the overarching Local Framework arrangements, and it is also acknowledged the speed with which these works needed to progress. However, it should be ensured that call-off agreements are executed as soon as possible, to ensure the UHB is afforded their full protection.	The UHB may not be afforded the full protection of a formal contract.
Recommendation 5	**Priority level**
At future schemes: Framework call-off agreements should be executed in a reasonable time frame (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Accepted. The UHB will endeavour to ensure all framework contract agreements and contracts are addressed in a timely manner.	Director of Capital, Estates & Facilities At future schemes

Finding 8: Appointments & Contracting – Advisers	Risk
The UHB appointed its external cost adviser from the SBS consultancy services framework. The adviser was selected primarily to provide continuity following their role at the Dragon's Heart Hospital project; but also recognised their particular expertise in the management of the design and build contract utilised at this project. The Service Level Agreement (SLA) had been signed by both parties, however not until after adviser duties had commenced. The pace of the project is recognised when considering the timeliness of contractual arrangements; and a recommendation has not been made. However, the dates recorded at the SLA are incorrect noting that the expiry date has been recorded as 31 July 2020 (whereas additional information in the SLA states duties will be required until February 2022). In mitigation, however, the SLA does state: "*Unless otherwise agreed by both parties, this SLA will remain in force until the expiry date agreed above. If no extension/renewal is agreed and the customer continues to access the supplier's services, the terms of this agreement shall apply on a rolling basis until the overarching Framework expiry date.*"	The UHB may not be afforded the full protection intended by a contractual document.
Recommendation 6	**Priority level**
At future schemes: Engagement dates should be accurately recorded at contractual documents (**O**)	**Low**

Management Response	Responsible Officer/ Deadline
Accepted. Correct engagement dates will be recorded in all instances and effectively quality assured before issue.	Director of Capital, Estates & Facilities At future schemes

Welsh Government Integrated Assurance Hub

Critical Friend Report recommendations (November 2020)

	Recommendation
1.	Clearly identify the capital and revenue costs of the preferred option and the supporting analysis. Set out clearly the objectives and outcomes for the surge capacity project, monetise the associated benefits and risks and establish clear benefits realisation plans
2.	Clearly set out the governance and evidence base for the two key decisions: one for the decision to vacate DHH, based on cost avoidance and other factors compared to short term alternatives; and the second that an investment in a new 400 bed modular surge capacity project was the right option.
3.	Confirm best value through benchmarking preferred suppliers price per square metre.
4.	Set out a clear record of the formal Board decisions and evidence base used for approving the different stages and aspects, including the construction method and site selection for the surge capacity project and the vacating of DHH.
5.	Once the modular surge facility is complete, update the project risk register and consider which risks require escalation for Corporate and Board consideration.

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 has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area 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

Compliance with the Nurse Staffing Levels Act (Wales) 2016

Final Internal Audit Report

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	CVU-2021-17
Report status:	Final Internal Audit Report
Fieldwork commencement:	6 October 2020
Fieldwork completion:	14 December 2020
Draft report issued:	17 December 2020
Management response received:	25 February 2021
Final report issued:	26 February 2021
Auditor/s:	Lucy Jugessur, Internal Audit Manager Ian Virgill, Head of Internal Audit
Executive sign off:	Ruth Walker, Executive Nurse Director
Distribution:	Jason Roberts, Deputy Executive Nurse Director Carys Fox, Director of Nursing Strategic Nursing Workforce Lisa Evans, Nurse Resourcing Programme 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 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 compliance with the Nurse Staffing Levels Act was completed in line with the 2020/21 Internal Audit Plan for Cardiff & Vale University Health Board (the 'Health Board').

The Nursing Staffing Levels (Wales) Act 2016 (the 'Act') became law in Wales in March 2018. The Act introduced a duty for Local Health Boards and NHS Trusts in Wales to calculate and take all reasonable steps to maintain nurse staffing levels and inform patients of the level.

The nurse staffing level is the number of registered nurses appropriate to provide care to patients that meets all reasonable requirements in the relevant situation. The duty to calculate nurse staffing levels currently applies to adult acute medical inpatient wards and adult acute surgical inpatient wards.

A previous Internal Audit review of Ward Nurse Staffing Levels was completed in April 2019 and provided a rating of Substantial Assurance. That audit focused on the processes for calculating, approving and reporting the ward staffing levels.

In March 2020 the Chief Nursing Officer (CNO) issued a letter clarifying the expectations and responsibilities relating to compliance with the Act during the Covid-19 pandemic. The current audit therefore included a review of the Health Board's compliance with those requirements during the pandemic.

The relevant lead for the review is 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 Nurse Staffing Levels. 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:

- Nurse staffing levels are appropriately calculated for adult acute medical and surgical inpatient wards within the Health Board and these levels are periodically reviewed (at least every six months) in accordance with the requirements of the Act, including any adjusted requirements during the Covid-19 pandemic;
- Effective processes are in place to recruit ward nurses to the Health Board;
- Effective processes are in place to retain ward nurses within the Health Board to ensure that appropriate nurse staffing levels at ward level are maintained;

- Effective processes are in place for monitoring and reporting on compliance with the ward nurse staffing levels; and
- Follow up of actions raised during the 2018/19 review of the Nurse Staffing levels (Wales) Act.

3. Associated Risks

The potential risks considered in the review were as follows:

- Lack of awareness of the requirements in the Act;
- Harm to patients due to inadequate nurse staffing levels;
- Non-compliance with the requirements of the Nurse Staffing Levels (Wales) Act; and
- Previously raised recommendations have not been actioned.

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 established controls within the Ward Nurse Staffing Levels Act is **Substantial assurance**.

RATING	INDICATOR	DEFINITION
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.

The Health Board's processes for calculating and monitoring nurse staffing levels and ensuring compliance with the requirements of the Act have been significantly impacted by the Covid-19 pandemic.

The CNO issued a letter to all Health Boards/Trusts in March 20 confirming what was required in relation to the Nurse Staffing (Wales) Act during the pandemic. The letter allowed Health Boards/Trusts the flexibility to decide when to undertake the annual calculation of nurse staffing levels on adult acute medical and surgical wards and whether to present their annual report to the Board as planned in May 2020. The Health Board therefore produced the annual report for the September 2020 Board.

It was identified that the Health Board has developed a process during Covid-19 whereby they monitor the Nurse staffing levels through a Summary of Required Establishments on Wards during Covid-19 Pandemic report. This confirms the adjusted establishments during covid-19 and the previous establishments. The report is updated as required and comments are included to ensure that all the information is correct. However, it was evidenced that the establishment levels recorded within Rosterpro and the Finance reports do not align with the report.

Nurse staffing levels reports have been taken to the Board meetings in May, July and September and the adjusted establishment levels have been formally approved. The Nurse Staffing Levels for Adult Acute Medical and Surgical Wards following the Bi-annual Calculation report was taken to the November Board.

The Health Board have a number of processes in place for nurse recruitment including social media such as Linked In, Facebook and Twitter, International recruitment, local adaption programme and Students. The International recruitment process successfully recruited 67 nurses for a number of areas and they are now hoping to recruit a further 75 staff.

The Health Board has established a Nurse Retention Task and Finish Group in place to ensure that both new and existing staff are supported and encouraged to remain within the Health Board. A draft programme has been produced for this but has not been updated due to covid-19 plus meetings have been unable to happen.

The current assurance rating reflects the fact that the Health Board has put in place robust processes to monitor and report nurse staffing levels during the pandemic and has appropriately followed the guidance received from the CNO in relation to adjustments to the requirements of the Nurse Staffing Levels Act.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Staffing levels			✓	
2	Recruitment Process				✓
3	Retention of ward nurses			✓	
4	Monitoring and reporting compliance levels				✓
5	Follow up previous actions				✓

** 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 that are classified as weaknesses in the system control/design for Ward Nurse Staffing Levels Act.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for Nurse Staffing Levels Act.

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: Nurse staffing levels are appropriately calculated for adult acute medical and surgical inpatient wards within the Health Board and these levels are periodically reviewed (at least every six months) in accordance with the requirements of the Act, including any adjusted requirements during the Covid-19 pandemic

We note the following areas of good practice:

- Due to Covid-19 it was agreed that the nurse staffing levels needed to be reviewed on a regular basis to ensure that Management were aware of the number of nurses on each ward and also any changes that were being made to numbers on the ward. A Summary of Required Establishments on Wards during Covid-19 Pandemic report was produced detailing establishments during covid-19 and previous establishments and any comments reporting the date when the purpose of the ward changed and the rationale.
- The bi-annual acuity review was undertaken in January 2020, however, the Health Board was prevented from completing the process at that time due to Covid.
- The next bi-annual acuity review was undertaken in July 2020 and the results were taken to the Board meeting in November.

We identified the following finding:

- We reviewed the Summary of Required Establishments on Wards during Covid-19 Pandemic report presented to the September 2020 Board against the Summary of Nurse Staffing Levels, Finance reports and the establishments on rosterpro for five wards within Medicine, Specialist Services and Surgery and there were a number of differences identified.

The following issue is also noted:

- The scope of the current audit focused on those wards under section 25B of the Act. However it should be noted that the Health Board is not currently fully compliant with Section 25A in relation to a number of wards within Mental Health. This issue has been fully reported to the Board and is detailed within the Annual Nurse Staffing Levels report that went to the September Board meeting.

Objective 2: Effective processes are in place to recruit ward nurses to the Health Board

We note the following areas of good practice:

- We were able to evidence that there were a number of processes and initiatives in place to recruit ward nurses within the Health Board. These include social media such as Linked in, Facebook and Twitter, international recruitment, local adaption programme and students. The Health Board have successfully recruited 170 students from the student scheme and 48 nurses from recruitment events that have been undertaken.
- International recruitment has been occurring within this year and 67 nurses were recruited within Medicine (20), Surgical (20), Critical Care (20) and seven Major Trauma Nurses. The Health Board is in the process of trying to recruit a further 75 Nurses to cover critical care, neurosurgery, peri-operative, surgery, emergency medicine and medicine. This further recruitment is for outstanding vacancies within the Clinical Boards.
- Within the Health Board there is a Nursing and Midwifery Preceptorship programme in place which provides essential training and support for newly registered nurses, midwives and ODPs and covers the first 12 months post registration to provide them with ongoing support to assist with retention.

We did not identify any findings under this objective.

Objective 3: Effective processes are in place to retain ward nurses within the Health Board to ensure that appropriate nurse staffing levels at ward level are maintained

We note the following area of good practice:

- There is a Nurse Retention Task and Finish Group in place within the Health Board and they have produced a draft Nurse Retention - Programme of Work for December 2019 - November 2020 to ensure that both new and existing staff are supported and encouraged to remain within the Health Board.
- There is a Development and Career Planning workstream in place within the Nurse Retention - Programme of Work and one of the processes that has been agreed is internal transfers within the Health Board. This process has been developed to enable employees to move to different roles within the Health Board to try and maintain staff within the Health Board.

We identified the following finding:

- The draft Nurse Retention - Programme of Work for December 2019 - November 2020 includes a number of objectives and actions under each of the work streams. There were sections for Leads, timescales, success

criteria and RAG but these had not been completed. We were advised that a meeting had been held in February 2020 prior to the pandemic and they are due to meet again to take forward the programme.

Objective 4: Effective processes are in place for monitoring and reporting on compliance with the ward nurse staffing levels

We note the following area of good practice:

- It was evident that compliance with the nurse staffing levels is monitored on a regular basis by the Board as the Executive Nurse Director has taken Nurse Staffing Levels update reports to the Board meetings for May, July, September and November. As part of the reports to the Board a Summary of Required Establishments on Wards during Covid-19 Pandemic was taken detailing the wards establishment during Covid-19 and previous establishment.
- An Annual Assurance Report on Compliance with the Nurse Staffing Levels Wales Act was presented to the Board at its September Meeting.
- The Nurse Staffing Levels for Adult Acute Medical and Surgical Wards following the Bi-Annual Calculation report was presented to the November meeting of the Board. The report summarised the calculated nurse staffing levels for all adult in-patient medical and surgical wards covering the period November 19 to October 20. The Board formally approved the calculated levels.
- At the operational hub the Director of Operations and or Director of Nursing have a number of meetings a day to discuss the hospitals and one of the areas they consider is nurse staffing levels.

We did not identify any findings under this objective.

Objective: Follow up of actions raised during the 2018/19 review of the Nurse Staffing levels (Wales) Act

The following areas of good practice were noted:

- It was evidenced that the majority of follow up actions raised during the 2018/19 review had been actioned. However, there were still issues with the financial reports not aligning with the establishment levels and a new recommendation has been made.

We did not identify any findings under this objective, although the following was noted:

- We could not carry out any testing to evidence whether the staffing levels were being displayed correctly on the wards due to covid-19 restrictions.

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 - Differences in establishment levels (Operating effectiveness)	Risk
An Annual Assurance Report on Compliance with the Nurse Staffing Levels Act was submitted to the September Board meeting. The report included an appendix titled 'Summary of Nurse Staffing Levels' which detailed the number of wards where Section 25(B) applied and the calculated nurse staffing levels for each ward. The report also included a second appendix titled 'Summary of Required Establishments on Ward During Covid-19 Pandemic'. This was produced so that there was one document that evidenced the nursing levels throughout the pandemic. We reviewed these 2 appendices to establish if the nurse staffing levels figures being reported within each reconciled. In addition, the establishment levels on Rosterpro and the Finance reports were checked to establish if they were consistent with the recorded nurse staffing levels. We conducted this review for a sample of wards and there were a number of areas whereby the figures corresponded. However, the following differences were identified within the testing: **Specialist Services** • B1 Ward - The required establishment levels recorded in Rosterpro were 22.44 WTE qualified Nurses and 8.32 WTE HCSW. This was inconsistent with the nurse staffing levels recorded on the 2 appendices and also within the finance report for month 6, all of which recorded levels of 29.89 WTE qualified Nurses and 10.56 WTE HCSW.	Lack of awareness of the requirements in the Act

Medicine • B7 ward – The Summary of Required Establishments on the Ward during Covid-19 Pandemic were consistent with the finance report for month 7. However, the figures did not reconcile with the Summary of Nurse Staffing Levels or Rosterpro. • East 4 - The Summary of Required Establishments on Ward during the Covid-19 Pandemic reported 20.9 WTE qualified Nurses and 17.06 WTE HCSW which was consistent with the Finance report. There was a small difference in the Summary for Nurse Staffing Levels which reported 19.89 WTE qualified Nurses. The required establishment levels in Rosterpro were 16.68 WTE qualified Nurses 13.34 WTE HCSW, which was inconsistent with both of the appendices. **Surgical** • Duthie - The Summary of Required Establishments on Ward during Covid-19 Pandemic reported 22.93 WTE qualified Nurses and 11.37 WTE HCSW. The previous establishment was different at 16.48 WTE qualified Nurses WTE and 8.54 WTE HCSW. There was a note on the report confirming that pre-Covid it was an 18 bedded ward but due to Covid it increased to a 24 bedded ward. This did not however reconcile with the Summary of Nurse Staffing Levels report which stated no qualified Nurses and no HCSW. The required establishment levels in Rosterpro confirmed 12.2 WTE qualified Nurses and 6.72 WTE HCSW which was inconsistent with the Summary of Required Establishments on the Ward during covid-19 Pandemic.	

We also reviewed the Nurse staffing levels that were recorded within the Finance reports and we were advised that for the Surgical wards, at the same time as the Nursing standards assessment, a review had been commissioned to better align activity to bed demand as often the beds were not full. The Clinical Board chose not to update the financial ledger until that review was complete as the full level of establishment was not required or affordable. That review has not been finalised due to the impact of Covid-19, but the intentions remain the same. • West 5 – The recorded nurse levels within the 2 appendices reconciled at 9.58 WTE qualified Nurses and 20.9 WTE HCSW. However, the figures recorded in Rosterpro (15.68 WTE qualified Nurses and 7.72 WTE HCSW) and Finance (18.05 WTE qualified Nurses and 12.79 WTE HCSW) did not reconcile.	
Recommendation	**Priority level**
It is acknowledged that the Summary of Required Establishments on Ward during Covid-19 Pandemic report has been utilised to inform ward staffing levels during the pandemic. However, management will need to ensure that following the pandemic all reports and systems recording nurse staffing and establishment levels are correct and consistent.	**Medium**
Management Response	**Responsible Officer/ Deadline**
COVID-19 pandemic created unprecedented demand on the Nursing resource through 2020-21. There is a clear awareness that the described documents do not entirely correspond due to the evolving staffing situation that was required to meet the increasing demand. A decision was made to step down the normal	Jason Roberts - Deputy Executive Nurse Director / Dependent on Covid situation

reporting process aligned to the Nurse Staffing (Wales) Act and this was reported to Board in November 2020. In order to provide assurance to Board, Cardiff and Vale has been undertaking a monthly internal tracking system to monitor nurse staffing. It is anticipated that the normal reporting schedule for 2021 will return as COVID situation settles.	

Finding 2 - Retention of staff (Operating effectiveness)	Risk
There is a Nurse Retention Task and Finish Group in place within the Health Board and they have produced a draft Nurse Retention - Programme of Work for December 2019 - November 2020 to ensure that both new and existing staff are supported and encouraged to remain within the Health Board. The programme of work was to be used to develop the retention strategy. We could evidence that work had been undertaken on the programme as under each workstream there were a number of objectives and actions. However, there were also sections for Leads, timescales, success criteria and RAG ratings, but these had not been completed. We were advised that a meeting had been held in February 2020 prior to the pandemic and the Group are due to meet again to take forward the programme.	Harm to patients due to inadequate nurse staffing levels
Recommendation	**Priority level**
Management should ensure that the Nurse Retention Task and Finish Group start to meet again and update the work programme for Nurse Retention. Following the update of the work programme the Health Board can produce a Retention Strategy for Nursing.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Whilst the meeting schedule through 2020 was stepped down, the focus of recruitment and retention of nurses to Cardiff and Vale continued. A revised and energised focus was provided through the 2020 COVID pandemic with the	Jason Roberts - Deputy Executive Nurse Director / Dependent on Covid situation

redeployment at Director of Nursing level to support this agenda. It is anticipated that the meeting schedule will return to normal as COVID period reduces.	

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.

Claims Reimbursement

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Review reference:	CVU2021.04
Report status:	Final Internal Audit Report
Fieldwork commencement:	22nd January 2021
Fieldwork completion:	15th March 2021
Draft report issued:	16th March 2021
Management responses received:	18th March 2021
Final report issued:	19th March 2021
Auditors:	Stuart Bodman, Cara Vernon
Executive sign off:	Ruth Walker, Executive Nurse Director
Distribution:	Angela Hughes, Assistant Director of Patient Experience Suzanne Wicks, Head of Clinical Negligence Claims & Inquests Vicky Stuart, Head of Concerns & Claims
Committee:	Audit and Risk Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the 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 Welsh Risk Pool concerns and compensation claims has been completed in line with the 2020/21 Internal Audit plan for Cardiff and Vale University Health Board (the 'Health Board').

Compensation claims usually take a number of years from receipt of claim to settlement and can involve a large number of payments and repayments; this gives rise to a potential for mistakes to occur. Welsh Risk Pool Services (WRP) requires that claims for reimbursement and repayment are made within specific timescales.

WRP have developed a standard: The Compensation Claims Management Standard, to ensure that NHS bodies:

- Have an effective process for managing concerns raised by patients and staff.
- Have an effective process for managing legal claims for financial compensation.
- Ensure that there is good organisational learning from all events.

Reimbursement of settled claims are either under NHS indemnity, or from April 2018, redress cases.

Area for Assessment 3 of the standard requires Internal Audit to review the accuracy of a representative sample of compensation claims for reimbursement, made on Welsh Risk Pool Services.

Compensation claims for reimbursement include concerns involving a qualifying liability in tort (a civil wrong that causes a claimant to suffer loss or harm) resolved by the settlement of damages to a *maximum of £25,000 under redress* in addition to concerns and *claims for negligence exceeding £25,000 and formal claims for negligence below £25,000* resolved in accordance with the relevant pre-action protocols and civil procedure rules.

The relevant lead Executive Director for this review is the Executive Nurse Director.

2. Scope and Objectives

The objective of this audit was to provide assurance to the Health Board's Audit and Risk Committee that the correct process is being followed and that claims are accurate.

The purpose of the review was to provide assurance to the Audit and Risk Committee that the claims reimbursement process is in compliance with the Welsh Risk Pool Standard.

The objectives of the review are to provide assurance that:

- An appropriately completed learning from events report, case management report, case financial record and a schedule of costs has been completed for each reimbursement claim within set timescales;

- There is appropriate evidence to support the costs incurred;
- Forms have been appropriately authorised aligning with delegated limits within the organisation; and
- Claims submitted are accurately entered onto the Datix risk management database.

3. Associated Risks

The potential risk considered in this review is that claims costs reimbursed from the Welsh Risk Pool are inaccurately recorded and not appropriately authorised by the Health Board's senior management.

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 the Claims Reimbursement is **Substantial assurance**.

RATING	INDICATOR	DEFINITION
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.

We tested 25 claims that had been paid in 2020/21 up to the date of our fieldwork. The claims covered clinical negligence, personal injury and redress. Our testing confirmed that the required Learning From Events Report (LFER), Case Management Report (CMR), Case Finance Record (Checklist U1/2) and the Losses and Special Payments Register (LASPAR) were in place, and documentation was in place to support the costs incurred.

In 2019 the WRP updated their standards and included the requirement that for cases submitted after 1 October 2019, LFERs had to be submitted within 60-days of the decision to settle the case. As the claims in our sample

had been submitted prior to October 2019, the 60-day timeframe requirement was not applicable.

Our testing confirmed that all claims had been appropriately authorised and there is appropriate evidence to support the costs incurred.

However, we identified a small number of issues that require management attention, such as the current process in which forms are completed initially by Claims and finalised by Finance.

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	Learning from Events, Case Management Report, Case Financial Record				✓
2	Evidence to support the costs incurred				✓
3	Appropriate authorisation of forms.				✓
4	Claims submitted are accurately entered onto Datix			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review did not identify any issues classified as weaknesses in the system control/design for Claims Reimbursement.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for Claims Reimbursement.

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: An appropriately completed learning from events report, case management report, case financial record and a schedule of costs has been completed for each reimbursement claim within set timeframes.

We note the following areas of good practice:

- Where applicable, 100% of claims were supported by a Learning From Events Report;
- Where applicable, 100% of claims were supported by a Case Management Report ;
- Where applicable, 100% of claims were supported by a Checklist (U1/2); and
- Where applicable, 100% of claims were supported by a LASPAR form.

We identified the following findings:

- 5/25 claims were not submitted within the required 4-month time frame. It is appreciated that COVID-19 will have had an impact on this. In 2 cases (both redress) time frames could not be determined as relevant information had not been recorded on the Case Management Report; and

  1 Clinical Negligence Case Management Report did not specify date of costs settled.

Objective 2: There is appropriate evidence to support the costs incurred.

We note the following area of good practice:

- All of the claims sampled across clinical negligence, personal injury and redress categories were found to have appropriate source documentation in place to support the costs incurred.

We did not identify any findings under this objective.

Objective 3: Forms have been appropriately authorised aligning with delegated limits within the organisation.

We note the following area of good practice:

- All of the claims we sampled across the clinical negligence, personal injury and redress categories were found to have been appropriately authorised.

We did not identify any findings under this objective.

Objective 4: Claims submitted are accurately entered onto the Datix risk management database.

We note the following areas of good practice:

- Welsh Risk Pool reimbursements are not routinely recorded on Datix, however, proof of transfer from Welsh Risk Pool could be provided for all sampled claims.

We identified the following findings:

- A sample of 25 claims across Clinical Negligence, Personal Injury and Redress had financial documentation in place that reconciled to the amount Welsh Risk Pool had reimbursed. However, this was only in relation to Checklist U1/2s as some discrepancies were noted between monetary values recorded on LASPARs in Datix and Welsh Risk Pool reimbursements

  Further to the above, the current process in which forms are completed initially by Claims and finalised by Finance, results in duplication of effort and differing information between what is held in Datix and what is submitted to Welsh Risk Pool.

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**	**1**	**1**	**2**

Finding 1 - Central Repository for Claims Reimbursement Documentation (Control design)	Risk
During testing of Redress claims it was found that there was no LASPAR documentation held on Datix. When queried at the time, it was advised that LASPAR documentation is not used. This was queried again at a later date for reporting purposes as LASPAR documentation is completed for Clinical Negligence and Personal Injury claims. Finance advised that LASPAR reference numbers are used, however, no explanation as to LASPAR documentation could be provided. Across Redress and Clinical Negligence Claims, discrepancies were identified between monetary values recorded on Checklist U1/2s and LASPAR documentation and Welsh Risk Pool reimbursements to the Health Board. Through conversations with the Claims Team, it was identified that claims documentation is completed by themselves, uploaded to Datix and then passed to Finance for completion. Upon completion, this documentation is submitted to Welsh Risk Pool, but not uploaded to Datix. Therefore, this process results in duplication of effort and differing information between what is held in Datix and what is submitted to Welsh Risk Pool. In these instances, a full email trail was not evident.	Claims costs reimbursed from the Welsh Risk Pool are inaccurately recorded and not appropriately authorised by the Health Board's senior management.

Recommendation	Priority level
The Claims Team should look into streamlining the current process and fully utilising Datix to retain all documentation submitted to Welsh Risk Pool. This will ensure a full audit trail is retained, and information is readily accessible to all staff involved in the claims reimbursement process.	**Medium**
Management Response	**Responsible Officer/ Deadline**
From April 1st 2021 as part of the RL datix system there is a redress system which will enable all documentation to be stored in the central stem.	Redress Manager from 1/4/21

Finding 2 - Case Management Report Time Frame (Operating effectiveness)	Risk
Under the revised WRP guidance issued in 2019, Claims Management teams are to complete a Case Management Report within 4 months of the final payment date which is the date that costs were settled. Our audit tested 25 claims across Clinical Negligence, Personal Injury and Redress. In total, across the three claim types: • 5 had not been completed within the 4 month time-frame • 2 it could not be determined if the time-frame had been achieved as relevant information had not been recorded on the Case Management Report • 1 Clinical Negligence Case Management Report did not specify date of costs settled We have been advised by management that the restraints imposed by the COVID-19 pandemic, had an impact on the Claims team being able to achieve the required deadlines.	Claims are not paid or only partly paid where reimbursement requests and associated paperwork is not submitted to the WRP in line with set timeframes.

Recommendation	Priority level
It is acknowledged that while COVID restraints would have impacted the timeliness in which Case Management Reports were submitted, every effort should be made to ensure claims are submitted within required timeframes. For each claim, all applicable fields within DATIX should be completed, thus allowing monitoring of adherence to timescales to take place.	**Low**
Management Response	**Responsible Officer/ Deadline**
Timescales are monitored and adhered to where possible –CMR 's are monitored and will be a focus for completion in a timely manner via a dashboard and regular meetings.	Head of Concerns and Claims- by 21 May dashboard and meetings established.

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 & Vale University Health Board

Charitable Funds

Final Internal Audit Report

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	CVU-2021-14
Report status:	Final Internal Audit Report
Fieldwork commencement:	26th November 2020
Fieldwork completion:	26th February 2021
Draft report issued:	9th March 2021
Management response received:	11th March 2021
Final report issued:	11th March 2021
Auditor/s:	Jayne Gibbon, Audit Manager
	Cara Vernon, Internal Auditor
Executive sign off:	Catherine Phillips, Executive Director of Finance
Distribution:	Christopher Lewis, Deputy Director of Finance
	Alun Williams, Head of Financial Services
	Simone Joslyn, Head of Arts and Health Charity
Committee:	Audit Committee

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ACKNOWLEDGEMENT
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1. Introduction and Background

The review of Charitable Funds was completed in line with the 2020/21 Internal Audit plan for Cardiff and Vale University Health Board.

The Cardiff and Vale University Health Board General Purpose Charitable Fund is a registered charity that is governed by the Trust Deed. Under the terms of this deed the Charitable Fund is administered by the Trustees, with the Cardiff and Vale University Health Board as a body corporate. The fund is an umbrella charity with a number of subsidiary charities registered therein and also managed by the Health Board.

During the Covid-19 pandemic the Cardiff and Vale Health Charity has received a significant volume of donations specifically linked to Covid-19. These have come from the following sources:

- 'Make it Better Fund' and the Health Charity's #Spreadthelove campaign;
- NHS Charities Together; and
- Gareth Bale Family Donation.

The relevant lead Executive for this review is the Executive Director of Finance.

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 Health Board for the management of the Charitable Funds, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The purpose of the review was to establish if the Health Board has appropriate processes in place to ensure that the Charitable Funds are appropriately managed and administered in accordance with relevant legislation and Charity Commission guidance.

The areas that the review sought to provide assurance on were:

- Up to date policies and procedures are in place for the management of the charitable funds;
- All Covid-19 donations and expenditure is appropriate and accounted for in compliance with approved Health Board guidance; and
- Effective governance arrangements are in place for dormant funds.

3. Associated Risks

The potential risks considered in this review were as follows:

- Charitable funds income may be incorrectly recorded and /or accounted for;

- Charitable funds expenditure may be inappropriate, excessive or may be incorrectly recorded; and
- Non-compliance with legislation and Charity Commission guidelines.

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 established controls within the Charitable Funds is **Substantial Assurance**.

RATING	INDICATOR	DEFINITION
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.

Overall, the controls in place for the management of dormant funds and Covid related expenditure were of a high standard.

The majority of fundholders of funds classified as dormant have now provided appropriate plans to utilise their funds. Where responses have not been received, the Trustees have agreed that funds should be transferred to a general reserve, although this action had not been completed at the time of audit. The Charitable Funds Financial Control Procedure has been updated and includes a specific section for the ongoing management of dormant funds.

There was a robust process agreed and put in place for the management of expenditure applications against Covid monies received.

Some minor weaknesses concerning record keeping and incomplete documentation were identified as part of the testing undertaken on the Covid Expenditure element of the audit.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Up to date policy and procedures are in place for the appropriate management of the charitable funds				✓
2	All Covid 19 donations and expenditure is appropriate and accounted for in compliance with approved Health Board guidance				✓
3	Effective Governance arrangements are in place for dormant funds				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review has highlighted one issue that is classified as a weakness in the system control/design for Charitable Funds.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for Charitable Funds.

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: Up to date policies and procedures are in place for the appropriate management of the charitable funds.

We note the following areas of good practice:

- There is an up to date Financial Control Procedure (FCP) in place for the management of Charitable Funds;
- The FCP provides guidance on the types of recognised funds, statutory responsibilities in relation to charitable funds, expenditure authorisation and control and fund management;
- The FCP has also been updated to reflect the changes in the management of dormant funds as agreed by the Charitable Funds Committee and Trustees; and
- Due to urgency of the situation the Charitable Funds Committee agreed that the process for the application and approval for all Covid related expenditure would mirror that of the Staff Lottery, noting that new Covid Specific Forms would be introduced.

No significant issues were identified for this objective.

Objective 2: All Covid 19 donations and expenditure is appropriate and accounted for in compliance with approved Health Board guidance.

We note the following areas of good practice:

- The Charitable Funds Committee received updates on all Covid related income as well as any food/gifts items received by the Health Board.
- New funds were set up for the significant monetary donations received.
- Testing undertaken on a sample of covid expenditure transactions to ensure compliance with the process implemented noted the following:
    - All transactions within the sample were supported by an appropriately authorised application form.
    - All applications had been appropriately approved.

We identified the following minor issues:

- When reviewing the application forms as part of our testing it was noted that one of the forms did not include an estimated cost
- It was noted that many Covid 19 income donations were credited to the existing 'Make it Better' fund.

Objective 3: Effective governance arrangements are in place for dormant funds.

We note the following areas of good practice:

- Following the approval by The Charitable Funds Committee and Trustees of the agreed changes regarding dormant funds, all fundholders of funds classified as dormant were written to advising of the change, provided with a copy of the updated Financial Control Procedure and requested to provide a response regarding the expenditure intentions by an agreed timescale.
- It was noted 42 of 69 fundholders (61%) responded with an expenditure proposal for their fund which equated to 76% of the fund balances as at May 2020.
- Our testing on a sample of responses received from dormant fundholders found that expenditure plans were appropriate.

We identified the following minor issue:

- Where no responses have been received from many of the dormant fund holders, at the time of the audit the funds are yet to be 'closed'.

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**	**0**	**3**	**3**

Finding 1 - COVID Application Forms (Operating effectiveness)	Risk
Testing of COVID Expenditure was undertaken to ensure that spends had derived from an approved bid with relevant documentation in place to support that expenditure. One application was found to not detail any cost information which had gone on to be approved. The application forms suggest that cost information should be provided under Section 3. While this has not gone on to cause problems the absence of costs on application bids could result in the bid being approved by the incorrect forum.	Charitable funds income may be incorrectly recorded and or accounted for. Charitable funds expenditure may be inappropriate, excessive or may be incorrectly recorded.
Recommendation	**Priority level**
Management should issue a general communication regarding the completion of application forms reminding staff that estimated costs should be included. In the event that a form is received without any costs it should be returned to the applicant for the information to be added and then resubmitted.	**Low**
Management Response	**Responsible Officer/ Deadline**
Current guidance includes the request for accurate costings and therefore going forward any forms received without appropriate costings will be returned to the applicant.	Simone Joselyn April 2021

Finding 2 - Make It Better Fund (Control design)	Risk
When undertaking the testing on a sample of Covid expenditure transactions, Audit were unable to cross reference some of the invoice/expenditure items to the schedules of approved bids that had been provided by the Head of Arts and Health Charity. Following further investigation, it transpired that one of the funds used to record Covid income, the 'Make it Better' fund, was an already existing Charitable Fund. Audit was advised that donations received by the Health Board with no specific request regarding what monies can be used for would be credited against this account, and monies could be applied for as per the 'normal' charitable fund's guidance. Therefore, a number of the transactions included in the sample would have been bids related to Non-Covid monies. Whilst these donations were received and administered under unprecedented circumstances best practice, to ensure the transparency of donations, would have been to have a separate fund.	Charitable funds income may be incorrectly recorded and or accounted for. Charitable funds expenditure may be inappropriate, excessive or may be incorrectly recorded.
Recommendation	**Priority level**
Should a similar situation arise in the future to ensure transparency of donations and associated expenditure management should ensure that a separate fund is set up.	**Low**

Management Response	**Responsible Officer/ Deadline**
Agreed	Alun Williams April 2021

Finding 3 - Dormant Funds to General Reserves (Operating effectiveness)	Risk
Following the agreed change by the Charitable Funds Committee and Trustees on the management committee for dormant funds, all applicable Fundholders were written to and advised of the change and requested to provide an up to date expenditure plan by 31st October 2020. Expenditure plans were subsequently received from fundholders for 42 of the 69 dormant unrestricted funds. In value this represents £460K of the total £605K dormant unrestricted funds. An update of the position was then presented at the Charitable Funds Trustees meeting held in January 2021. At that meeting it was agreed that those dormant funds for which no responses had been received should be closed and the monies transferred to a general reserve. At the time of the fieldwork this action had not taken place.	Non-compliance with legislation and Charity Commission guidelines.
Recommendation	**Priority level**
Management to ensure that the actions approved at the Charitable Funds Trustees meeting are actioned by the end of the financial year.	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed. Dormant Funds will be closed and monies transferred to General Reserve.	Alun Williams February 2021

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

Tentacle System Follow-Up

Final Internal Audit Report

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	C&V-2021-26
Report status:	Final Internal Audit Report
Fieldwork commencement:	3 March 2021
Fieldwork completion:	11 March 2021
Draft report issued:	16 March 2021
Management response received:	16 March 2021
Final report issued:	18 March 2021
Auditor/s:	Ian Virgil, Martyn Lewis
Executive sign off:	David Thomas, Director of Digital & Health Intelligence
Distribution:	Alyn Coles, Service Improvement Manager (Cancer Services)
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.

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1. Introduction and Background

The follow-up review of the Tentacle System report was completed in line with the Internal Audit Plan.

The Tentacle IT system is an in house developed system which is used for tracking and reporting on cancer patients within the UHB.

The original report was finalised in January 2020 and highlighted nine issues, which resulted in an overall assurance rating of limited assurance.

The relevant lead for the assignment is the Director of Digital & Health Intelligence.

2. Scope and Objectives

The objective of the original review was to evaluate and determine the adequacy of the systems and controls in place for the management of the Tentacle IT System in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of system's objectives are managed appropriately.

The scope of this follow up review **did not** aim to provide assurance against the full scope and objectives of the original audit. The 'follow up review opinion' provides an assurance level against the implementation of the agreed action plan only.

In following up the agreed actions the main areas that the review sought to provide assurance on were:

- An appropriate governance process is in place for the system;
- Appropriate control is maintained over the database.
- All input is authorised, complete, accurate, timely and input once only;
- Proper control is exercised over access to application systems;
- Controls ensure the accuracy, completeness, confidentiality and timeliness of output, reports and interfaces;
- A complete audit trail is maintained which allows an item to be traced from input through to its final resting place;
- Appropriate business continuity arrangements are in place which include backing up copies of data and programs, storing and retaining them securely, and recovering applications in the event of failure;
- The system is fully used and fits within the strategic aims of the organisation.

3. Associated Risks

The potential risks considered in this review were as follows:

- Inappropriate access to system / data.
- Inaccurate data held in system.
- Loss of processing / data.

- The UHB is not maximising the benefits from the system.

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 review did not aim to provide assurance against the full scope and objectives of the original audit. The 'follow-up' 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.

RATING	INDICATOR	DEFINITION
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. **Follow up -** All recommendations implemented and operating as expected.

From discussions with key staff we note that actions were undertaken to mitigate issues identified in the report. Subsequently the use of Tentacle has ceased with the functionality now being delivered from a module within PMS which was developed specifically to replace Tentacle.

Data from after January 1st 2020 has been transferred into the PMS module, with older data being retained within Tentacle to enable historical reporting. Discussions are ongoing over the optimal course of action for enabling reporting, with an upload of all data to PMS along with a partition and archiving as a separate data store within the warehouse being the two options.

We do note however that although the use of the system has ceased, the database is still being held in an open Information folder and as such remains accessible to numerous staff.

The progress made against the original recommendations and subsequent replacement of Tentacle means that the level of assurance that can be given to manage the risks associated with the Tentacle system can now be considered **Substantial Assurance**.

5. Summary of Audit Findings

Follow up work was undertaken to confirm the progress that the Health Board has made against the agreed management responses from the original audit, as detailed within Appendix A.

Priority rating	No of management responses to be implemented	Fully actioned	Partially actioned	Not actioned
High	1	1	0	0
Medium	6	5	0	1
Low	2	2	0	0
Total	**9**	**8**	**0**	**1**

In summary, progress against the nine management responses that required implementation is as follows:

- Actions were undertaken to mitigate issues identified in the report. Subsequently the use of Tentacle has ceased with the functionality now being delivered from a module within PMS which was developed specifically to replace Tentacle.

Finding 1 - Database (Operating effectiveness)	Risk
The system is built on Access databases, with the versions used being 2013 and 2007. Both of these have critical vulnerabilities, in addition access 2007 has come to the end of support and so is unsupported, with no further patches being developed. This increases the risk of unauthorised access and loss of data.	Inappropriate access to system / data.
Recommendation 1	**Priority level**
The database should be updated to the latest, supported version.	**High**
Management Response	**Responsible Officer/ Deadline**
Due to the work ongoing to replace Tentacle, Management do not agree with the recommendation to update the database to the latest version given the fact that a formal project is underway to replace Tentacle within the next 18 months. 1. Whilst not accepting the recommendation to upgrade to the latest version, it is accepted that the database should be on a version that is supported. The data base has recently been updated, therefore, to version 2013 – where the end date of mainstream support is 10/04/2023.	Service Improvement Manager, Cancer Services Completed (Update to version 2013)
Current Position	
Implemented As noted in the response, the database was upgraded to a supported version. Subsequent to this the use of Tentacle has now ceased, with functionality delivered via a PMS module.	

Finding 2 – Change Management (Operating effectiveness)	Risk
There is no formalised structure to changes and developments made to Tentacle and no formal record or sign off of testing or readiness. This is mainly due to the minimal resource available to Tentacle. • Without this in place there is a loss of audit trail and a risk that the change will not deliver the appropriate functionality.	The UHB is not maximising the benefits from the system.
Recommendation 2	**Priority level**
The level of recording of developments and changes to Tentacle should be improved. At a minimum the record should record what change was made, the date of testing, staff involved with UAT and a formal agreement of user acceptance.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. A record is now maintained of changes made. The User Acceptance Testing process will be agreed and added into this record.	Service Improvement Manager, Cancer Services – partially completed with final deadline of 21st February 2020
Current Position	
Implemented As noted in the response, a record of changes was established. Subsequent to this the use of Tentacle has now ceased, with functionality delivered via a PMS module.	

Finding 3 – User Access (Operating effectiveness)	Risk
A review of user access to the system noted the following issues: • a generic user in place (worker); and • from a random check of 20 people 4 have left C&V with 3 still having a NADEX account. This leads to a risk of inappropriate access to information	Inappropriate access to system / data.
Recommendation 3	**Priority level**
The use of generic accounts should be restricted. Staff who have left the UHB should be removed from the system.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Generic Accounts – Generic Accounts for Tentacle are already restricted. They are tied to an individual PC in a controlled room – for MDT purposes. Management agree that staff who have left the UHB should be removed from having access to the Tentacle system.	Service Improvement Manager, Cancer Services – by 21st February 2020
Current Position	
Implemented. As noted above the use of Tentacle has ceased, with functionality now delivered via a PMS module.	

Finding 4 – System Location (Operating effectiveness)	Risk
The system is stored on the UHB network, and is in a folder under the Information Area folder. This area is where information is stored and used for sharing across the UHB. Although Tentacle is in a separate folder it is still accessible by everyone. This means that the system / database and data can be copied / accessed.	Inappropriate access to system / data.
Recommendation	**Priority level**
Tentacle and its associated databases should held in a secure location on UHB network.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Management partially accept this recommendation due to the technicalities of access to Tentacle. Tentacle users need access to the folder where the database is stored to be able to access Tentacle. It is, therefore, not possible to restrict access completely. **It should also be noted that the database is password protected – therefore affording security around inappropriate access to the system.** Given the technicalities, Management will explore whether access to the folder can be limited to Tentacle Users only.	Service Improvement Manager, Cancer Services – by 21st February 2020

Current Position
Not Implemented As noted above the use of Tentacle has ceased. The database still remains within the Information area, and as such the access remains. We note that the database needs to be retained to ensure access to the historical data, however the database should be moved to a secure folder.

Updated Management Response	Updated Responsible Officer / Deadline
The database will be moved to a secure area.	Service Improvement Manager (Cancer Services) June 2021

Finding 5 – Future Compatibility (Control Design)	Risk
The system works best using Access 2007 and is adequate using Access 2013, which most users have. However the current version of Access is Access 2016 and the direction of travel for the UHB is to Office 365. The system does not work with 64 bit versions of office. As such Tentacle may not be compatible with future iterations of office software within the UHB.	Loss of processing / data.
Recommendation	**Priority level**
The future use of office software should be established to ensure Tentacle remains viable until a replacement is developed.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The use of Tentacle will be considered as part of the roll out of updated office software.	Assistant Director of ICT September 2020
Current Position	
Implemented. The use of Tentacle has now ceased. The functionality is now delivered via a PMS module and as such this point is no longer relevant.	

Finding 6 - Imports (Operating effectiveness)	Risk
Data for Tentacle is downloaded from other systems and imported into Tentacle. The upload process is manual and scripts have to be run in the correct order. This process is not set out anywhere in a formal procedure and there are only 2 people who know how to do it, and who have access to the relevant databases. This leads to a risk of the system being out of date in the event of both staff members being absent.	Inaccurate data held in system.
Recommendation	**Priority level**
The process for loading information into Tentacle on a daily basis should be set out in a procedure, together with the required passwords for access. This should be available to key staff in the event of the Tentacle leads being absent.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. A Standard Operating procedure will be developed.	Service Improvement Manager, Cancer Services – by 29th February 2020
Current Position	
Implemented. The use of Tentacle has now ceased. The functionality is now delivered via a PMS module and as such this point is no longer relevant.	

Finding 7 – Import Failures (Operating effectiveness)	Risk
Where items in the download are valid, but the consultant is not known to the system then the item will not be loaded. There is no report of these and the missing data is only identified during use of data / discussion with users. This means that there is risk of incomplete data being used / reported on.	Inaccurate data held in system.
Recommendation	**Priority level**
The load process should be amended to identify items that have not loaded. E.g. by including a batch check against items to load and loaded items in order to identify instances where items have not successfully loaded.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. The process will be amended and Standard Operating procedure will also include the process for error checks.	Service Improvement Manager, Cancer Services – by 29th February 2020
Current Position	
Implemented. The use of Tentacle has now ceased. The functionality is now delivered via a PMS module and as such this point is no longer relevant.	

Finding 8 – System Documentation (Operating effectiveness)	Risk
The system has been developed on an ad hoc basis over time to suit the needs to the organisation, however there is no system documentation. In the event of the system developer leaving the organisation would have to try to establish the systems structure from the beginning. Audit notes that the developer has entered notes into tables and scripts which would assist in this process.	The UHB is not maximising the benefits from the system.
Recommendation	**Priority level**
If the system is to be continued to be used, then system documentation should be developed.	**Low**
Management Response	**Responsible Officer/ Deadline**
The system is being replaced within a planned 18 month timescale. Management do not feel resource should be expended on writing documentation. It should be noted that code within the system has been annotated as a back-up.	Annotation of code - completed
Current Position	
Implemented. The use of Tentacle has now ceased. The functionality is now delivered via a PMS module and as such this point is no longer relevant.	

Finding 9 – User Guides (Operating effectiveness)	Risk
There are no user guides for the system. Audit notes that training is given to all users and the system manager is integrated into the directorate, so staff come and ask if there is a problem. However the lack of guides may mean that staff do not use the system properly.	The UHB is not maximising the benefits from the system.
Recommendation	**Priority level**
Brief user guides should be developed for the system.	**Low**
Management Response	**Responsible Officer/ Deadline**
The system is being replaced within a planned 18 month timescale. Management do not feel resource should be expended on writing a detailed user guide. A brief user guide will be developed for the interim period.	Service Improvement Manager, Cancer Services – by 17th April 2020
Current Position	
Implemented. The use of Tentacle has now ceased. The functionality is now delivered via a PMS module and as such this point is no longer relevant.	

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.

Follow up - All recommendations implemented and operating as expected.

 **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.

Follow up - All high level recommendations implemented and progress on the medium and low level recommendations.

 **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.

Follow up - No high level recommendations implemented but progress on a majority of the medium and low recommendations.

 **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.

Follow up - No action taken to implement recommendations.

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.

Integrated Health Pathways

Final Internal Audit Report

Cardiff and Vale University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	CVU-2021-20
Report status:	Final Internal Audit Report
Fieldwork commencement:	24th September 2020
Fieldwork completion:	4th January 2021
Draft report issued:	11th January 2021
Management response received:	3rd February 2021
Executive sign off received:	24th February 2021
Final report issued:	25th February 2021
Auditors:	Ian Virgill, Stuart Bodman, Cara Vernon
Executive sign off:	Stuart Walker, Executive Medical Director
	Steve Curry, Chief Operating Officer
Distribution:	Ruth Jordan, Head of Improvement and Implementation
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	Patricia Osborne, HealthPathways Project 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 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:

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1. Introduction and Background

A review of Integrated Health Pathways was completed in line with the 2020/21 Internal Audit Plan for Cardiff and Vale University Health Board.

An Integrated Health Pathway is a GP facing single point pathway for access to a database of medical conditions and clinical advice. It forms an online repository of pathways used by clinicians to undertake assessments, manage patients and make specialist referrals.

The relevant lead Executive Directors for this review are the Executive Medical Director and 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 for the management of Integrated Health Pathways, 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 in place for the development, implementation and utilisation of Integrated Health Pathways within GP practices and establish if outcomes from their use are being realised.

The areas that the review sought to provide assurance on were:

- An Integrated Health Pathways Project Group is in place that provides oversight and control of the project objectives;
- A work plan and timescales are in place supported by documentation that outlines the development and implementation of the pathways;
- Procedures and user guides are in place that set out the use of pathways and outline 'troubleshooting' processes. These are supported by appropriate dissemination and ease of user access;
- Identify the current progress with the implementation of the pathways and ascertain the level of utilisation of those pathways that have already been set up;
- Mechanisms are in place to enable user feedback and monitoring of pathway use and effectiveness and record any issues arising; and
- Performance metrics and reporting of effectiveness to Integrated Health Pathways Project Group and IT & Informatics Directorate.

3. Associated Risks

- Delays in GP's accessing appropriate clinical advice in an efficient manner.

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 the Integrated Health Pathways 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.

The Health Board has introduced an online Integrated Health Pathways system known as Community HealthPathways that went live in February 2019. The HealthPathways database is a New Zealand based website provided and hosted by Streamliners NZ Limited.

The introduction and implementation of the HealthPathways database was not subject to a formal project structure or methodology, but its acquisition was undertaken via a formal Service Level Agreement (SLA) with the software provider in respect of user and software management support.

Additionally, the UHB officer responsible for the day-to-day management of the database has no administrative support or cover in the event of extended absence.

It is noted that work plans are in place to enable the ongoing creation and review of clinical pathways on the basis of liaison and feedback provided by GP and Consultant users. Full training was provided to users prior to and post implementation and user support is readily accessible to facilitate any 'troubleshooting' required. However, no online user guides are available in the event that UHB staff cannot be contacted.

Whilst HealthPathways can provide reports that identify clinical pathways frequency of use, there is no means by which the system can identify who accessed the pathways.

Questionnaires sent to GP users identified overall satisfaction with the database and its functionality, but the limited response could not provide a definitive and complete feedback measure.

It is also noted that no performance metrics or reporting of the effectiveness of the HealthPathways database are produced or reported within the organisation.

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	Project Group and Oversight			✓	
2	Workplan and Timescales			✓	
3	Procedures, user guides & dissemination			✓	
4	Implementation and utilisation progress			✓	
5	User feedback and monitoring of Pathway usage		✓		
6	Performance metrics and reporting		✓		

** 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 4 issues that are classified as weaknesses in the system control/design for Integrated Health Pathways.

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 Integrated Health Pathways.

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: An Integrated Health Pathways Project Group is in place that provides oversight and control of the project objectives.

The following findings were noted:

- There was no formal project group and its associated support structures to underpin the inception and use of the HealthPathways system as it is part of an established database and software support company based in New Zealand and was adopted as part of the wider UHB Canterbury inspired Transformation Programme as one of the 'Enablers' and is not a stand-alone, or 'from scratch' system that would warrant a full project implementation approach.
- The HealthPathways Project Lead is the sole person dealing with the database and has no UHB administrative support or appropriate cover during periods of absence or in the event of long-term sickness.

Objective 2: A work plan and timescales are in place supported by documentation that outlines the development and implementation of the pathways.

The following areas of good practice was noted:

- Structured work plans are in use in respect of the creation of new clinical pathways and/or the amendment of existing pathways.

The following finding was noted

- The introduction of the HealthPathways system was never supported by a formally documented work plan and supporting implementation timescales.

Objective 3: Procedures and user guides are in place that set out the use of pathways and outline 'troubleshooting' processes. These are supported by appropriate dissemination and ease of user access.

The following areas of good practice was noted:

- User training was provided to GPs and Consultants prior to and post implementation of the HealthPathways database.
- The HealthPathways database is easily accessible and user support is in place that facilitates 'troubleshooting' and additions/changes to clinical pathways.

The following finding was noted:

- Absence of user guides or online desktop procedures available to GPs and Consultants for the use of the HealthPathways database.

Objective 4: Identify the current progress with the implementation of the pathways and ascertain the level of utilisation of those pathways that have already been set up.

The following area of good practice was noted:

- Reports can be sourced from the HealthPathways database that can identify which clinical pathways are being accessed by clinicians and the frequency of access over a given period of time.

The following findings were noted:

- The HealthPathways database cannot identify individual users logged on and clinical pathways they have accessed.
- Use of HealthPathways is currently optional.

Objective 5: Mechanisms are in place to enable user feedback and monitoring of pathway use and effectiveness and record any issues arising.

The following areas of good practice was noted:

- User feedback is reported to the UHB through the HealthPathways database and there is evidence to show how this is undertaken and actions taken to correct or improve issues raised.
- All Questionnaires returned by GPs indicate satisfaction with the training provided in the use of HealthPathways, the database functionality and the overall worth of the database.

The following finding was noted:

- Frequency of HealthPathways use appears to be irregular but due to the low response rate the answers to the questions cited cannot be viewed as definitive or conclusive.

Objective 6: Performance metrics and reporting of effectiveness to Integrated Health Pathways Project Group and IT & Informatics Directorate.

The following areas of good practice was noted:

- The introduction of or amendment to Clinical pathways within HealthPathways are subject to a formal work plan review.

The following finding was noted:

- No performance metrics or reporting of their effectiveness are retained or reported within the UHB.

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**	**5**	**1**	**6**

Finding 1 - Health Pathways Project Group and Oversight (Control design)	Risk
There was no formal project group and its associated support structures to underpin the inception and use of the HealthPathways system. It is acknowledged that this was partly because the HealthPathways system is part of an established database and software support company based in New Zealand and was adopted as part of the wider UHB Canterbury inspired Transformation Programme as one of the 'Enablers' and is not a stand-alone, or 'from scratch' system that would warrant a full project implementation approach. The purchase and use of the HealthPathways system is subject to and supported by two SLAs through its company 'Streamliners NZ Limited' which includes online, real-time technical support and therefore no hosting or support is required by the UHB IM&T Department. Additionally, there is no documentary evidence of the historical decision making process that underpinned the reasons for the adoption and use of the HealthPathways system or evidence of any other attempts as an organisation to source a similar database potentially at a cheaper cost (e.g. VFM study, tender exercise etc.). It is also noted that the HealthPathways Project Lead is the sole person dealing with the day-to-day local management of the database and has no UHB administrative support, nor is there any appropriate cover for her role other than the GP Clinical Editors who would take over the technical aspect of revisions made to the database should she be away for a period time or during long term sickness.	Delays in GP's accessing appropriate clinical advice in an efficient manner.

Recommendation	Priority level
Any future such projects must be supported by a fully documented project management structure and approach that includes an effective decision making process to justify the reasons for the adoption of the system through a VFM study and subsequent tender exercises in accordance with All Wales Procurement procedures. Additionally, appropriate support should be put in place for the HealthPathways Project Lead that ensures effective cover for their role should they be away for a period of time or during long term sickness.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Future projects from the Transformation Team will be processed according to the recommendation. A joint post between procurement, governance and transformation will be explored. The HealthPathways team will be transferred to the management of the PCIC Clinical Board to support operational stability now that it is 'Business as Usual'.	Ruth Jordan 28/2/21 Ruth Jordan 31/3/21

Finding 2 - Absence of an implementation work plan and timescales (Control design)	Risk
There was never a formally documented work plan and supporting implementation timescales that outlined the development and delivery of the HealthPathways system.	Delays in GP's accessing appropriate clinical advice in an efficient manner.
Recommendation	**Priority level**
Future projects must be supported by a formally documented work plan and implementation timescales that outline the development and implementation of any system.	**Medium**
Management Response	**Responsible Officer/ Deadline**
HealthPathways has an annual documented work plan and timescales and will continue to do so.	Patricia Osborne / complete

Finding 3 - Health Pathways User Guides/Desktop Procedures (Control design)	Risk
There are currently no written user guides or online desktop procedures available to GPs and Consultants for the use of HealthPathways. It is acknowledged that direct face-to-face training was provided to GPS via GP CPET in January 2019 and further updated training relating to newly introduced pathways via a local Royal College of General Practitioners (RCGP) training event in January 2020. Further training on the use and update of new pathways was also provided in March 2020 prior to the COVID-19 lockdown by the Health Pathways Project Lead. However online user guides / desktop procedures would help to ensure that user guidance remains up to date and available to new users of HealthPathways. It is additionally noted that ongoing local management of the database, 'troubleshooting' and subsequent action taken when GPs/Consultants have issues or queries with its use, or pathway content/accuracy is provided by the Health Pathways Project Lead.	Delays in GP's accessing appropriate clinical advice in an efficient manner.
Recommendation	**Priority level**
Written user guides or online desktop procedures should be provided to GPs/Consultants which will further their understanding and use of Health Pathways.	**Low**

Management Response	Responsible Officer/ Deadline
It is noted that whilst there are no written guides to use HealthPathways, the HealthPathways site is very user friendly and has all the help information needed on the main site under this link – How to use HealthPathways https://cardiffandvale.communityhealthpathways.org/72344.htm • A request will be made to Streamliners NZ that this link gets pinned to the homepage of the HealthPathways site for ease of access to GPs/consultants. • Information on using HealthPathways will be given to GPs in all future CPET sessions.	Patricia Osborne / 10.02.21 Maria Dyban / 10.02.21

Finding 4 - Utilisation Reporting (Operating effectiveness)	Risk
Good practice is noted that reports can be sourced from the HealthPathways database that can identify which clinical pathways are being accessed by clinicians and the frequency of access over a given period of time. However, the HealthPathways database has no means of being able to identify who logged on and what specific clinical pathway that any named clinician has accessed. An absence of this type of functionality means that data is not available to confirm regularity or non-use of the database in comparison to other clinical databases in use.	Delays in GP's accessing appropriate clinical advice in an efficient manner.

Currently, the use of HealthPathways is not mandated and as such there is a risk that some clinicians may not be accessing and diagnosing upon current and accurate clinical pathway knowledge.	
Recommendation	**Priority level**
Consideration should be given to requesting from Streamliners NZ Limited a report written into the system that can identify which clinician has accessed what clinical pathway, thereby enhancing functionality and aiding analysis of trends or frequency of use.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Streamliners New Zealand will be contacted to discuss if this functionality is possible. 17.01.21 Response received back from Streamliners New Zealand advising that unfortunately this functionality is not possible due to Data Protection and other factors.	Patricia Osborne / 17.01.21

Finding 5 - User Feedback on HealthPathways (Operating effectiveness)	Risk
Six GP Cluster Leads covering Cardiff and the Vale of Glamorgan were contacted by the Auditor in respect of obtaining a sample of at least three GPs from each Cluster to whom a Questionnaire could be emailed so as to obtain a view and opinion as to the functionality, usage and satisfaction of the HealthPathways database from a user perspective. Three GP Cluster Leads responded and provided a sample base of eleven GPs of which only three replied. All returned Questionnaires indicate satisfaction with the training provided in the use of HealthPathways, the database functionality and its overall worth but frequency of its use appears to be irregular. However, due to the low response rate the answers to the questions cited cannot be viewed as definitive or conclusive. Some recommendations for improvement of HealthPathways arising from the questionnaire were; • *"Key is ensuring that all parties (primary and secondary care) are invested in it and use it regularly. All users across health board need to be invested in it and use it regularly- it needs to become second nature to all to maximise its potential. Linking into a referral system would be very useful. Secondary care directorate Clinical Portal pages should be mothballed/ removed and replaced by Health Pathways links."* • *"Good principle. To be truly effective it needs all specialisms and departments on it and be up to date. It's helpful to identify where and how to refer patients"*	Delays in GP's accessing appropriate clinical advice in an efficient manner.

Recommendation	Priority level
Whilst there are sound and accessible processes in place that allow GPs and Consultants to feedback issues and HealthPathways reports are in place that can monitor pathways in use, the review was not able to comprehensively establish user perceptions in this respect across Cardiff and the Vale of Glamorgan. UHB management should obtain further opinion and feedback from GPs to establish the level of current usage and current satisfaction with database functionality.	**Medium**
Management Response	**Responsible Officer/ Deadline**
• GP Clinical Editors to continue to attend regular CPET Training Sessions, feedback and opinions will continue to be sought regularly at these sessions. • HealthPathways webinars will be set up every 2 months, first one taking place 10.02.21. • Google Analytics will continue to be regularly monitored and usage figures recorded and reported	Maria Dyban / ongoing Patricia Osborne / 10.02.21 Patricia Osborne / ongoing

Finding 6 - Performance Metrics and Reporting (Control design)	Risk
Whilst the introduction of, and changes to existing clinical pathways within the database are subject to a work plan review and subsequent revisions are based on GP and Consultant requests, no performance metrics or reporting of their effectiveness are retained or reported within the organisation.	Delays in GP's accessing appropriate clinical advice in an efficient manner.
Recommendation	**Priority level**
Feedback provided by GPs and Consultants as to the effectiveness and worth fullness of the HealthPathways performance data should be reported within the organisation as a means of 'lessons learned' and continuous improvement.	**Medium**
Management Response	**Responsible Officer/ Deadline**
• Feedback to continue to be monitored and reported from feedback button functionality of the HealthPathways site.	Patricia Osborne / ongoing
• A Survey Monkey to be undertaken to Consultant colleagues.	Maria Dyban & Patricia Osborne / 01.05.21
• A further Survey Monkey to be undertaken to GP colleagues and data compared to the survey undertaken in 2020.	Maria Dyban & Patricia Osborne / 01.04.21
• Vitamin D Deficiency pathway (that is currently one of the top used pathways) performance data evaluation to be undertaken.	Maria Dyban / 12.02.21
• HealthPathways to become part of the CAV Convention work currently being undertaken in PCIC and will report through that route.	Maria Dyban / with immediate effect

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.

UHB Core Financial Systems

Final Internal Audit Report

2020/21

Cardiff and Vale University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

Review reference:	CVU-2021-13
Report status:	Final Internal Audit Report
Fieldwork commencement:	20 January 2021
Fieldwork completion:	23 February 2021
Draft report issued:	10 March 2021
Management response received:	17 March 2021
Final report issued:	23 March 2021
Auditor/s:	Olubanke Ajayi- Olaoye, Principal Auditor Ian Virgill, Head of Internal Auditor
Executive sign off:	Chris Lewis, Interim Executive Director of Finance
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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 & 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

A review of the Cardiff and Vale University Health Board (the UHB or the 'Health Board') Core Financial Systems has been completed in line with the 2020/2021 Internal Audit Plan.

Given the high level of assurance that has been provided for the Core Financial Systems reviews in previous years, the individual areas are now covered on a cyclical basis. Last year's review covered the General Ledger and Accounts Receivable systems and this year's review focused on the Asset Register and Cash Management systems.

The relevant lead Executive Director for this review is the Executive Director of Finance.

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 Health Board for the management of the Core Financial systems, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The purpose of the review was to establish if the Health Board had appropriate processes in place to ensure the effective management of the Asset Register and Cash Management systems. The areas that the review sought to provide assurance on were:

Asset Register

- Procedural guidance is in place and is appropriate and up to date;
- The Health Board has an up to date asset register in place that accurately records all assets;
- New assets and asset disposals are accurately identified and promptly recorded on / removed from the register; and
- Assets are appropriately accounted for including valuation, depreciation and indexation.

Cash Management

- Procedural guidance is in place and is appropriate and up to date;
- A full year cash forecast is produced in a format consistent with the financial Monitoring returns;
- Regular updates to the cash forecast are made and reviewed, with significant changes being appropriately reported;

- Cash balances are regularly reviewed to ensure that there are sufficient funds against forecasts with cash allocation requests appropriately requested and authorised; and
- Transfers between accounts are appropriately authorised.

3. Associated Risks

The potential risks considered in this review were as follows:

- The capital asset register may be inaccurate, and assets may be incorrectly recorded or valued;
- Required payments cannot be made due to insufficient cash; and
- Surplus cash is drawn down unnecessarily and not in line with Welsh Government 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 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 Core Financial Systems 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.

The asset register and treasury management Financial Control Procedure (FCP) are both currently out of date.

There are generally good processes in place for the management of the Health Board's Fixed Asset Register. Good practices were observed within all the areas covered as documented in section 6 of this report.

Due to COVID, the training session which is usually held in the 3rd quarter of the year with key members of staff responsible for the maintenance of the asset register in the various departments did not take place. However, the capital asset booklet which is usually provided during training is available to all staff on the intranet.

The asset verification exercise has commenced although at the time of the audit confirmation had not been received by Finance from all the areas. A review was done by randomly selecting departments that had responded and performed the verification exercise. On review of the asset register, it was identified that changes flagged by the departments from the verification exercise undertaken were yet to be updated.

Overall, the controls in place to manage the risks associated with the cash management systems and the processes tested within, are of a good standard and in line with the Welsh Government requirements.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Procedural Guidance			✓	
2	Up to date and accurate Asset Register		✓		
3	Recording of new assets and asset disposal				✓
4	Accounting for asset valuation, depreciation and indexation				✓

Assurance Summary					
5	Cash Forecast				✓
6	Forecast updates and reporting				✓
7	Review of cash balances			✓	
8	Transfers between accounts				✓

** 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 classified as a weakness in the system control/design for UHB Core Financial Systems.

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 UHB Core Financial Systems.

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: Procedural guidance is in place and is appropriate and up to date.

The following areas of good practice were noted:

- The FCP is readily accessible to Finance staff and is stored within Finance's shared folder;
- There is a Capital Asset Booklet which details the relevant information that key staff responsible for the maintenance of the asset register should be aware of; and

- The Capital Asset booklet is up to date and available to all staff on the intranet.

The following significant finding was noted for this objective:

- The asset register and treasury management Financial Control Procedures (FCP) are currently both out of date.

Objective 2: The Health Board has an up to date asset register in place that accurately records all assets.

The following areas of good practice were noted for this objective:

- The physical asset verification exercise is undertaken once a year and a guidance booklet provided; and
- Emails are sent out to the Clinical Boards, Managers and relevant members of staff where they are informed of the verification process. An updated asset register is usually sent out to the various departments in October.

The following significant finding was noted for this objective:

- A sample of 10 departments were selected to review the physical asset verification exercise undertaken. It was identified that relevant changes that had been identified from the exercise were yet to be updated within the main asset register.

Objective 3: New assets and asset disposals are accurately identified and promptly recorded on / removed from the register.

The following areas of good practice were noted for this objective:

- Fixed Asset additions are identified (as stated in the Financial Control Procedure) by periodically reviewing:
  - The Capital Programme.
  - Revenue expenditure over £5,000.
  - Charitable funds donations greater than £5,000.
- 10 additions were randomly selected from the main asset register for testing. All 10 assets had their details accurately entered into the asset register.

There were no significant findings noted for this objective

Objective 4: Assets are appropriately accounted for including valuation, depreciation and indexation.

The following areas of good practice were noted for this objective:

- Review of a sample of 20 assets with varying life spans confirmed that the correct valuation and required depreciation had been accurately calculated and recorded.

There was no significant finding noted for this objective.

Objective 5: A full year cash forecast is produced in a format consistent with the financial Monitoring returns.

The following areas of good practice were noted for this objective:

- The HB completes a cash forecast (which is an estimate of funding required for the following month) and sends to WG as stated within the timetable;
- The various timelines provided by WG annually to the HB have been collated into one document by the HB in order to have an overview of all the timelines in one view; and
- The 3 cash forecast submissions selected for review were timely submitted.

There was no significant finding noted for this objective.

Objective 6: Regular updates to the cash forecast are made and reviewed, with significant changes being appropriately reported.

The following areas of good practice were noted for this objective:

- A review of 3 Financial Information System (FIS)/ funding request forms confirmed that they were authorised via email before being forwarded to WG;
- Finance has a key custodian who stores and keep records of the WG allocation letter. This is done by collating relevant information such as date received, description and cash limits; and
- Draw down requests are based on WG allocation letter.

There was no significant finding noted for this objective.

Objective 7: Cash balances are regularly reviewed to ensure that there are sufficient funds against forecasts with cash allocation requests appropriately requested and authorised.

The following areas of good practice were noted for this objective:

- A bank reconciliation statement is prepared on a monthly basis.

The following significant finding was noted for this objective:

- The bank reconciliation is not signed off to evidence review.

Objective 8: Transfers between accounts are appropriately authorised.

The following areas of good practice were noted for this objective:

- The HB has 3 distinct accounts for specific purposes.
  - Exchequer/ revenue
  - Charitable funds
  - Patient's money

Charitable funds and patient's money account do not have any interaction with the monies from WG cash allocation.

There was no significant finding noted 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	**1**	**2**	**0**	**3**

Finding 1 - Financial Control Procedure (FCP) Guidance (Control design)	Risk
Capital Asset Register FCP The asset register FCP reflects the processes for asset additions, disposals, physical verification, depreciation and indexation. It was formally approved October 2014 by the heads of Finance Group with September 2019 being its next review date. This is now out of date. It was confirmed to require some updates/ changes: • 'Qlikview' which is now the new oracle reporting system is expected to be substituted to replace all references to Discoverer reports within the FCP; • In the FCP, section 2.01 (b) a spreadsheet is required to be prepared quarterly. This is currently completed by the Senior Finance Accountant (SFA) not Losses, taxation & Capital Accountant (LTCA) as stated within; and • All reference to the 'shared team' extracting a report in the additions to the asset register section- 2.03(a) and 2.02 (a) would be replaced by the 'SFA'. **Treasury Management FCP** The treasury management FCP was due for review in 2015 and so is currently out of date. Health boards have been required to comply with the HM Treasury cash management system. The TAG (Technical Advisory Group) – Cash and Banking	The capital asset register may be inaccurate and assets may be incorrectly recorded or valued. Surplus cash is drawn down unnecessarily and not in line with Welsh Government requirements

sub-group reviewed and agreed the procedures that had been enacted previously. The TAG Cash and Banking subgroup agreed to produce a FCP (high level on an all-Wales basis) in the previous year- 2020. In bid to assist with this, C&V's Treasury Management FCP was forwarded in February 2020 to the key lead on this project. However, due to COVID this has not progressed as expected. The Health Board's FCP has not been amended in the meantime. It is however noted that most of the information is current, except where: • Due to the current COVID-related circumstances, due processes such as authorisations which are now done by email confirmation instead of paper signing would be adjusted to reflect the current process; • The FCP states the use of a citi account, however this requires to be taken off as the HB does not own such an account; and • The HB's stance regarding the application (or non-application) of the +/- 5% target over/ above their monthly cash forecast, the required explanation of significant variances in the monthly monitoring returns and how this fits overall with the WG guidance.	
Recommendation	**Priority level**
Management should ensure the FCPs are updated as soon as possible.	**Medium**

Management Response	Responsible Officer/ Deadline
Capital Asset Register FCP The FCP will be updated in 2021/22. **Treasury Management FCP** Agreed – FCP to be amended to reflect appropriate findings in relation to the Citi bank account and the use of email authorisations. The monthly cash forecast target will not be included in the FCP as the Health Board are not held accountable from WG for this.	Helen Lawrence – Sept 2021 Alun Williams - March 2021

Finding 2 – Asset Verification Review (Operating effectiveness)	Risk
10 departments were selected for review of the verification exercise that had been undertaken by the various departments. Selection was limited to the departments that had responded and sent confirmatory emails updating Finance of the true position of their assets. Copies of returned registers were obtained. The review was performed to ensure that recorded changes had been accurately updated on the main asset register. Although it was a 100% review of the 10 departments for all identified changes, the focus of review was specifically on changes relating to disposal/ removal and additions of assets. Changes which may pose a reasonable level of risk have also been included. The 10 departments selected were: • Acute medicine; • Artificial Limb and Appliance Service;	The capital asset register may be inaccurate and assets may be incorrectly recorded or valued

• Cardiac Services; • Cellular Pathology; • Paediatrics Child Health; • Dental Hospital Medical Services; • Gastroenterology; • Mental Health Services for older people; • Radiology; and • Trauma and Orthopaedic As previously stated, at time of audit some departments were yet to provide a response to the verification exercise. Finance is working through the responses as evidenced in the documentations provided, however, they are yet to update the asset register to reflect changes from responses already received. The major findings noted are: • Missing assets • Assets requiring disposal and removal from the asset register • New assets yet to be added to the asset register • Assets requiring Finance number tag *A detailed breakdown of findings per department can be found in appendix C.* However, it was noted that there were several assets which required editing of serial numbers, change in asset location due to asset transfer.	

Recommendation	Priority level
Management should ensure that the main Asset Register is updated to reflect the accurate position. The required Due process follow up should be commenced as soon as possible specifically for missing assets and all other applicable assets. For future verification exercise, it may be helpful if Finance provides a key with various categories (e.g. D- Disposal, A- Additions, M- Missing, O- others for unique issues: departments specifying on a separate column what O denotes etc). This can be forwarded at the point the initial email is sent out to the departments. This would help ensure standardization across the board, managing the time used in collating the information and help to analyse with ease if required.	**High**
Management Response	**Responsible Officer/ Deadline**
All essential updating will be completed before year end.	Helen Lawrence - March/April 2021

Finding 3 - Bank reconciliation (Operating effectiveness)	Risk
A bank reconciliation is expected to be prepared on a monthly basis by the appropriate officer with a signature as the preparer and a sign off by the appropriate lead confirming review and approval. Pre COVID, the reviewer sign-off was done on paper. An electronic system for sign off has been adopted, however since adoption no evidence has been retained to confirm that these reconciliations have been signed off by a reviewer. On request of the bank reconciliation, audit observed that the November and December 2020 reconciliations were not signed off by the reviewer.	Required payments cannot be made where sufficient cash is not drawn down
Recommendation	**Priority level**
Management should ensure that the bank reconciliation statement is reviewed with evidence of signoff from the reviewer retained.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed – Email confirmation of review and approval will be copied into the reconciliation file each month.	Alun Williams - March 2021

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.

Appendix C – Departmental Asset Verification review detail

1) **Acute medicine**
   - 2 assets missing or broken

2) **Artificial Limb and Appliance Service**
   - 2 assets written off or damaged during flood.

3) **Cardiac Services**
   - 11 assets required disposal. 1/11 could not be located.
   - 4 assets within the Department could not be located.

4) **Cellular Pathology**
   - There was the list of assets showing assets found that's required addition to the asset register. No further information has been given to determine if these assets have asset numbers, purchase cost or date purchased.
   - 3 assets were not located.
   - 3 no longer in the departments possession it has been given to clinical engineering to sell.

5) **Paediatrics Child Health**
   - 9 assets requiring disposal still in the asset register.
   - 26 new assets are yet to be added to the register. 3 of these have no purchase value.

6) **Dental Hospital Medical Services**
   - 7 verified assets with missing Finance asset number stickers/ illegible print. 5 of these have purchase dates of 15/3/20.

7) **Gastroenterology**
   - **5** assets requiring disposal still in the asset register.

8) **Mental Health Services for older people**
   - 1 condemned asset still in the asset register.

9) **Radiology**
   - Some assets which have been decommissioned several years ago and still within the asset register e.g. asset number 104500 and 111045.
   - 36 assets requiring disposal still in the asset register. 3 of these no longer useful as upgrade is not required.
   - 40 new assets not in the asset register.
     - 4 of these had purchase dates of 2015 & 2017.
     - 15/40 had no asset number or purchase date available.
   - 3 assets missing.
   - 2 assets not in use.
   - 10 home working laptops bought during COVID with no serial number.

10) **Trauma and Orthopaedic**
   - 4 assets requiring disposal still in the asset register.

Cardiff and Vale University Health Board

Risk Management

Final Internal Audit Report

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference: CVU-2021-02

Report status: Final Internal Audit Report
Fieldwork commencement: 11th February 2021
Fieldwork completion: 19th March 2021
Draft report issued: 23rd March 2021
Management response received: 24th March 2021
Final report issued: 24th March 2021
Auditor/s: Wendy Wright, Deputy Head of Internal Audit
Executive sign off: Nikki Foreman, Director of Corporate Governance

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Specialist Services Clinical Board
Cath Heath, Director of Nursing
Children and Women's Clinical Board

Committee: Audit Committee

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1. Introduction and Background

The review of Risk Management has been completed in line with the 2020/21 Internal Audit Plan. The opinion provided through this review is a key component, which will inform the Head of Internal Audit's Annual Opinion.

Effective risk management enhances strategic planning and prioritisation, which assists in achieving objectives and strengthens the ability to be agile to respond to the challenges faced. The challenges placed upon the Health Board as a result of COVID-19 through 2020/21 have been unprecedented.

The Lead Executive Director for this review is the Director of Corporate Governance.

2. Scope and Objectives

The review sought to provide Cardiff and Vale University Health Board with assurance that risk management arrangements are effectively designed and operating to support the achievement of strategic priorities. The review will assess the extent to which internal controls are being applied, with a view to providing an audit assurance rating over the management of risk.

The 2020/21 audit sought to provide assurance over the following areas:

Governance and Leadership

Risk management is an essential part of governance and leadership, and fundamental to how the Health Board is directed, managed and controlled at all levels:

- A Risk Management and Board Assurance Framework Strategy has been approved by the Board, which outlines:
  - roles and responsibilities for risk management;
  - the Board's approach to risk appetite;
  - the risk management process, including the escalation, consolidation and aggregation of risk.
- Documented risk management procedures underpin and support the effective delivery of the strategy.

Collaborative risk management

Risk management is a collaborative process and informed by the best available information and expertise:

- The risk management framework is designed to support a comprehensive view of the risk profile, aggregated where appropriate, in support of governance and decision-making requirements.

- Risk management processes are conducted systematically, iteratively and collaboratively, drawing on the appropriate knowledge.
- The management of risk facilitates the factual, timely, relevant, accurate and understandable exchange of information and evidence.
- Communication should be continual and iterative in supporting dialogue, providing and sharing information and promoting awareness and understanding of risks.

Risk Management Processes

Risk management processes are structured to include:

- risk identification and assessment to determine and prioritise how the risks should be managed;
- the selection, design and implementation of risk treatment options that support achievement of intended outcomes and manage risks to an acceptable level, cognisant of risk appetite;
- the design and operation of integrated, insightful and informative risk monitoring;
- timely, accurate and useful risk reporting to enhance the quality of decision-making and to support management and the Board in meeting their responsibilities; and
- there is a clear link between the Corporate Risk Register and the Board Assurance Framework.

Internal Audit Recommendation 2019/20

- The audit will identify progress of implementing the internal audit recommendations raised in the 2019/20 audit of risk management.

3. Associated Risks

The risks considered in the review are as follows:

- Ineffective governance and leadership of risk management, which fails to support strategic priorities;
- Risk management operates in silos and fails to provide a comprehensive risk profile of the Health Board, through a lack of collaboration;
- The risk management framework is poorly designed, which impacts effective implementation;
- Continual improvement cannot be evidenced, as a result of limited progress in taking forward recommendation raised in the 2019/20 risk management audit.

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 the Risk Management audit is **Reasonable** assurance.

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.

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.

The 2019/20 audit of risk management reported an assurance rating of reasonable, the same assurance is offered in 2020/21. Since the previous audit it is evident that the Health Board is progressing its maturity of risk management, with a clear sense of direction and additional resource to deliver, resulting in an improvement on last year. Recommendations arising from this review will support the Health Board through their journey of improvement. The Board received the Board Assurance Framework in January 2021, which highlighted the impact of COVID-19 on the pace of delivering some actions.

The Risk Management (RM) and Board Assurance Framework (BAF) Strategy directs the Heath Board's approach to maturing risk management arrangements. Since Board approval of the Strategy in 2019, the Board have been kept informed of progress and approved future direction through updates of the BAF, Corporate Risk Register (CRR), and wider considerations of Board risk appetite.

The RM and BAF Strategy is underpinned by procedure UHB024, Risk Assessment and Risk Register Procedure, which was under review at the time of the audit.

The design of the strategy and procedure ensures alignment to the UHB's strategic objectives, which is illustrated in the BAF and CRR. There is minimal reference to RM standards / best practice guides in the strategy, which if referenced would provide greater assurance to the Board, whilst evidencing and progressing RM maturity *(Recommendation 1 – low priority)*.

The Health Board's risk management framework is designed to support a comprehensive view of the risk profile, aggregated where appropriate but this is an area which requires further development. Risk Registers are currently held in Microsoft Excel spreadsheets, a sample of Clinical Boards and Corporate Departments were made available upon request (in most instances). Visibility of all registers, particularly at a directorate level was limited. The means of capturing and recording risks requires consideration, to facilitate greater aggregation and transparency, also aiding efficiency and effectiveness *(Recommendation2 – medium priority)*.

Whilst the Health Board continues to use Excel spreadsheets to capture risks, consideration should be given to further developments to support users, at the avoidance of added burden *(Recommendation 5 – low priority)*.

There is a clear link between the CRR and the BAF, which has improved since the previous audit of risk management arrangements. Reporting the CRR to the Board is established and consideration should be given to enhancing the current report to facilitate Board focus and discussion, for instance, highlighting corporate risks which are the most extreme or on an upward trend within the summary register *(Recommendation 3 – low priority)*.

The BAF update to the Board in January 2021 detailed a BAF and RM action plan, with reported progress, acknowledging the impact of COVID-19. The results of audit testing aligned with reported progress in the paper, noting that continuing and ongoing action is required to support RM and BAF maturation *(Recommendation 4 – medium priority)*.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Governance and Leadership				✓
2	Collaborative Risk Management			✓	
3	Risk Management Process			✓	
4	Internal Audit Recommendations 2019/20				✓

** 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 2 issues that are classified as weaknesses in the system control / design for Risk Management.

Operation of System / Controls

The findings from the review have highlighted 3 issues that are classified as weaknesses in the operation of the designed system / control for Risk 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: Governance and Leadership

The following areas of good practice were noted:

- A Risk Management and Board Assurance Framework Strategy has been approved by the Board;
- Documented risk management procedures underpin and support the effective delivery of the strategy;

- A Board approved risk appetite statement, which aligns to the 'Good Governance Institute Matrix for NHS Organisations', and supported by a risk delivery plan; and
- Dedicated resource identified to support the Head of Risk and Regulation to take forward the risk management agenda.

One recommendation is made under this objective:

- Continual improvement of the BAF and RM Strategy **(Recommendation 1)**

Objective 2: Collaborative risk management

The following areas of good practice were noted:

- The risk management framework is designed to support a comprehensive view of the risk profile, aggregated where appropriate, in support of governance and decision-making requirements; and
- A programme of risk management training designed and introduced, for further roll out, which builds collaborative relationships with clinical boards and corporate departments.

One recommendation is made under this objective:

- Aggregation and visibility of risk across the Health Board **(Recommendation 2)**

Objective 3: Risk Management Processes

The following areas of good practice were noted:

Risk management processes are structured to include:

- A clear link between the Corporate Risk Register and the Board Assurance Framework;
- Risk identification and assessment to determine and prioritise how the risks should be managed;
- The selection, design and implementation of risk treatment options that support achievement of intended outcomes and manage risks to an acceptable level; and
- Timely, accurate and useful risk reporting to the Board to enhance the quality of decision-making.

Three recommendations are made under this objective:

- Reporting style of Corporate Risks to the Board **(Recommendation 3)**;
- Risk Management Maturity **(Recommendation 4)**; and
- Functionality of the corporate risk register template **(Recommendation 5)**

Objective 4: Internal Audit Recommendations 2019/20

We are satisfied that the internal audit recommendations from the 2019/20 audit of risk management have been implemented or addressed more widely in the BAF action plan, progress of which is reported to the 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	**0**	**2**	**3**	**5**

Finding 1 - Continual improvement of the BAF and RM Strategy (Control design)	Risk
The 'Risk Management and Board Assurance Framework Strategy', which informed this review was approved by the Board on 25th July 2019. The strategy includes the assessment method for articulating the Board's risk appetite, the Good Governance Institute (GGI) Matrix for NHS Organisations. Within section 7.1 the strategy refers to an annual review, in accordance with good practice guidance. Within the strategy there is no reference beyond the GGI to further risk management standards or best practice guides.	The risk management framework is poorly designed, which impacts effective implementation; The BAF and RM Strategy does not improve in line with best practice guidance / risk management standards.
Recommendation	**Priority level**
To demonstrate the periodic assessment of risk management maturity, future reviews of the BAF and RM Strategy should incorporate references and alignment to best practice guidance / risk management standards (See Appendix B).	**Low**
Management Response	**Responsible Officer/ Deadline**
Recommendation agreed - The Risk Management Strategy is due to be reviewed and presented to the Board for approval in May 21 therefore we will incorporate the best practice references and risk management standards in this review.	Head of Risk and Regulation / Risk and Regulation Officer May 2021

Finding 2 - Aggregation and visibility of risk across the Health Board (Operating effectiveness)	Risk
The Health Board's risk management framework is designed to support a comprehensive view of the risk profile, aggregated where appropriate. A sample of Clinical Boards / Corporate Directorates participated in the review and it was evident that although risk registers were present, there was not complete visibility of all registers, particularly at a directorate level. Risk registers were held in the format of the Corporate Risk Register template, in Microsoft Excel. Spreadsheets used to hold risk registers are only effective if collaborative efforts are made to facilitate factual, timely, relevant, accurate and understandable exchange of information and evidence. The BAF report to the Board on 28th January 2021 references a move to web based risk reporting.	Risk management operates in silos and fails to provide a comprehensive risk profile of the Health Board, through a lack of collaboration.
Recommendation	**Priority level**
Continued efforts should be made to embed current processes for recording risks, which will facilitate the aggregated risk profile of the Health Board. To aid efficiency and effectiveness of current processes, consideration should be given to the means of capturing and recording risks, to facilitate greater aggregation and visibility.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Recommendation agreed – The Health Board will be moving to web based risk reporting when the All Wales system goes live. This will aid the capturing and	Head of Risk and Regulation / Risk and Regulation Officer

recording of risks and also help ensure that the approach across the Health Board is consistent.	December 2021 (6 months after go live)

Finding 3 - Reporting style of Corporate Risks to the Board (Operating effectiveness)	**Risk**
As noted in the Corporate Risk Register report to the Board on 28th January 2021, *"The Corporate Risk Register has been developed to enable the Board to have an overview of the key operational risks from the Clinical Boards and Corporate Directorates"*. The register in January 2021 held 27 extreme risks, which are presented and grouped by Clinical Board / Corporate Directorate, rather than highlighting risks by highest score, or alternatively those on an upward trend, which may be of greatest concern to the Board.	Risk management operates in silos and fails to provide a comprehensive risk profile of the Health Board, through a lack of collaboration.
Recommendation	**Priority level**
Consideration should be given to alternative styles of reporting the corporate risk summary, to highlight the risks with the most extreme score or on an upward trend in the first instance, for Board consideration.	**Low**
Management Response	**Responsible Officer/ Deadline**
Recommendation agreed this can be incorporated in the next Corporate Risk Register to the Board.	Head of Risk and Regulation May 2021

Finding 4 - Risk Management Maturity (Operating effectiveness)	Risk
On 28th January 2021 the Board received the Board Assurance Framework, which noted, *"Risk Management continues to develop at Cardiff and Vale Health Board. Significant progress had been made but actions have been stalled for a number of months due to COVID-19"*. An action plan was detailed in the paper, and the results of audit testing aligned with reported progress of the continuing and ongoing actions, to include: • Work is required to roll out the 'risk appetite'… ensuring it is embedded in decision making; • A phased approach to the development of risk registers within Corporate Directorates and Clinical Boards; • A continuing programme of risk management training; and • BAF risk reviews will also be added to the Committees of the Board going forward routinely.	The risk management framework is poorly designed, which impacts effective implementation.
Recommendation	**Priority level**
To continue as planned to roll out the delivery of effective risk management systems and processes, as detailed in the BAF action plan to the Board on 28th January 2021.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Recommendation Agreed – will continue to roll out the application of good risk management across the Health Board incorporating the key areas and actions identified.	Head of Risk and Regulation December 2021

Finding 5 - Functionality of the Corporate Risk Register Template (Control design)	Risk
A 'Risk Assessment and Risk Register Procedure' is in place, which underpins the BAF and Risk Management Strategy (reference number UHB 024, version 2). The procedure was under review at the time of the audit. A corporate risk register template is appended to the procedure. The register requires a comprehensive level of risk detail but could be enhanced by utilising Excel functionality. Data validation and conditional formatting is not applied within the spreadsheet, which if used can reduce errors and support users when considering different risk ratings.	The risk management framework is poorly designed, which impacts effective implementation.
Recommendation	**Priority level**
Consideration should be given to utilising greater Microsoft Excel functionality, to enhance the maturity of the corporate risk register template. *(For example, data validation and conditional formatting functionality could be applied to the risk rating and assurance committee columns)*	**Low**
Management Response	**Responsible Officer/ Deadline**
Recommendation agreed – improvement to be made to the template risk register which will aid completion e.g. drop down menu etc. This will also aid consistency in approach across the Health Board	Head of Risk and Regulation May 2021

Appendix B – References

Examples of Risk Management Standards / useful guidance and best practice

HM Government Orange Book: Management of risk principles and concepts - https://www.gov.uk/government/publications/orange-book

Risk Appetite: Guidance Note (Government Finance Function) - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/929385/Risk_Appetite_Guidance_Note_v1.0_FINAL.pdf

ISO 31000 – Risk Management - https://www.iso.org/publication/PUB100426.html

COSO: Enterprise Risk Management – Integrating with Strategy and Performance (2017) https://www.coso.org/Documents/2017-COSO-ERM-Integrating-with-Strategy-and-Performance-Executive-Summary.pdf

COSO Compliance Risk Management: Applying the COSO ERM Framework (2020) https://www.coso.org/Documents/Compliance-Risk-Management-Applying-the-COSO-ERM-Framework.pdf

Institute of Internal Auditors Position Paper: The three lines of defence in effective risk management and control (2013) - https://na.theiia.org/standards-guidance/Public%20Documents/PP%20The%20Three%20Lines%20of%20Defense%20in%20Effective%20Risk%20Management%20and%20Control.pdf

Appendix C - 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.