Audit and Assurance Meeting -

08 September 2020, 09:00 to 12:30
VIA SKYPE

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 7th July 2020
John Union

1.4 Draft Public Audit Mins - July.pdf (5 pages)

5. Action log following meeting held on 7th July 2020
John Union

1.5 Public Action Log - 08.09.2020 - A&A.pdf (2 pages)

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

7. Items for Review and Assurance

7.1. Internal Audit Progress and Tracking Reports
Ian Virgill

7.1 Internal Audit Progress and Tracking Reports.pdf (3 pages)

7.1 A&A Progress Report.pdf (14 pages)

7.2. Audit Wales Update
Audit Wales

7.2 C&VUHB AC Update (September 2020).pdf (12 pages)

7.3. The 2019-20 Audit of Accounts Addendum Report
Audit Wales

7.3 Audit of Accounts Report Addendum – Recommendations.pdf (10 pages)

7.4. Effectiveness of Counter-Fraud Arrangements Report
Audit Wales

7.4 Counter Fraud Report (final).pdf (16 pages)

7.4 Counter Fraud Report Management Response.pdf (2 pages)

7.4 Tackling Fraud in Wales.pdf (50 pages)

8. Items for Approval / Ratification

8.1. Declarations of Interest and Gifts and Hospitality Tracking Report including Declarations of Interest and sign off in relation to Ysbyty Calon Y Ddraig
Nicola Foreman

8.1 DOI Report.pdf (3 pages)

8.2. Regulatory Compliance Tracking Report including Ysbyty Calon Y Ddraig

Nicola Foreman

- 8.2 - Regulatory Compliance Covering Report.pdf (6 pages)
- 8.2.1 Regulatory Heat Map - September.pdf (15 pages)

8.3. Internal Audit Tracking Report

Nicola Foreman

- 8.3 Internal Audit Tracker Covering Report.pdf (3 pages)
- 8.3 Internal Audit Summary Tables - Appendix 1.pdf (3 pages)
- 8.3 Internal Audit Tracker - Sept 2020 v1.pdf (10 pages)

8.4. Audit Wales Tracking Report

Nicola Foreman

- 8.4 External Audit Recommendation Tracking report covering report.pdf (2 pages)
- 8.4 External Audit Summary Table - Appendix 1.pdf (1 pages)
- 8.4 WAO Sept 2020.pdf (4 pages)

9. Items for Information and Noting

9.1. Internal Audit reports for information:

Ian Virgill

- 9.1 AQS Final Report.pdf (11 pages)
- 9.1 Strategic Planning IMTP.pdf (16 pages)

10. Review and Final Closure

John Union

11. Items to be deferred to Board / Committee

John Union

12. To note the date, time and venue of the next Committee meeting:• Tuesday 19th November 2020 – 9.00am TBC, Woodlands House

Unconfirmed Minutes of the Public Audit and Assurance Committee
Held on Tuesday 7 July 2020 09:00am – 11:00am
Via Skype

Chair		
John Union	JU	Independent Member – Finance
Present:		
Eileen Brandreth	EB	Independent Member – ICT
In Attendance:		
Anne Began	AB	Audit Wales
Bob Chadwick	BC	Executive Director of Finance
Nicola Foreman	NF	Director of Corporate Governance
Craig Greenstock	CG	Counter Fraud Manager
Darren Griffith	DG	Audit Wales
Mark Jones	MJ	Audit Wales
Chris Lewis	CL	Deputy Finance Director
Mike Usher	MU	Audit Wales
Ian Virgil	IV	Head of Internal Audit
Secretariat		
Laura Tolley	LT	Corporate Governance Officer
Apologies:		
Dawn Ward	DW	Independent Member – Trade Union

AAC 20/07/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting.	**ACTION**
AAC 20/07/002	**Apologies for Absence** Apologies for absence were noted.	
AAC 20/07/003	**Declarations of Interest** There were no declarations of interest.	
AAC 20/07/004	**Minutes of the Committee Meetings held on 28th May 2020 and 29th June 2020** The Committee reviewed the minutes of the meeting held on 28th May 2020. The Counter Fraud Manager (CFM) advised his apologies needed to be noted. The Committee reviewed the minutes of the meeting held on 29th June 2020. The CFM advised he was in attendance.	

	Resolved that: Subject to the above amendments; (a) the Committee approved the minutes of the meetings held on 28th May 2020 and 29th June 2020 as a true and accurate record.	
AAC 20/07/005	**Action Log following the Meetings held on 28th May 2020 and 29th June 2020** The Committee reviewed the action log and the following updates were made: **AAC 19/12/015 –** It was agreed that this would be brought back to the Committee in September; **AAC 20/05/006** – It was agreed that Internal Audit Progress, would be brought back to the Committee in September; **AAC 20/05/006** – The Director of Corporate Governance (DCG) advised the committee that a final feedback session was held with KPMG, the information could not be shared as confirmation was required from Welsh Government. The Committee agreed to close this action. **Resolved that:** (a) the Committee reviewed and noted the action log and the updates provided.	
AAC 20/07/006	**Internal Audit Progress and Tracking Reports** The Head of Internal Audit (HIA) introduced the report and confirmed that the main focus of the report were the proposed adjustments to the Audit Plan due to the impact of COVID-19. The HIA explained the main addition to the plan was work that focussed on the governance arrangements around COVID-19. The recommendation came from All Wales Financial Service Group and was for all Health Board across Wales. The HIA confirmed it would be an advisory review, therefore there would be no assurance rating, however, there would be recommendations highlighted for the UHB to facilitate change. The HIA commented that the review may also identify other areas which had changed process controls during COVID-19. The HIA advised the committee of two areas removed from the Audit plan: • 1 audit removed from Public Health; • 1 audit removed from IT, the strategy and implementation of IT systems was proposed to be moved to the 2021-22 plan due to the pressure from COVID-19 on the department.	

	The Independent Member – ICT (IM-ICT) asked if an advisory piece of work could be undertaken instead of the IT Audit? After Committee discussion it was agreed this would be further discussed at the Special Digital & Health Intelligence Committee. **Resolved that:** (a) the Committee considered the Internal Audit Progress Report; (b) the Committee approved the proposed amendments to the Internal Audit Plan for 2020/21.	
AAC 20/07/007	**Audit Wales Update** Audit Wales (AW) advised the Committee that they were working very closely with Internal Audit and the DCG to discuss progress on the structured assessment, governance, internal audit and KPMG work to ensure AW were not placing additional burdens on the UHB. AW confirmed they will ensure that AW and Internal Audit work was aligned and advice would be taken on board from KPMG when made available. AW advised that the governance review of WHSSC was now reinstated, a survey would be send to Chief Executives and Health Board Chairs, once these had been completed a draft report would be circulated. The CC thanked AW for supporting the UHB with the work undertaken. **Resolved that:** (a) the Committee noted the Audit Wales Update.	
AAC 20/07/008	**Declarations of Interests, Gifts, Hospitality & Sponsorship Tracking Report** The DCG introduced the report and confirmed it outlined the end of year position and that Declarations of Gifts, Hospitality & Sponsorship had now moved to Risk & Regulation. The DCG advised the Committee that communication around declarations would be reinstated and the team would look to see continued development within this area. In relation to donations received during COVID-19, the Charitable Funds Committee had received a comprehensive list of all donations received to ensure there was appropriate governance around donations recieved and the Bale Donation was going to be discussed at the Special Board of Trustee meeting at the end of July 2020. **Resolved that:** (a) the Committee noted the ongoing work in this area; (b) the Committee noted the Declarations of Interests, Gifts, Hospitality & Sponsorship Tracking Report.	

AAC 20/07/009	**Regulatory Compliance Tracking Report** The DCG introduced the report and confirmed that some responses had been received and Internal Audit were conducting spot checks to ensure recommendations were being actioned. The IM-ICT advised it would be difficult to see good progress in this area due to COVID-19 but requested that the team hold discussions with relevant staff to determine when the work would likely be undertaken. It was explained that a re-assessment and new target date would give teams an aim to work towards. The DCG further advised the Committee that all external visits had ceased due to COVID-19, however a letter was received on 6th July 2020 from HIW which set out how they plan to conduct visits going forward. These would be tiered as: Tier 1 – Completely offsite Tier 2 – Combination of offsite and limited on site Tier 3 – Onsite inspections The DCG advised a commencement date had not been confirmed, however it was anticipated by the September meeting the UHB may see this activity coming back. **Resolved that:** (a) the Committee noted the Regulatory Compliance Tracking Report.	**NF**
AAC 20/07/010	**Internal Audit Tracking Report** The DCG introduced the report and it was taken as read by all Committee members. **Resolved that:** (a) the Committee noted the tracking report which is now in place for tracking audit recommendations made by Internal Audit. (b) the Committee noted that progress will be seen over coming months in the number of recommendations which are completed/closed.	
AAC 20/07/011 Bricknell,Helen 09/03/2020 08:30:14	**Audit Wales Tracking Report** The DCG introduced the report and it was taken as read by all Committee members. The DCG confirmed the report outlined 3 years' worth of tracking of recommendation from Audit Wales.	

	Resolved that: (a) the Committee noted the Audit Wales Tracking Report.	
AAC 20/07/012	**Items to bring to the attention of the Board / Committees** There were no items to be brought to the attention of the Board / Committees.	
AAC 20/07/013	**Review of the Meeting** The CC thanked everyone for their attendance and contribution to the meeting	
AAC 20/07/014	**Date and Time of Next Meeting** Tuesday 8th September 2020 9.00am – 12:00pm Via Skype	

Action Log
Following Audit & Assurance Committee Meeting
7th July 2020

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
Actions in Progress					
AAC 20/03/008 **AAC 20/04/005**	Consultant Job Planning Follow-up: Limited Assurance Report	For an update to be presented to the Committee in February 2021. It was agreed a follow up Internal Audit Report would be carried out at an appropriate time agreed with Stuart Walker	Stuart Walker	9.02.21 TBC	Update to be provided at February 2021 meeting. March 2021
AAC 19/12/012 **AAC 20/05/005**	Effectiveness of Clinical Audit Report	To consider arrangements to deliver effective programme of Clinical Audit To clarify plans to progress post COVID-19 with WAO	S Walker Nicola Foreman	Dec 2020	This is currently being considered as part of the Self-Assessment of Current Quality Governance arrangements - May 2020
AAC 19/12/015	Internal Audit Tracking Report	The acting Head of Internal Audit to provide sample of validation from Clinical Boards to test for accuracy in a future Internal Audit and Review	I Virgil	Nov 2020	To be brought to the November meeting

AAC 20/04/008	Declarations of Interest	A report detailing Declarations of Interest in relation to Ysbyty Calon Y Drraig be brought to a future meeting	Nicola Foreman	**08.09.20**	On agenda for September
AAC 20/04/009	Regulatory Compliance Tracking Report	A report detailing all visits and sign off for Ysbyty Calon Y Ddraig be brought to a future meeting	Nicola Foreman	**08.09.20**	On agenda for September
AAC 20/04/010	Internal Audit Tracking Report	Work be carried out with the Director of Digital & Health Intelligence to improve transparency and detailed responses	Aaron Fowler	**08.09.20**	Meeting with the Director of Digital Health Intelligence and Head of Risk Management to take place prior to September Audit Committee Meeting
AAC 20/04/015	Annual Audit Plan – Impact of COVID-19	Work undertaken on an All Wales Level relating to learning from the pandemic be shared with the UHB	Mike Usher	To be confirmed	To be confirmed
AAC 20/05/006	Internal Audit Progress	Draft Internal Audit reports presented at the May meeting to be followed up with managers and confirmed action plans to be brought to a future meeting	Ian Virgil	**08.09.20**	On agenda for September.
AAC 20/05/007	Losses and Special Payments	To provide Committee members with information on how much debt write off had been referred to a collection agency and what percentage of this became a write off	Chris Lewis	June 2020 (TBC)	In 2019/20 circa £250k was referred to the debt collection agency and of this circa 40% was written off.
AAC 20/05/008	Internal Audit Reports	To congratulate areas on positive assurance findings.	John Union	**08.09.20**	
AAC 20/07/009	Regulatory Compliance Tracking Report	Re-assessment and new targets be agreed for trackers	Nicola Foreman	TBC	
Actions referred to other Committees / Board					

REPORT TITLE:	Internal Audit Progress Report								
MEETING:	Audit & Assurance Committee						**MEETING DATE:**	08.09.20	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**	**x**	**For Information**		
LEAD EXECUTIVE:	Director of Governance								
REPORT AUTHOR (TITLE):	Head of Internal Audit								

PURPOSE OF REPORT:

SITUATION:

The Internal Audit progress report provides specific information for the Audit & Assurance Committee covering the following key areas:

- Detail relating to outcomes, key findings and conclusions from the finalised internal Audit assignments
- Specific detail relating to progress against the audit plan and any updates that have occurred within the plan.

REPORT:

BACKGROUND:

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 programme 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, amendments to the plan and also assignment follow ups.

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.

ASSESSMENT:
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 amendments to the timing of specific audits within Internal Audit Plan for 2020/21.

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

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	Prevention		Long term	x	Integration	x	Collaboration	x	Involvement		

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee September 2020

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.

1. INTRODUCTION

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

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

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

2. ASSIGNMENTS WITH DELAYED DELIVERY

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

Audit	Current Position	Draft Rating	Reason
Regional Partnership Board	Draft	Reasonable	Delay in completion of fieldwork due to availability of Internal Audit resources
Governance Arrangements During Covid-19	Draft	n/a (Advisory Review)	Awaiting sign-off by the Health Board
Sustainability Reporting	Work in Progress		Delay in completion of fieldwork due to availability of HB staff and supply of information
IM&T Control & Risk Assessment	Work in Progress		Delay in completion of fieldwork due to availability of HB staff and supply of information
Asbestos Management	Work in Progress		Delay in completion of fieldwork due to availability of HB staff and supply of information

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 in progressing with delivery of the plan. This is due to the significant level of staff resource that was required to complete the

Covid-19 Governance reviews for the five organisations supported by the South Central Audit & Assurance Team. We have also experienced general delays in being able to meet with Health Board managers and staff due to the on-going effects of the pandemic and annual leave over the summer period.

3. OUTCOMES FROM COMPLETED AUDIT REVIEWS

3.1. One assignment has been finalised since the previous meeting of the committee and is highlighted in the table below along with the allocated assurance ratings.

3.2. One of the two reports from the 2018/19 plan, which were reported to the audit committee in draft in May, has now been finalised and is detailed below. Management responses for the second report are still to be agreed and it has not therefore been finalised yet. Once agreed the final report will be presented to a future meeting of the Committee.

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

FINALISED AUDIT REPORTS (2019/20 Opinion)	ASSURANCE RATING	
Strategic Planning / IMTP	Reasonable	

FINALISED AUDIT REPORTS (2020/21 Plan)	ASSURANCE RATING	
Annual Quality Statement	Substantial	

4. DELIVERY OF THE 2020/21 INTERNAL AUDIT PLAN

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

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

4.2. As highlighted above, delivery of the 20/21 audits to date has not progressed as planned. It is however anticipated that better progress will be made as we move into quarter 3 and we will therefore be able

to deliver a higher number of finalised reports to the November and February Committee meetings.

This may however be negatively impacted if there is a second wave of the Covid-19 pandemic and in that circumstance the plan may need to be further adjusted. Any such required adjustments will be discussed with the Director of Governance and relevant lead Executives as they arise and will be communicated to future meetings of the Audit and Assurance Committee for formal approval.

4.3. Adjustments to the 20/21 plan.

The planned timings for commencement of the following audits have been postponed:

- Fire Safety – Changed from Quarter 2 to Quarter 3 following discussion with management.
- Engagement Around Service Planning - changed from Quarter 2 to Quarter 3 due to a lack of Internal Audit resource.
- Health & Care Standards - Changed from Quarter 2 to Quarter 3 due to a change in the lead manager.

The planned timings for commencement of the following audits have been brought forward:

- Surgery CB – Sickness Absence Management – Brought forward to Quarter 2 from Quarter 4 following agreement with CB management.
- Specialist CB – Patient Assessment & Provision of Equipment in ALAS – Brought forward to Quarter 2 from Quarter 3 following agreement with CB management.
- MH CB – Outpatient Clinic Cancellations – Commencement brought forward to Quarter 2 from Quarter 3 following agreement with CB management.

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

5. FINAL REPORT SUMMARIES

5.1 Strategic Planning / IMTP

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 current review has identified that there are generally good processes and controls in place for managing the risks associated with the development, evaluation approval and implementation of business cases.

There is a Health Board Business Case flow chart in place, however this needs to be updated to reflect the current practices of the system.

There was evidence that Clinical Boards and key staff responsible for the preparation of the business cases were being adequately supported by the corporate planning team.

The two sampled business cases had relevant backing and supporting documentation which explained the basis and need to fund the project. Although the selected copy of the business case documents were either not signed or only partly signed by key staff, they were found to be comprehensive having relevant fields to ease review and enable the Business Case Approval Group (BCAG) to reach an appropriate decision.

Adequate processes are in place for monitoring the on-going delivery of the developments and service changes that have been approved and funded through the business case process.

5.2 Annual Quality Statement

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.

Our review of the Annual Quality Statement has confirmed that the UHB has robust processes in place to ensure that the Statement is produced and published in line with the required timetable set by Welsh Government.

The Health Board has worked to the revised deadline this year and at the time of review they were on track to publish the document by the required date of 30th September 2020.

The draft statement that we reviewed is presented in a clear and user friendly format that should be easily understood by its audience. The AQS provides a clear assessment of how well the Health Board is doing, identifies areas that require improvements and effectively reports on the progress it has made year on year.

The detail of the UHBs achievements and challenges are effectively communicated within the AQS through the key themes that are in line with the Health and Care Standards for Wales and the Health Boards Quality Safety and Improvements (QSI) Framework.

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**
Governance During COVID-19 (Advisory Review)	46	Corporate Governance / Finance	Q2	Draft – Issued August 20		Nov
Regional Partnership Board	07	Strategic Planning	Q2	Draft – Issued August 20		Nov
IM&T Control & Risk Assessment	01	Transformation & Informatics	Q2	Work in Progress		Nov
Concerns / Serious Incidents	18	Nursing	Q2	Work in Progress		Nov
Integrated Health Pathways	20	Transformation & Informatics	Q2	Work in Progress		Nov
Surgery CB - Sickness Absence Management	29	COO	Q2	Work in Progress (Brought forward from Q4)		Nov
Sustainability Reporting	38	Finance	Q2	Work in Progress		Nov
Asbestos Management	40	Finance	Q2	Work in Progress		Nov
Specialist CB – Patient Assessment & Provision of Equipment in ALAS	28	COO	Q2	Work in Progress (Brought forward from Q3)		Nov
MH CB – Outpatient Clinic Cancellations	31	COO	Q2	Work in Progress (Brought forward from Q3)		Nov

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Claims Reimbursement	04	Nursing	Q3	Planning		Nov
Health and Care Standards	03	Nursing	Q3	Planning		Nov
CD&T CB – US Governance	33	COO	Q3	Planning		Nov
Whistleblowing Policy	05	Corporate Governance	Q3			Feb
Engagement Around Service Planning	06	Strategic Planning	Q3			Feb
Charitable Funds	14	Finance	Q3			Feb
Fire Safety	39	Finance	Q3	Planning		Feb
Capital Systems Management	*44*	*Strategic Planning*	*Q3*	*Planning*		*Feb*
Strategic Performance Reporting	09	Transformation & Informatics	Q3			Feb
UHB Core Financial Systems	13	Finance	Q3			Feb
Directorate Level Financial Control	15	Finance	Q3			Feb
ITIL Service Management	21	Transformation & Informatics	Q3			Feb
Nurse Staffing Levels Act	17	Nursing	Q3			Feb
Clinical Board QS&E Governance	19	Nursing	Q3			Feb

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Medicine CB – Bank & Agency Nurses Scrutiny Process	30	COO	Q3			Feb
PCIC CB – GP Access	32	COO	Q3			Feb
Recruitment & Retention of Staff	35	Workforce	Q3			Feb
Management of Staff Sickness Absence	36	Workforce	Q3			Feb
Commissioning	08	Strategic Planning	Q3			April
Public Health	12	Public Health	Q3			April
Infrastructure / Network Management	23	Transformation & Informatics	Q3			April
Major Capital Scheme – UHW New Academic Avenue	42	Strategic Planning	Q3			April
Risk Management	02	Corporate Governance	Q4			April
Data Quality Performance Reporting	10	Transformation & Informatics	Q4			April
Departmental IT System	25	Transformation & Informatics	Q4			April
Tentacle IT System Follow-up	26	Transformation & Informatics	Q4			April
Cyber Security System Follow-up	27	Transformation & Informatics	Q4			April

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
C&W CB – Rostering in Community Children's Nursing	34	COO	Q4			April
Consultant Job Planning Follow-up	37	COO	Q4			April
Major Capital Scheme – UHW II	41	Strategic Planning	Q1-4			April
Shaping Future Wellbeing in the Community Scheme	43	Strategic Planning	Q4			April
Development of Integrated Audit Plans	45	Strategic Planning	Q1-4			April
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 has 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		

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	
Governance During Covid-19	n/a	Draft	21/08/20	18/09/20				
Regional Partnership Board	Reasonable	Draft	28/08/20	21/09/20				

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2020/21	G	April 2020	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 20/21	R	60% 3 from 5	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 3 from 3	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	100% 1 from 1	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 1 from 1	80%	v>20%	10%<v< 20%	v<10%

Audit and Assurance Services
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Archwilio Cymru
Audit Wales

Audit Committee Update – Cardiff & Vale University Health Board

Date issued: September 2020

Document reference: 1996A2020-21

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

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).

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2019-20 Accountability Report and Financial Statements	Completed. Certified by the Auditor General and laid by the Senedd in early July 2020. On 8 September, the Audit Committee will consider our 2019-20 Audit of Accounts Addendum Report. This report sets out our formal audit recommendations and provides an update on the Health Board's progress with the previous year's recommendations.
Audit of the 2019-20 Funds Held on Trust Accounts	The audit will be undertaken in the autumn and is scheduled to be completed (and the accounts certified) in December 2020, ahead of the Charity Commission's deadline of 31 January 2021.
Audit of the 2020-21 Accountability Report and Financial Statements	Audit planning is scheduled to start in December.

Performance audit update

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

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

Exhibit 2 – Work completed

Area of work	Considered by Audit Committee
Counter Fraud Arrangements	September 2020
Structured Assessment 2019	December 2019
Implementing the Wellbeing of Future Generations Act	December 2019

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Structured Assessment 2020 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. In the context of Covid-19, this work will examine governance arrangements, managing financial resources and operational planning.	Draft report in clearance November 2020

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Follow-up of previous IM&T recommendations Executive Lead – Director of Informatics	In 2014, we carried out work to assess progress in addressing previous IM&T related issues and recommendations. We concluded that the Health Board had made some progress, but further work was needed. At that time, we made some additional recommendations. This work will follow up progress against these recommendations.	Draft report in clearance November 2020
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 November 2020
Follow-up of operating theatres Executive Lead – Chief Operating Officer	We have previously reviewed operating theatres in 2011 and again in 2013. Although our work had highlighted progress, we identified that there had not been a focus on improving service quality and addressing problems with staff engagement. We also made some additional recommendations. This work will follow up progress against these recommendations.	Report being drafted November 2020
Review of WHSSC	This work will use aspects of our structured assessment methodology to examine the governance arrangements of WHSSC.	Fieldwork underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Executive Lead – Chief Executive Officer	Our findings will be summarised into a single national report.	November 2020
Test, Track and Protect Executive Lead – Director of Public Health	In response to the Covid-19 pandemic, this work will take the form of an overview of the whole system governance arrangements for Test, Track and Protect, and of the Local Covid-19 Prevention and Response Plans for each part of Wales.	Fieldwork underway TBC

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Quality Governance Executive Lead – Director of Nursing and Patient Experience	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured assessment work across Wales which has pointed to various challenges with quality governance arrangements.	Fieldwork on hold TBC
Review of Unscheduled Care	This work will examine different aspects of the unscheduled care system and will include analysis of	Data analysis currently being completed

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Executive Lead – Chief Operating Officer	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.	Further work postponed to 2021 and replaced with work on Test, Track and Protect TBC
Local work 2020 (TBC)	The precise focus of this work is still to be determined.	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
Unearth the value in your data (January 2020)	This webinar was for organisations that want to transform the way they collect, analyse and use data, at all levels. There are no materials available following the webinar.

Event	Details
Working together to identify and reduce vulnerability (February 2020)	This seminar focussed on how to achieve effective governance and accountability in partnership working to deliver efficient public services. There are no materials available following the seminar.

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
'Raising Our Game' - Tackling Fraud in Wales	July 2020
Rough Sleeping in Wales – Everyone's Problem; No One's Responsibility	July 2020
NHS Wales Finances Data Tool - up to March 2020	July 2020

Title	Publication Date
Findings from the Auditor General's Sustainable Development Principle Examinations	May 2020

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Archwilio Cymru
Audit Wales

Audit of Accounts Report Addendum – Recommendations – **Cardiff and Vale University Health Board**

Audit year: 2019-20

Date issued: August 2020

Document reference: 1986A2020-21

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Contents

Audit of accounts report addendum

Introduction

1 This report is an addendum to our Audit of the Financial Statements Report that we presented to you on 29 June 2020. It sets out the recommendations arising from our audit of the 2019-20 accounts, and also provides an update on the progress you have made against our previous years' recommendations.

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

Recommendations from this year's audit

3 In our Audit of Financial Statements Report we noted that we would present a separate report with details of the recommendations arising from our financial audit work. **Exhibits 1 to 3** set out three audit findings and recommendations, together with the management responses to each.

Exhibit 1

Matter arising 1 – some of the accounting processes and records need to be simplified, with far less use of manual adjustments to financial ledger outputs	
Findings	In 2018 we reported on the format of the coding structure within the financial ledger, which does not directly support key parts of the financial statements. This arrangement has led to a high level of manual adjustments being required outside the ledger, using spreadsheets. We still consider the process in place to be overly complex and therefore difficult and time consuming to audit. In 2018 management partially accepted our findings and recommendation and, while explaining why the level of manual adjustments is necessary, agreed to reduce the need for manual adjustments where feasible. We are raising these findings again, two years later, because we consider there is still a need to improve the coding format and some of the underlying processes in place. Also, for your awareness, Audit Wales has been piloting an increased use of data analytics, based on financial ledger data, as part of its audits of health boards' annual financial statements. The Health Board's current arrangements are unlikely to support

Matter arising 1 – some of the accounting processes and records need to be simplified, with far less use of manual adjustments to financial ledger outputs	
	the use of meaningful data analytics, reducing the scope for audit efficiencies and any resultant fee savings.
Recommendation	The Health Board should re-evaluate why so many manual adjustments are currently necessary and, in doing so, liaise with us and consider engaging with a health board that has the same finance system and avoids a similar level of manual intervention.
Accepted in full by management	Yes
Management response	The Health Board agrees to review its manual adjustments and assistance from Audit Wales in identifying good practice would be very helpful.
Implementation date	April 2021

Exhibit 2

Matter arising 2 – the quality of some of the Health Board's underlying working papers requires further improvement	
Findings	Some of the Health Board's working papers that supported the financial statements were very complex and unnecessarily difficult and time consuming to comprehend and audit. Examples included: • supporting spreadsheets that had numerous manual entries, rather than stronger formula-based entries. This inefficient basis of preparation generated extended audit work which found errors, often due to incorrect manually-entered data. • the volume of certain working papers was excessive, such as the year-end debtors which

Matter arising 2 – the quality of some of the Health Board's underlying working papers requires further improvement	
	were supported by around 30 individual working papers. This also led to extended audit work. We have liaised with officers on the underlying detail and have agreed to discuss areas for improvement as part of our respective early planning for the preparation and audit of the 2020-21 financial statements.
Recommendation	The Health Board should review and simplify its supporting records for certain areas of its annual financial statements, 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 how some of the documentation affects our audit.
Accepted in full by management	Yes
Management response	The Health Board will work with Audit Wales to review its supporting records with the aim of simplification to support the final accounts audit.
Implementation date	April 2021

Exhibit 3

Matter arising 3 - related party declarations need to be signed and submitted after the end of each financial year.	
Findings	The Health Board sought signed 2019-20 related party declarations from its Independent Members (IMs) and Senior Officers (SOs) prematurely, by doing so before the financial year had concluded.

Matter arising 3 - related party declarations need to be signed and submitted after the end of each financial year.	
	For example, the Health Board had received 55% of the signed returns by January 2020 and 79% of them by 1 March 2020. Each year it is essential that all declarations are signed and submitted after 31 March (ie for 2019-20 the signed declarations should have been due after 31 March 2020). One exception to this principle is when IMs and SOs leave the Health Board and, per our 2018 audit recommendation, are required to provide a signed declaration at the time of departure. Due to the premature signing and submission of most of the 2019-20 declarations, where necessary, the Health Board had to request written confirmation from IMs and SOs that there had been no changes in their circumstances between the date of their signed declarations and 31 March 2020.
Recommendation	The Health Board should update its annual 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.
Accepted in full by management	Yes
Management response	The Health Board will revert to requesting returns after 31 March in 2021. The Health Board will continue to obtain signed declarations from IMs and SOs at the time of departure. In addition, the Health Board Policy reinforces the need to review and declare interests when a possible conflict is identified.
Implementation date	31 March 2021

Recommendations from last year's audit

4 We raised ten recommendations last year, all of which the Health Board's management fully accepted. We are pleased to report that the Health Board has implemented all the recommendations.

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Effectiveness of Counter-Fraud Arrangements – Cardiff and Vale University Health Board

Audit year: 2020

Date issued: August 2020

Document reference: 2009A2020-21

This document has been prepared for the internal use of Hywel Dda University Health Board as part of work performed in accordance with statutory functions.

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

Contents

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.

Summary report

Background

1 On 11 June 2019, the Auditor General published Counter-Fraud Arrangements in the Welsh Public Sector: An Overview for the Public Accounts Committee. The report was a high-level, descriptive review of the arrangements in place within the Welsh Government, the NHS and local government (unitary authorities only), and highlighted some important messages:

- Losses caused by fraud in the public sector are significant. In a time of austerity, every pound lost to fraud is a pound that could be spent on public services.
- Fraud in all its forms is constantly evolving, so counter-fraud measures need to keep pace with the fraudsters.
- Resources devoted to counter-fraud activity vary widely across the public sector in Wales.

2 Following publication of the report, the Public Accounts Committee endorsed the Auditor General's proposal to undertake further work across a range of Welsh public sector bodies to examine how effective counter-fraud arrangements are in practice and to make recommendations for improvement. This work was undertaken during December 2019 – February 2020.

3 On 30 July 2020, the Auditor General published a national report called 'Raising our game - Tackling Fraud in Wales' which summarises the key finding from our review across Wales. It does not describe in detail the arrangements in place in individual bodies, but it identifies a range of opportunities to improve counter-fraud arrangements across Wales.

4 Whilst the national report identified that NHS counter-fraud arrangements are the most developed across the public sector, it identified that there is still a challenging agenda to make counter-fraud fit for the next decade where globalisation and the advent of digital technology have created new risks, and opportunities for the fraudsters.

5 The report calls on NHS bodies to satisfy themselves that:

- Counter-fraud resources are determined based on an assessment of local risk factors.
- Counter-fraud risk assessments are integrated with corporate risk management arrangements.
- Strategies are in place to make greater use of data analytics to both prevent and detect fraud.
- Strategies are in place to improve collaboration within the sector and more widely across sector boundaries.

6 This summary report sets out our assessment of Cardiff and Vale University Health Board's (the Health Board's) arrangements for preventing and detecting fraud. Our

assessment is based on document reviews, including board and committee papers, and interviews with a small number of staff.

Main findings and areas for improvement

7 Our assessment identified that 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. Our key findings from the work are set out in more detail in the following section of this report.

8 In undertaking this work, we identified some areas for improvement (**Exhibit 1**), they should be considered alongside the themes identified in the national report. The Health Board's management response to the areas for improvement is available in **Appendix 2**.

Exhibit 1: areas for improvement

Areas for improvement
Counter-fraud training
I1 Implement mandatory counter-fraud training for some or all staff groups
Counter-fraud staff capacity
I2 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.

Exhibit source: Audit Wales

Detailed report

Our findings

9 The following table sets out the areas of focus within our work and our findings.

Areas of work	Findings
We considered whether the top tier demonstrates a commitment to counter-fraud and provides the necessary leadership to fight fraud. We expected to see: • The Board/Executive team promoting a clear commitment to zero tolerance of fraud and championing counter-fraud work. • Senior leadership actively promoting and cascading an anti-fraud culture. • An organisation-wide understanding of responsibilities for preventing fraud and reporting suspected fraud. • An organisational commitment to counter-fraud and ethics awareness training, with appropriate and targeted mandatory counter-fraud training for all staff.	We found the following good practice: • The Executive Director of Finance is the Board executive responsible for counter-fraud. • Counter-fraud is a standing item on the Audit Committee agenda. • All fraud related issues are treated as a priority by the organisation, and there is a clear commitment from the Executive Director of Finance and the Chair of the Audit Committee • Policies and strategies send out a consistent message that fraud will not be tolerated, and that all steps will be taken to take criminal or disciplinary sanctions against perpetrators. The Health Board ensures that there are effective lines of communication between those responsible for counter-fraud, bribery and corruption work and other key staff groups and managers within the organisation. • The Health Board publicises proven frauds and the action taken. We identified the following areas for improvement: • Whilst the Health Board provides refresher counter-fraud training for staff, it is not mandatory. However, the Health Board does provide counter-fraud induction training for new starters.

Areas of work	Findings
We considered whether the organisation has a suitable structure and sufficient skilled resources to prevent and detect fraud. We expected to see: • A designated Local Counter-Fraud Specialist (LCFS) with designated responsibility for counter-fraud and the ability to influence the level of counter-fraud resources. • An appropriate level of experienced, trained and accredited counter-fraud staff to undertake investigations and counter-fraud work. • Clarity in respect of counter-fraud roles, responsibilities and lines of accountability. • Investment in counter-fraud based on informed decisions derived from a fraud risk assessment which highlights risks and determines the resources needed to address them. • An annual programme of proactive counter-fraud work (fraud prevention work) which covers the risks identified in the risk assessment with ring fenced time allocated to proactive work.	We found the following good practice: • The Health Board has a dedicated LCFS, with the ability to influence the level of counter-fraud resources designated by the Executive Director of Finance. • The LCFS is also the designated lead for three other health organisations. • The Health Board employs accredited and trained counter-fraud staff, who attend training and professional development as required. • The level of counter-fraud resources within the Health Board is just below the average for Wales (**Appendix 1**). The whole time equivalent (WTE) of local counter-fraud resources per 1,000 staff is 0.12 WTE compared to the average for NHS Wales of 0.19 WTE. • The Health Board has clearly articulated counter-fraud roles and responsibilities. There is a protocol which sets out the roles and responsibilities of the counter-fraud, finance and workforce teams in relation to pursuing fraud sanctions. • The LCFS and counter-fraud staff have access to all systems, records and premises required to do their work. • The LCFS completes the NHS Counter-Fraud Authority Self-Review Tool (SRT) on an annual basis. Where issues (risks) are identified, they are incorporated into the counter-fraud work plan, together with any issues/risks identified through general counter-fraud work. The SRT identifies proactive work priorities for the year. • The number of days allocated to proactive and reactive counter-fraud work is broadly based on previous years but is flexible and can adapt to demands as cases arise.

Areas of work	Findings
	We identified the following area for improvement: • Staffing levels are just 1.8 WTE. If the level of investigative work increased, or if any member of staff were to be absent, this could impact the ability to deliver the agreed level of proactive counter-fraud work.
We considered whether the organisation has a sound policy framework to support effective counter-fraud arrangements. We expected to see: • A counter-fraud strategy/policy which sets out the organisation's approach to managing fraud risks and defines specific counter-fraud responsibilities. • A Code of Conduct setting out acceptable behaviours and how to report and manage conflicts of interest. • Sound whistleblowing arrangements which set out mechanisms for reporting fraud. • Maintained registers of gifts and hospitalities. • Pre-employment screening.	We found the following good practice: • The Health Board has a current anti-fraud, bribery and corruption policy (the policy), which is reviewed, evaluated and updated regularly. The policy includes a counter-fraud response plan. • Staff awareness of the policy is raised in counter-fraud awareness sessions. • The Health Board has an appropriate Code of Conduct, and whistleblowing and cyber security policies with review and renewal processes in place. • The Health Board has appropriate arrangements to maintain and review registers of interests, gifts and hospitality. • The Health Board has arrangements in place to ensure that all new staff are subject to the pre-employment checks before commencing employment within the organisation. We did not identify any areas for improvement.

Areas of work	Findings
We considered whether the organisation has an effective fraud risk assessment together with appropriate responses to emerging issues. We expected to see: • Regular and comprehensive fraud risk assessments discussed and agreed with senior leaders and the Audit Committee. • Fraud risk assessments featuring as part of the organisation's overall risk management framework. • Fraud risk built into system design to minimise opportunities for fraud.	We found the following good practice: • The Health Board completes the NHS Counter-Fraud Authority's SRT on an annual basis. • Annual work plans are based upon intelligence received and identified, a review of ongoing cases, referrals and proactive work priorities identified across Wales. Counter-fraud resource levels are proportionate to the risk level identified. Measures to mitigate identified risks are included in the workplan, which is approved by the Audit Committee. • Policies and paper-based procedures are fraud proofed using guidance issued by the NHS Counter-Fraud Authority. The LCFS reviews policies and proposes changes where it is deemed necessary. • Fraud risk features within the Health Board's overall risk management framework. We did not identify any areas for improvement.
We considered whether the organisation's internal control environment support effective arrangements for preventing and detecting fraud. We expected to see: • Internal controls designed and tested to address identified fraud risks and help prevent fraud occurring.	We found the following good practice: • The Health Board's Internal Audit team review fraud risks and test controls designed to prevent and detect fraud as part of its annual programme of work. Information and intelligence are shared with local counter-fraud services in line with the agreed information sharing protocol. • The Health Board acts upon recommendations to strengthen controls if internal controls are found to be not operating as well as intended and learn lessons from fraud incidents.

Areas of work	Findings
• Internal Audit reviews of fraud risks and testing of controls designed to prevent and detect fraud. • The organisation acting on recommendations to strengthen controls if internal controls are found to be not operating as well as intended and lessons learned from fraud incidents. • The organisation uses data matching to validate data and detect potentially fraudulent activity.	• The Health Board participates in the National Fraud Initiative data matching exercise, primary care post-payment verification checks and other local checks (such as payroll). • System weaknesses are put on a tracker and go through formal internal audit process. System and policy changes are implemented as a result of weaknesses identified. We identified the following areas for improvement: • The Health Board uses NHS Shared Services Partnership for procurement and tendering which contains an automated checking service, and the Post Payment Verification team but there was concern that the more use could be made of post payment verification. • Our national review identified only a few examples of data analytics being used as a means of preventing fraud, predominantly the National Fraud Initiative data matching exercise.
We considered whether the organisation has an appropriate response to fraud. We expected to see: • A comprehensive fraud response plan which sets out clear arrangements for reporting and investigating allegations of fraud.	We found the following good practice: • The Health Board's Fraud Response Plan follows best practice as advised by the NHS Counter-Fraud Authority. • Qualified staff investigate all cases of suspected fraud, and in line with the Fraud Response Plan. Outcomes of investigations are reported to the Audit Committee and to the NHS Counter-Fraud Authority.

Areas of work	Findings
• Action to ensure that all allegations of fraud are assessed. Documented procedures for conducting fraud investigations. • Investigations which follow proper professional practice and in line with the fraud response plan • Consideration of the full range of sanctions available, and redress sought (for example the recovery of money and assets) where appropriate. • An appropriate case management system to record and monitor the progress of potential fraud cases. • Collaboration with external partners to tackle fraud.	• The Health Board utilises the full range of sanctions available (staff disciplinary action, civil action and criminal action) and seeks to recover monies where appropriate and cost effective to do so. • All investigations are documented on case management software. Learning from fraud is shared with appropriate staff to action and implement changes to systems and procedures where appropriate. • The Health Board liaises proactively and on a regular basis with other organisations and agencies such as NHS Legal and Risk Services, the police, Home Office Immigration Services, local authorities, and regulatory and professional bodies to assist in countering fraud, bribery and corruption. Specialist services can be purchased from the NHS Counter-Fraud Authority where necessary. We did not identify any areas for improvement.
We considered whether the organisation has proper reporting and scrutiny in place to ensure its counter-fraud culture and framework is operating effectively. We expected to see: • A record kept of fraud losses and recoveries. • The Audit Committee taking a proactive approach to prevent fraud and promote an effective anti-fraud culture.	We found the following good practice: • The Health Board maintains a record of fraud losses and recoveries. • Counter-fraud is a standing item on the Audit Committee agenda. • The annual plan is presented to the Audit Committee along with regular progress reports on delivering the annual programme of work, along with identified fraud risks and actions to minimise them. • Case updates are produced for the private session of Audit Committee outlining the case, status, and recoveries of money/assets.

Areas of work	Findings
• The Audit Committee challenging and reviewing counter-fraud work, and ensuring it discharges its duties in relation to counter-fraud.	We did not identify any areas for improvement.

Appendix 1

Counter-fraud resources

The following exhibit sets out the number of LCFS resources per 1,000 staff.

Exhibit 1: Number of LCFS resources per 1,000 staff (in order of highest to lowest)

	LCFS WTE	Total number of staff within the organisation	LCFS WTE per 1,000 staff (headcount)
Health Education and Improvement Wales[1]	0.2	280	0.71
Welsh Ambulance Services NHS Trust	2.0	3,535	0.57
Powys Teaching Health Board[2]	1.2	2,286	0.52
Cwm Taf Morgannwg University Health Board[2]	2.6	11,944	0.22
Hywel Dda University Health Board	2.0	10,032	0.20
Aneurin Bevan University Health Board	2.6	13,659	0.19
NHS Wales (average)	**18.2**	**94,614**	**0.19**
Swansea Bay University Health Board[2]	2.2	12,962	0.17
Betsi Cadwaladr University Health Board	2.9	18,491	0.16
Public Health Wales NHS Trust[1]	0.3	1,903	0.16
Velindre University NHS Trust[1]	0.4	4,411	0.16
Cardiff and Vale University Health Board[1]	1.8	15,111	0.12

[1] The Cardiff & Vale University Health Board LCFS Team also provide services to Health Education and Improvement Wales, Public Health Wales NHS Trust and Velindre University NHS Trust via an annual Service Level Agreement.

[2] The Swansea Bay University Health Board LCFS Team also provide services to Cwm Taf Morgannwg University Health Board and Powys Teaching Health Board via an annual Service Level Agreement.

Source: Counter-Fraud Authority NHS Wales, Operational Performance Report 2019-20 (Quarter 3), and Stats Wales Headcount as at 30 September 2019 (extracted from the NHS Electronic Staff Record system)

Appendix 2

Management response

The following table sets out the Health Board's management response to the areas for improvement (**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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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Management response

Report title: Effectiveness of Counter-Fraud Arrangements – Cardiff and Vale University Health Board

Completion date: August 2020

Document reference: 2009A2020-21

Ref	Area for Improvement	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
I1	**Counter-fraud training** Implement mandatory counter-fraud training for some or all staff groups	To improve staff understanding of fraud and how to prevent it	No	No	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.	Ongoing with review date of 31st March 2021	Bob Chadwick (Finance Director) and Martin Driscoll (Director of Workforce &OD)

I2	**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.	To ensure enough resource to meet counter fraud activity demands	No	No	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.	31st March 2021	Craig Greenstock (LCFS) and Bob Chadwick (Director of Finance)

Archwilio Cymru
Audit Wales

‘Raising Our Game’
Tackling Fraud in Wales

Report of the Auditor General for Wales

July 2020

This report has been prepared for presentation to the Senedd under the Government of Wales Acts 1998 and 2006 and the Public Audit (Wales) Act 2004.

The Audit Wales study team comprised Rachel Davies, Christine Nash and Ian Hughes, under the direction of Mike Usher.

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.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Foreword by the Auditor General

1 In June 2019, I published a report giving an overview of the scale of fraud in the Welsh public sector, together with a description of counter-fraud arrangements across the Welsh Government, the NHS and Local Government. I noted that the sums lost annually in Wales to fraud and error are significant – and could be anywhere between £100 million and £1 billion. The Crime Survey for England and Wales recognises fraud as being one of the most prevalent crimes in society today.

2 However, some senior public sector leaders are sceptical about the levels of fraud within their organisations. As a result, they are reluctant to invest in counter-fraud arrangements and assign a low priority to investigating cases of potential fraud identified to them by the National Fraud Initiative, even though there are many examples of a good return on investment in this area. Their stance runs contrary to all the research being done by recognised leaders in the field such as CIPFA and the UK Government's Counter Fraud Function. This latest report, which examines the effectiveness of counter-fraud arrangements at over 40 public-sector bodies in Wales, has found that where such scepticism arises, it is not based on any significant local counter-fraud work or robust fraud risk assessments.

3 But we also know that fraudsters appear the very instant that an opportunity presents itself. Fifteen individuals have to date been jailed for fraud in the light of the Grenfell fire tragedy. Fraudsters and scammers were quickly on the scene earlier this year whilst the flooding in South Wales was ruining the homes and lives of local people. There has been an explosion in fraudulent activity, and especially in cyber crime, during the current COVID-19 pandemic. I welcome the proactive steps which the Welsh Government has taken to raise awareness across the public sector in Wales about this risk.

4 Public sector bodies can mitigate these risks by having the right organisational culture supported by strong counter-fraud arrangements. Many local authorities have invested so little in counter-fraud arrangements that they have only a few of the key components in place. Whilst the position is generally much more robust across the NHS in Wales, there is still a challenging agenda to make counter-fraud fit for the next decade where globalisation and the advent of digital technology have created new risks, and opportunities, for the fraudsters.

5 I was heartened to see the Welsh Government's positive response to my 2019 report and, following the one-day conference organised by the Public Accounts Committee in July 2019, the Permanent Secretary's commitment (see **Appendix 2**) to provide Wales-wide leadership in raising the profile of counter-fraud activity.

6 In this latest report, based on a more extensive programme of field work, we identify a significant range of further opportunities to improve on the current national position, including:

a strengthening strategic leadership, coordination and oversight for counter-fraud across the Welsh public sector;

b increasing counter-fraud capacity and capabilities, especially across local government, and exploring the potential for sharing resources and expertise across public bodies;

c getting the right balance between proactive and reactive counter-fraud activities;

d improving awareness-raising and staff training in counter-fraud; and

e better evaluation of fraud risks and sharing of fraud information, both within and across sectors.

7 There is also significant potential for Wales to take advantage, where appropriate, of many of the counter-fraud initiatives underway across the wider UK public sector. These include the recent establishment of a recognised government counter-fraud profession, with defined competencies and career paths, and the increasing focus on tackling fraud by smarter use of data analytics.

8 As I publish this report, Wales continues to grapple with the effects of the COVID-19 pandemic. This report contains a timely illustration of some of the ways in which fraudsters have moved rapidly in recent months to exploit the pandemic for criminal gain. I have already taken steps to extend the scope of our National Fraud Initiative (NFI) to enable local authorities in Wales to undertake eligibility checks on applications for COVID-19 support grants. I am also proposing to mandate that all local authorities, together with the Welsh Government, should submit COVID-19 grant and payment data to the NFI, to help identify fraudulent applications.

Adrian Crompton
Auditor General for Wales

4 Summary and recommendations

Ensuring that the arrangements for preventing and detecting fraud in the Welsh public sector are effective

This report examines seven **'key themes'** that all public bodies need to focus on in raising their game to tackle fraud more effectively:

- leadership and culture;
- risk management and control frameworks;
- policies and training;
- capacity and expertise;
- tools and data;
- collaboration; and
- reporting and scrutiny.

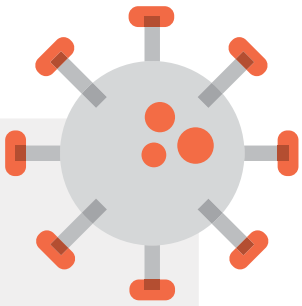
For each theme in turn, the report examines:

- why it is important;
- what our audit fieldwork identified in terms of current working practices and their effectiveness across the 40 Welsh public sector bodies that we examined (listed in **Appendix 1**); and
- what needs to happen next to generate improvement.

Our **recommendations for improvement** which are addressed to all public bodies in Wales within the Auditor General's remit, are as follows:

Theme	What needs to happen next?
Leadership and Culture 	**R1** The Welsh Government should enhance its strategic leadership of counter-fraud across the public service in Wales, playing a coordinating role where it can, while recognising that individual bodies remain responsible for their own counter-fraud activities. **R2** All public bodies should champion the importance of a good anti-fraud culture and actively promote its importance to give confidence to staff and members of the public that fraud is not tolerated.
Risk management and Control framework 	**R3** All public bodies should undertake comprehensive fraud risk assessments, using appropriately skilled staff and considering national intelligence as well as organisation-specific intelligence. **R4** Fraud risk assessments should be used as a live resource and integrated within the general risk management framework to ensure that these risks are appropriately managed and escalated as necessary.
Policies and Training 	**R5** All public bodies need to have a comprehensive and up-to-date set of policies and procedures which together represent a cohesive strategy for identifying, managing and responding to fraud risks. **R6** Staff working across the Welsh public sector should receive fraud awareness training as appropriate to their role in order to increase organisational effectiveness in preventing, detecting and responding to fraud. **R7** Cases where fraud is identified and successfully addressed should be publicised to re-enforce a robust message from the top that fraud will not be tolerated.

Theme	What needs to happen next?
Capacity and Expertise 	**R8** All public bodies need to build sufficient capacity to ensure that counter-fraud work is resourced effectively, so that investigations are undertaken professionally and in a manner that results in successful sanctions against the perpetrators and the recovery of losses. **R9** All public bodies should have access to trained counter-fraud staff that meet recognised professional standards. **R10** All public bodies should consider models adopted elsewhere in the UK relating to the pooling /sharing of resources in order to maximise the availability of appropriately skilled staff.
Tools and Data 	**R11** All public bodies need to develop and maintain dynamic and agile counter-fraud responses which maximise the likelihood of a successful enforcement action and re-enforces the tone from the top that the organisation does not tolerate fraud. **R12** All public bodies should explore and embrace opportunities to innovate with data analytics in order to strengt hen both the prevention and detection of fraud.
Collaboration 	**R13** Public bodies should work together, under the Digital Economy Act and using developments in data analytics, to share data and information to help find and fight fraud.
Reporting and Scrutiny 	**R14** Public bodies need to collate information about losses and recoveries and share fraud intelligence with each other to establish a more accurate national picture, strengthen controls, and enhance monitoring and support targeted action. **R15** Audit committees must become fully engaged with counter-fraud, providing support and direction, monitoring and holding officials to account.



The COVID-19 pandemic: a case study in how scammers and fraudsters are ready to exploit a crisis

We know from experience that fraudsters appear the very instant that an opportunity presents itself. Fifteen individuals have to date been jailed for fraud in the light of the Grenfell fire tragedy. Fraudsters and scammers were quickly on the scene earlier this year whilst the flooding in South Wales was ruining the homes and lives of local people.

Predictably, there has been an explosion in fraudulent activity, and especially in cyber crime, during the current COVID-19 pandemic.

The first reported positive cases of COVID-19 were reported in the UK on 31 January 2020. By this time the fraudsters and scammers had mobilised and were already hard at work.

The first fraud report relating to COVID-19 was received on February 9 by Action Fraud, the UK's fraud reporting centre. Since that time, the number of reports has increased significantly across the UK – the media reporting an unprecedented number of scams linked to the virus.

We have seen examples of good practice by some public bodies and organisations in Wales in identifying the fraud risks and sharing them with other bodies and citizens. The Welsh Government is liaising with the UK Cabinet Office and is sharing its guidance and learning on counter-fraud with the rest of the public service in Wales, including Local Authority Counter Fraud leads. Welsh Government officials have agreed to maintain and develop this group post-COVID. The intelligence obtained from these meetings has also assisted the Head of Counter Fraud with fraud intelligence sharing with Cabinet Office and the three other devolved administration fraud leads.

But has the Welsh public sector response been more reactive than proactive? What can we do better? Whilst globalisation has benefited the fraudsters it can also be to the advantage of counter-fraud specialists; we had early notice of scams from thousands of miles away a few weeks before the first case of COVID-19 was identified in the UK.

The COVID-19 pandemic: a case study in how scammers and fraudsters are ready to exploit a crisis

We believe that the COVID-19 pandemic provides an important opportunity for the Welsh counter-fraud community to come together (by appropriate means) and reflect on the speed and effectiveness of its response to the scammers and fraudsters.

The key issues and recommendations set out in this report could help set an agenda or framework for such an event. There has never been a timelier opportunity for Welsh public sector leaders and counter-fraud specialists to consider how to:

- create stronger strategic leadership, coordination and oversight for counter-fraud across the Welsh public sector;
- make best use of counter-fraud capacity and capabilities and explore the potential for shared arrangements, resources and expertise;
- get a better balance between proactive and reactive counter-fraud activities;
- raise awareness amongst employees and provide the necessary training to those most likely to come across a fraud; and
- evaluate fraud risks more effectively and share fraud information both within and across sectors.

So, what do we already know about the fraudsters' response to the pandemic?

The mobilisation of fraudsters has benefited from a number of factors, for example:

- more people are spending time online to shop and socially interact. Elderly people are seen as particularly vulnerable, being generally less computer literate and more susceptible to scams such as phishing emails and ordering fake products such as face masks and sanitisers.
- working patterns have changed at short notice which can leave weaknesses in processes and procedures.
- an unprecedented amount of public money has been put into a range of new and innovative financial support schemes to businesses and individuals.

The COVID-19 pandemic: a case study in how scammers and fraudsters are ready to exploit a crisis

Fraudsters and scammers mobilised quickly for a number of reasons:

- they are very good at evaluating risks and exploiting vulnerabilities which can be at a process or at an individual level;
- they have well-established tools and methodologies and can adapt them at short notice to a new opportunity; and
- they do not recognise geographical boundaries and can be effective individually and by collaborating with like-minded individuals.

There are more examples of COVID-19 frauds and scams coming to light than can be mentioned here. There are, however, a number of themes emerging:

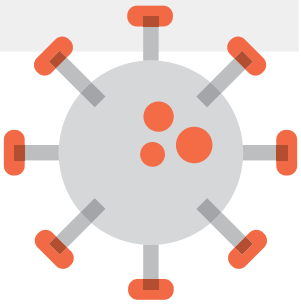
- the early reports related to the sale of Personal Protective Equipment such as face masks and hand sanitiser and testing kits. Typically, the items were fake or often failed to arrive after payment had been made[1].
- the next to emerge were phishing emails. For example, one claiming to be from the Department for Work and Pensions (DWP) asking the individual for debit or credit card details by saying that they are entitled to a council tax refund.
- as the attentions and resources of organisations were diverted to new ways of working and many staff were laid off, the incidence of cyber security attacks to steal business-sensitive and personal data increased.
- with more people working from home following the UK-wide lockdown, phishing campaigns then targeted applications that are being relied upon during remote working, in particular popular conference calling applications and parcel delivery firms.

1 NHS in Wales introduced arrangements to mitigate against this fraud risk and it did not become an issue.

The COVID-19 pandemic: a case study in how scammers and fraudsters are ready to exploit a crisis

- as the national focus turned to test and track, the fraudster's net became wide and indiscriminate, as shown by a fake text message attempting to dupe people into believing they have been in contact with someone who has tested positive for the virus, directing recipients to a website for more information. The link is then used to harvest personal and financial data.

A world-leading counter-fraud response would mean that counter-fraud specialists had identified the risks at least at the same pace as the fraudsters, if not sooner. It would also mean they had the right tools to prevent and detect fraudsters exploiting any new opportunities; and that the counter-fraud response was mobilised rapidly through effective collaboration and information sharing.



Culture and leadership across the Welsh public sector

01

Why is it important?

1.1 The Crime Survey for England and Wales recognises fraud as one of the most prevalent crimes in society today. Every pound stolen from the public sector means that there is less to spend on key services such as health, education and social services. Public sector bodies can mitigate the risks from fraud by having the right organisational culture supported by effective counter-fraud arrangements.

1.2 Strong leadership sets the appropriate tone from the top of an organisation and plays a crucial part in fostering a culture of high ethical standards. It is important that senior management leads by example and sends a clear message that fraud will not be tolerated either from inside or outside of the organisation. A strong tone at the top can raise the profile of fraud risks and promote the best standards and approaches in counter-fraud work.

What did we find?

1.3 Other than in the NHS there is an absence of any overarching strategic approach, guidance, coordination and oversight.

1.4 In NHS Wales, the NHS Counter Fraud Service[2] provides leadership, specialist investigation skills, support and guidance to the sector and a Counter Fraud Steering Group[3] provides strategic direction and oversight. This leadership model delivers a coordinated approach to counter-fraud across the NHS in Wales and a good counter-fraud culture complemented by inbuilt scrutiny of the arrangements. The legal framework specific to the NHS Wales and the levels of investment give counter-fraud a high profile and robust enforcement and recovery mechanisms. At a local level, strategic leadership was evident within Health Boards through the dissemination of a consistent message, both internally and externally, that fraud is not tolerated.

2 Which is hosted by the NHS Wales Shared Services Partnership

3 A sub-group of the All Wales Directors of Finance Forum

1.5 Across local authorities there is an absence of sector-wide strategic leadership, guidance, coordination and oversight of counter fraud. Within the individual authorities we found statements espousing a zero tolerance of fraud in policies and strategic documents. But there is much more that can be done to re-enforce the tone from the top at a practical level. We found examples where the leadership team actively promotes the importance of a good anti-fraud culture through awareness campaigns, newsletters to staff and active engagement with counter-fraud teams. But we also found in many authorities that there was little evidence that the message is driven down from the top and little priority is given to counter-fraud work. There were often competing priorities and, as a result, little time was given to counter-fraud and it often had a low profile.

1.6 In Central Government, the position is mixed. Within Welsh Government, we found evidence that counter-fraud is taken seriously, and a small team has achieved many successful outcomes, albeit its emphasis leans towards reactive rather than proactive work. We have been encouraged to see that the Welsh Government has accepted both of the recommendations made by the Public Accounts Committee following our first report. However, there remains a leadership gap that still needs to be addressed.

1.7 Across the other central government bodies that we examined, counter-fraud is not always given such a high priority. One reason for this appears to be the very low incidence of fraud being identified and reported; this poses the difficult question of whether this is due to a lack of investment in counter-fraud or a genuine low incidence of crime taking place. However, this latter explanation runs contrary to all the research being done by recognised leaders in the field such as CIPFA and the National Crime Agency.

1.8 The threat posed by fraud is also getting greater recognition within the UK. The UK government, for example, is working to make central government, and the public sector more widely, a place where fraud is actively found and robustly dealt with. It is transforming its whole approach to counter-fraud by:

a establishing a counter-fraud function;

b developing and launching a Government Functional Standard (GovS013);

c establishing a 'Government Counter Fraud Profession' to develop people and increase capability;

d providing expert advice to the rest of government on how to deal with fraud;

e delivering specialist services to assist public bodies; and

f collaborating with overseas governments to bring further expertise to the UK.

What can the Welsh public sector do to improve?

Recommendations

R1 The Welsh Government should enhance its strategic leadership of counter-fraud across the public service in Wales, playing a co-ordinating role where it can, while recognising that individual bodies remain responsible for their own counter-fraud activities. In doing so it could consider:

- forming strategic partnerships with the key players nationally and internationally;
- developing and delivering an all Wales counter-fraud strategy and vision;
- advocating/promoting minimum standards in terms of public sector counter-fraud arrangements similar to those established by the UK Government;
- elevating the status of counter-fraud staff by recognising counter fraud as a profession with essential competencies;
- supporting the other sectors by, for example, providing invest-to-save funding opportunities, and supporting the development of professional competencies across the Welsh public sector; and
- providing timely advice and guidance on 'hot' issues by gathering and disseminating important information and analysing trends.

R2 All public bodies should champion the importance of a good anti-fraud culture and actively promote its importance to give confidence to staff and members of the public that fraud is not tolerated.

Risk management and control frameworks

02

Why is it important?

2.1 Fraudsters are becoming more sophisticated and are evaluating opportunities and risks on a real-time basis. The management and mitigation of risk in public bodies often fails to keep up with changes in the nature and impact of potential fraud. The recent flooding in South Wales created opportunities for scams within days of the floods. Security experts have reported an explosion in fraudulent activity during the COVID-19 outbreak as the pandemic has created a myriad of opportunities for fraudsters (see **Case Study on page 10**).

2.2 A fraud risk assessment should be an honest appraisal of risks using a range of sources such as national intelligence, local intelligence, audit reports, brainstorming exercises and data-matching results. Risk assessments should be live documents and kept under constant review. Having identified the risks, bodies can then evaluate them, assessing their likelihood and the impact if the fraud were to occur. It is only when risks are properly identified and evaluated that public bodies can tackle the risks in a prioritised and proportionate way and put appropriate actions and controls in place to manage or mitigate these risks.

2.3 It is important that organisations have an effective control framework to help mitigate the risks identified. A strong internal control environment can help to prevent fraud from happening in the first place and detect fraud if an instance has occurred. Fraudsters will try to circumvent established controls and it is important that controls are regularly reviewed. A strong control programme whereby fraudsters are faced with a real prospect of detection helps mitigate the risk. When frauds are discovered, controls should be reviewed to identify weaknesses and introduce improvements. Internal Audit have expertise in designing and testing controls and they should undertake work on key systems on a risk-based approach.

What did we find?

2.4 The quality of counter-fraud risk assessment and mitigation varies significantly in the Welsh public sector and there is generally scope to improve their quality and timeliness.

2.5 In the NHS, National Fraud Risk Alerts are produced by the NHS Counter Fraud Authority. These are routinely circulated to all Local Counter Fraud Specialists (LCFS) and Directors of Finance across NHS Wales. The LCFS are also required to conduct their own local risk assessments. This is a relatively new requirement and we found that these assessments are still being developed and embedded. The NHS Fighting Fraud Strategy recognises that a key challenge for the sector is the need to develop a comprehensive analysis of specific fraud risks to ensure counter-fraud resources are being directed to the most appropriate areas within the sector. The Counter Fraud Steering group has undertaken an overall risk assessment and produced assurance maps in respect of each main area of fraud. These maps will be used to target area of proactive work.

2.6 Our work identified that while some local authorities and central government bodies have undertaken fraud risk assessments, there were many who had not prepared a fraud risk assessment for several years. Some bodies in these sectors did not have a fraud risk assessment and therefore had not properly assessed the likelihood or impact of the risk. Without this key component, bodies cannot direct resources appropriately or adequately mitigate the risks of losses due to fraud. As a result, fraud strategies and work programmes are not particularly useful or relevant as they are not targeting the key areas of risk.

2.7 Our work also identified that, even where risk assessments were undertaken, they may not be integrated within the wider risk management framework. Fraud is not commonly reflected in corporate risk registers. We did not find many coordinated mechanisms for ensuring that fraud risks are appropriately communicated, owned and monitored within the audited body. Instead, fraud risk assessments are often held as standalone documents without any corporate ownership or active management of the risk. As a result of this approach, fraud risks are not adequately shared across departments.

2.8 We did identify some good practice in the sharing of fraud risks. In response to the Coronavirus pandemic, the Welsh Government issued a fraud risk bulletin early in April 2020, highlighting the emerging risks to the Welsh public sector. Ahead of the Welsh Government's bulletin, the UK Government Counter Fraud Function published its own guide: Fraud Control in Emergency Management – COVID-19 UK Government Guidance. The guide highlights the importance of risk assessment, effective payment verification and due diligence arrangements and the need for robust claw-back arrangements to recover funds that are paid out incorrectly. There were also good examples in local authorities of raising awareness of scams with local residents.

2.9 We found that, in general, public bodies across all sectors have internal control frameworks that are well established and internal audit teams test controls as part of their annual programmes of assurance work. However, we found that internal audit teams do not always consider the fraud risks associated with systems as part of their work programmes. Furthermore, where new systems and processes are established, we found that organisations are not always using counter-fraud contacts and internal audit teams to try to design fraud out of systems.

What can the Welsh public sector do to improve?

Recommendations

R3 All public bodies should undertake comprehensive fraud risk assessments, using appropriately skilled staff and considering national intelligence as well as organisation-specific intelligence.

R4 Fraud risk assessments should be used as a live resource and integrated within the general risk management framework to ensure that these risks are appropriately managed and escalated as necessary.

Policies and training

03

Why is it important?

3.1 A sound policy framework enables organisations to direct their approach to counter-fraud and to promote good ethical behaviour. There should be a suite of policies and procedures in place that set out what is expected and what the consequences are for breaking the rules. Codes of conduct should set out the standards expected of employees and highlight the importance of declaring conflicts of interest and establish rules around gifts and hospitality.

3.2 Publicising frauds and the recovery action undertaken, helps to re-enforce the message from the top that fraud will not be tolerated. Publicity can help to discourage wrongdoing by others as it can highlight the damaging repercussions of their actions.

3.3 Staff are often the first to notice something irregular or potentially fraudulent and are the often the first line of defence in the fight against fraud. These staff need easy access to a good counter-fraud policy and whistleblowing policy so they can be clear about their roles and responsibilities and the process they must follow if they suspect a fraud.

3.4 Effective training helps staff interpret policies and codes of conduct, giving them the confidence and skills to report suspected fraud. However, training and awareness-raising campaigns should be kept under continual review and must be linked to the live risk assessments so that new frauds or risks facing public bodies are quickly shared amongst staff and contractors if appropriate.

What did we find?

3.5 Generally, we found that public bodies have prepared and approved a range of policies setting out the processes to follow if staff suspect that they have uncovered a fraud. However, we identified that some policies were outdated, some were still in draft form and some were not easily accessible to staff.

3.6 Whilst NHS bodies have each developed comprehensive counter-fraud strategies (informed by an over-arching national strategy), we found that only a few other public sector bodies had done so. Such strategies set out clear approaches to managing fraud risks along with responses and actions, they define roles and responsibilities and are cross-referenced to other policies so that they can be readily understood by staff.

3.7 The NHS has a policy of proactively publicising successful fraud cases. The NHS Counter Fraud Service does this by issuing press releases and engaging with local media for interviews and promotional opportunities. Publicity helps raise awareness of fraud risks and also deters staff and contractors from committing fraud. By publicising counter-fraud work and raising awareness of the effects of fraud, the NHS involves staff, key stakeholders and the public in the fight against fraud.

3.8 We did not identify the same level of proactive publicity work in other sectors. Some local authorities take the view that publicising cases can be reputationally damaging and are therefore reluctant to publish such information. The Welsh Government recognises that more can be done to publicise fraud cases. The very low levels of fraud identified at central government bodies also means there is little publicity that can act as a further deterrent.

3.9 Our audit work also identified wide variation in levels of training and awareness-raising specifically relating to counter-fraud across the Welsh public sector. We found that a few public bodies provide fraud awareness training to all their staff. Some others provide training as part of the induction of new staff but do not provide this training for longstanding staff. We found some examples of refresher training sessions and e-learning modules provided for staff, but these are not widespread. There are many bodies that do not provide any counter-fraud training or awareness-raising events.

3.10 These findings suggest that there could be a significant proportion of the public sector workforce in Wales who have either received no fraud-awareness training at all or have not received training for several years.

3.11 There are good examples of awareness-raising in the NHS where the LCFS has an ongoing work programme to develop and maintain an anti-fraud culture within their health board. These programmes include the preparation of presentations and publications to raise awareness of fraud. There are also examples of LCFS undertaking staff surveys to capture the levels of staff awareness of fraud in order to act if necessary. In addition, the NHS has developed a fraud awareness e learning package for all staff and levels of compliance across organisations is reported the Directors of Finance on a quarterly basis. However, even in the NHS sector, counter-fraud training for new staff is generally not a mandatory requirement.

What can the Welsh public sector do to improve?

Recommendations

R5 All public bodies need to have a comprehensive and up-to-date set of policies and procedures which together represent a cohesive strategy for identifying, managing and responding to fraud risks.

R6 Staff working across the Welsh public sector should receive fraud-awareness training as appropriate to their role in order to increase organisational effectiveness in preventing, detecting and responding to fraud.

R7 Cases where fraud is identified and successfully addressed should be publicised to re-enforce a robust message from the top that fraud will not be tolerated.

Capacity and expertise

04

Why is it important?

4.1 It is important that public bodies each designate a counter-fraud champion who understands fraud and leads the organisation's approach and response. Public bodies need access to sufficient appropriately skilled counter-fraud specialists to prevent, detect and investigate suspected fraud and protect their assets. As fraud risks change, public bodies should have resources available to provide a response that is appropriate to the threat.

4.2 Skilled and experienced staff will also help to ensure investigations are undertaken properly with evidence being obtained and handled lawfully in order to secure successful sanctions and the recovery of losses.

4.3 Investigations, whilst crucial, can be time consuming and costly and the low numbers of successful prosecutions mean that public bodies cannot rely on investigations alone to combat fraud. Public bodies need to have the capacity to undertake both proactive counter-fraud work and reactive investigation work. Proactive work includes fraud awareness campaigns, training, designing policies and strategies and strengthening controls to prevent attacks.

What did we find?

4.4 Insufficient capacity arose frequently as a key challenge faced by public bodies in their efforts to combat fraud. On the ground, capacity and skills in counter-fraud vary widely across and within public sector bodies in Wales. Most of the capacity is allocated to responsive work and investigations with any spare capacity being used in preventative counter-fraud work.

4.5 In local government, some officers are sceptical about the levels of fraud within their organisations and question the need for additional resources. However, these same local authorities allocate little resource to counter-fraud arrangements, do not have robust fraud risk assessments and the following up of matches from the National Fraud Initiative is assigned a low priority. Their assumptions about low levels of fraud run contrary to all the research being done by recognised leaders in the field such as CIPFA and the National Crime Agency.

4.6 Local authorities suffered a significant loss in counter-fraud capacity when the independent Single Fraud Investigation Service (SFIS) was created in 2014. SFIS is a partnership between the Department for Work and Pensions, HMRC and local authorities and which covers welfare benefit fraud. Most of the counter-fraud specialists left the sector to work for this new organisation. A small number of authorities have retained experienced and skilled counter-fraud staff, but the workload has mostly fallen on Internal Audit teams.

4.7 Our work found that the counter-fraud arrangements were generally more advanced in the local authorities that retained a dedicated and specialist counter-fraud resource. Where Internal Audit teams carry out the counter-fraud work we found a trade-off between counter-fraud work and the general programme of assurance work due to limited resources and competing priorities.

4.8 We also found that, within some local authorities, several teams play a role in counter-fraud work; for example, Internal Audit, Council Tax, and Human Resources teams all contribute. Whilst helpful in terms of adding capacity, we found that this can result in a lack of coordination and integration between these teams and a lack of clarity in the overall picture of counter-fraud activity.

4.9 Counter-fraud is generally better resourced in the NHS than other public sector bodies and there has been an increase in LCFS resource over recent years. There is a central team within the NHS Counter Fraud Service Wales which investigates complex, large scale frauds and provides a financial investigation resource. The team also provides guidance, intelligence and investigative support to the network of finance directors and LCFS at health bodies in Wales. In addition, Welsh Government Directions require that each health body should appoint at least one LCFS who is an accredited counter-fraud professional. These LCFS are the primary points of contact for counter-fraud work at their respective health bodies and have a key role in fraud prevention and detection. Increasing staffing levels above the minimum number is a matter of local discretion.

4.10 The mixture of LCFS and support and guidance from the NHS Counter Fraud Service and the Counter Fraud Steering Group has resulted in improved counter-fraud arrangements within the NHS sector in comparison to the other sectors. However, whilst LCFS staff are often shared between individual health boards, they are not pooled across the entire sector. As a result, the relatively low counter-fraud staff numbers in some health boards can cause issues if staff members are absent from work. Even within the NHS Wales, there is a general recognition that more proactive work should be undertaken.

4.11 The Counter Fraud Team at the Welsh Government is skilled and experienced and has secured a number of high-profile prosecutions over recent years. However, a recent Government Internal Audit Agency review of the Welsh Government in 2017 concluded that the counter-fraud function could achieve more with increased resources. The Counter Fraud Team is able to draw on resources from within the Welsh Government to assist with investigations where appropriate and there are plans to increase the resource in the team in the near future.

4.12 Our audit also found that public bodies in Wales bodies are generally following traditional counter-fraud approaches with a focus on detection and investigation rather than prevention. Most public bodies recognise that more proactive and preventative work should be done, but they acknowledge that the lack of time, resources and expertise are barriers to making this shift of focus.

4.13 We did not find many examples of public bodies in Wales outside the NHS pooling resources to help reduce duplication of effort and improve the efficiency and effectiveness of counter-fraud arrangements across sectors. Pooled resources could also help to improve continuity and add flexibility to adapt to changing needs going forward.

4.14 In 2018 the UK government launched the Counter-Fraud Profession to enhance overall counter-fraud capability across government. The profession develops the skills of specialist staff and moves beyond the traditional focus of investigations, placing greater emphasis on fraud prevention and the use of data analytics. Membership across UK Government Departments has been steadily increasing, and the Welsh Government is engaged with this initiative. Organisations joining the profession are required to have learning environments that support their staff to develop and maintain professional standards.

What can the Welsh public sector do to improve?

Recommendations

R8 All public bodies need to build sufficient capacity to ensure that counter-fraud work is resourced effectively, so that investigations are undertaken professionally and in a manner that results in successful sanctions against the perpetrators and the recovery of losses.

R9 All public bodies should have access to trained counter-fraud staff that meet recognised professional standards.

R10 All public bodies should consider models adopted elsewhere in the UK relating to the pooling and/or sharing of resources in order to maximise the availability of appropriately skilled staff.

Tools and data

05

Why is it important?

5.1 An effective counter-fraud function will ensure that those responsible for it are equipped with up-to-date methodologies and the right tools for the job. Counter-fraud staff must make best use of data and intelligence in order to:

a prevent fraud by 'fraud-proofing' systems and processes; and

b mounting an effective response to suspicions of fraud.

5.2 New fraud threats are continually emerging, both globally and nationally. It is important that public bodies have flexible, cutting-edge counter-fraud approaches that are fit for a digital age and agile enough to keep up with, or better still, ahead of the fraudsters.

5.3 Cyber-attacks are an alternative means of committing traditional frauds such as the theft of assets, cash or intellectual property. PricewaterhouseCoopers' most recent global economic crime survey found that cyber crime is now the most common fraud facing UK businesses, overtaking asset misappropriation for the first time since the survey began. We can see this in the explosion in number of cyber scams linked to the COVID-19 pandemic.

5.4 Preventing fraud is always preferable to responding to an instance. Many organisations are now looking to 'fraud-proof' systems at the point of entry using the latest developments in data analytics. For example:

a the Cabinet Office has developed on-line tools that can look at 10,000 records in seven seconds to provide due diligence checks on grant applications; and

b the Department of Work and Pensions have been trialling an Artificial Intelligence system that detects fraudulent claims by searching for certain behaviour patterns, such as benefit applications that use the same phone number or are written in a similar style. Any suspicious activity is then passed on to specialist investigators.

5.5 Data analytics provide an increasingly important tool in preventing fraud as well as in its detection. We look at how public bodies can share data to help find fraud in the next section of this report.

5.6 Sophisticated technology and data analytics are of little use if they are not used effectively and this requires adequately trained resource to understand it. Therefore, it is important that public bodies have access to staff adept in data analytics in order to achieve better counter-fraud results.

5.7 Knowing what to do in the event of a suspected fraud improves the chances of a successful enforcement action. It also re-enforces the tone from the top that the organisation does not tolerate fraud. Fraud response plans need to provide a clear direction to relevant parties so that bodies are able to respond to allegations quickly and appropriately. A response plan should be reviewed regularly to ensure that responses to fraud keep abreast with changing times and emerging risks. They should outline:

a the fraud investigation process from receipt of allegation to outcome report;

b roles and procedures for securing evidence and undertaking interviews;

c details of how and when to contact the police;

d a commitment to pursuing a range of sanctions;

e reporting arrangements; and

f how lessons learned will be used to strengthen system and process controls.

What did we find?

5.8 Generally speaking, we found that more work is needed to bring counter-fraud tools and methodologies up to date to reflect the new world of cyber attacks and digitally-facilitated crimes. Many local authorities and central government bodies we looked at as part of our fieldwork did not have information security policies that reflected the risks associated with cyber crime. The situation was more positive in NHS Wales bodies.

5.9 Our review identified only a few examples of data analytics being used as a means of preventing fraud. Data analytics are used more widely to detect fraud, in following up on NFI data matches, for example, but our previous audit work[4] has shown that the level of engagement with the NFI varies considerably across Welsh public bodies.

5.10 We found that some local authorities and central government bodies did not have a fraud response plan that was communicated to all staff and which made it clear that all allegations of fraud would be investigated. The Welsh Government had a fraud response plan, but this was in draft form at the time of our audit work and was not, therefore, available to staff. Again, the position was much more positive in NHS Wales.

4 **Our October 2018 NFI report** stated that 'most Welsh public sector bodies participating in the NFI were proactive in reviewing the data matches, but a small number of participants did not review the matches in a timely or effective manner'.

5.11 NHS bodies all use the same case management system to record and monitor the progress of potential fraud cases. In other sectors, few bodies have a case management system although some do have a spreadsheet log that records information. The variation in the information collected makes it very difficult to report an all-Wales position on the level of fraud taking place. The reasons that many local authorities and central government bodies do not have a case management system or detailed records was the very low numbers of fraud cases that were being identified and handled.

5.12 Most of the public bodies we looked at consider the full range of possible sanctions (disciplinary, regulatory, civil and criminal) against fraudsters and will seek redress including the recovery of assets and money where possible. However, many bodies report such low levels of fraud that it is impossible to substantiate their claims. For any internal frauds identified, most bodies tend to deal with the perpetrators through internal disciplinary procedures.

5.13 Most of the public bodies we looked at reflected on the weaknesses revealed by instances of proven fraud and corruption and fed back to departments and teams so that they might fraud-proof their systems. The arrangements at local NHS bodies were particularly robust because fraud cases in their case management system cannot be closed down without providing assurance that any system weaknesses have been considered and remedied if necessary.

What can the Welsh public sector do to improve?

Recommendations

R11 All public bodies need to develop and maintain dynamic and agile counter-fraud responses which maximise the likelihood of a successful enforcement action and re-enforce the tone from the top that the organisation does not tolerate fraud.

R12 All public bodies should explore and embrace opportunities to innovate with data analytics in order to strengthen both the prevention and detection of fraud.

Collaboration

06

Why is it important?

6.1 Fraudsters do not respect geographical or other boundaries. This means that individual public sector bodies cannot establish effective counter-fraud arrangements by themselves. They must work collaboratively to maximise the effectiveness of their response to fraud.

6.2 Collaboration is an increasingly important aspect of public service, particularly in the context of reduced funding and the need to do more with less. Collaboration is also one of the 'five ways of working' as defined in the Welsh Government's 'Well-being of Future Generations (Wales) Act 2015: the essentials'[5] document. It is therefore essential that collaboration and the sharing of intelligence and good practice take place between public, private and third-sector bodies across the UK and internationally.

6.3 Collaboration can mean sharing people or pooling resources and, more commonly these days, in the sharing of information. This information can be shared between departments, between bodies, across different elements of the public sector and with other key stakeholders such as law enforcement authorities and the private sector. The information shared can be about the nature of a fraud or information about the identities of the perpetrators.

6.4 The sharing of data to help find fraud is a rapidly evolving area and is being facilitated by changes in the law. In 2017, the Digital Economy Act became law, enabling public authorities to share personal data to prevent, detect, investigate and prosecute public sector fraud. The Act recognises that the wider use of data-sharing could improve the prevention, detection and investigation of fraud in a number of ways, including:

a improved targeting and risk-profiling of potentially fraudulent individuals;

b streamlining processes, enabling the government to act more quickly; and

c simplifying the legislative landscape.

5 Well-being of Future Generations (Wales) Act 2015: the essentials', Welsh Government (2015)

What did we find?

6.5 Our field work across forty public sector bodies in Wales found that collaboration was insufficiently developed, reinforcing the findings of our 2019 review.

6.6 Within local authorities and central government bodies there are some good examples of bodies working jointly and some regional networks, but these tend to be informal arrangements and there is no consistency in approach. Formalising arrangements can help improve accountability and governance and can influence commitment and results.

6.7 The picture is generally more positive across local NHS bodies and the Welsh Government than in local authorities and central government bodies. However, there is scope for all public bodies to work more closely with each other and with other stakeholders to tackle fraud.

6.8 Because of the tiered approach to counter-fraud within NHS Wales and established formal partnerships with the NHS Counter Fraud Authority, there is good access to specialist fraud investigation teams such as surveillance, computer forensics, asset recovery and financial investigations. The NHS Counter Fraud Service Wales provide the surveillance, asset recovery and financial investigations services to NHS Wales, while the NHS Counter Fraud Authority provides forensic computing services and other specialist support services to NHS Wales under the terms of their annual agreement with Welsh Government.

6.9 The existence of these formal access arrangements is less well established within other sectors, but most organisations told us that they could access specialist services if required. The low level of fraud being identified was one of the reasons given for the absence of formal partnerships between public sector bodies.

6.10 We also found wide variations in the amounts of data that are shared. In most bodies, the sharing of data was typically limited to the National Fraud Initiative (NFI), although not all central government bodies currently take part in NFI. We found that some local authorities do not invest much resource into following up NFI matches and these are often the same authorities in which counter-fraud arrangements were limited.

6.11 There were very few examples of organisations working frequently across internal and external boundaries and sharing information. Common reasons for this lack of collaboration was lack of time and resources, and concerns about the sharing of data.

What can the Welsh public sector do to improve?

Recommendations

R13 Public bodies should work together, under the Digital Economy Act and using developments in data analytics, to share data and information to help find and fight fraud.

Reporting and scrutiny

07

Why is it important?

7.1 Arriving at a reliable estimate for the cost of fraud is a difficult task. This is particularly so for the Welsh public sector as our 2019 report highlighted. Whilst the UK Government produces annual estimates, there is no breakdown of this estimate to each of the devolved administrations in the UK. CIPFA's most recent analysis estimates that fraud costs the UK public sector £40.3 billion annually. The Cabinet Office[6] estimates losses due to fraud and error at between 0.5% and 5% of budget. Applying this range to annual public expenditure in Wales of around £20 billion gives a possible estimated value of losses to fraud and error between £100 million and £1 billion per annum. The losses are therefore significant and take valuable funding away from our public services.

7.2 Fraud is often under-reported as some suspicious activity identified through NFI matches, for example, is not classified as fraudulent and therefore not reported. Also, some public bodies fail to report fraud as it can attract unwanted publicity and perceived reputational damage. This situation leads to an incomplete national intelligence picture.

7.3 The International Public Sector Fraud Forum[7] has recognised that 'finding fraud is a good thing' and this is one of their 'Key Fraud and Corruption Principles'. The Forum noted that, if bodies do not find fraud, then they are unable to fight it, and that a change of perspective is needed so that the identification of fraud is seen as a positive and proactive achievement.

7.4 Reporting fraud to those charged with the governance of public sector organisations is important as it provides managers and audit committees, for example, with the information and intelligence they need to challenge and scrutinise. To facilitate accountability, public bodies should provide copies of counter-fraud reports detailing numbers of cases and outcomes to audit committees so that they are fully informed of any issues of concern and can hold management and counter-fraud teams to account. Audit committees can also promote the message that fraud will not be tolerated, supporting the efforts of counter-fraud teams.

6 Cabinet Office Cross Government Fraud Landscape Report 2018

7 International Public Sector Fraud Forum A Guide to Managing Fraud for Public Bodies in Feb 2019

What did we find?

7.5 The arrangements in NHS Wales to record, collate and share information about fraud losses and recoveries are well established. The NHS Counter Fraud Service collates information on the number of fraud cases and recoveries from each health body as a matter of course. There are quarterly and annual Operational Performance Reports which summarise information about resources, referrals and the work of the Counter-Fraud Service and LCFS based at each health body. These reports are reviewed by the Counter Fraud Steering Group and shared with Directors of Finance and the audit committees of each health body, helping to facilitate meaningful comparisons within the sector. The NHS Counter Fraud Authority also reports to the Welsh Government on a quarterly basis.

7.6 In other sectors, audit committees are not generally provided with as much information:

a in the Welsh Government, the Audit and Risk Assurance Committee is not provided with, nor does it request, detailed information about fraud cases, although information about major cases and anti-fraud activity is included in the regular report from the Head of Internal Audit;

b in the local government sector, fewer than half the authorities report information about fraud cases, losses and recoveries to their audit committees on a regular basis; and

c even fewer central government bodies report on cases of fraud, reflecting a very low incidence of fraud being identified and managed.

7.7 The absence of both the reporting of information and arrangements to collate and share this information across the Welsh public sector is troubling for a number of reasons. It does little to help re-enforce a zero-tolerance message from the top of an organisation to both staff and external stakeholders. It may also send the wrong message to fraudsters that Wales does not see fraud as a priority and makes it difficult to assess the level of risk and how best to respond to it by senior public sector officials and politicians.

7.8 When frauds are identified, Internal Audit (or, where they exist, counter-fraud specialists) provide audit committees with reports and updates. On balance, however, audit committees outside of the NHS Wales have not been sufficiently proactive in recognising the increasing risk of fraud and in asking the searching questions necessary about the matching of resources to risk or about the lack of information being supplied about fraud risk.

What can the Welsh public sector do to improve?

Recommendations

R14 Public bodies need to collate information about losses and recoveries and share fraud intelligence with each other to establish a more accurate national picture, strengthen controls, and enhance monitoring and support targeted action.

R15 Audit committees must become fully engaged with counter-fraud, providing demonstrable support and direction, monitoring and holding officials to account if insufficient information is being provided about counter-fraud activity.

Appendices

1 Audit methods

Our audit was structured around seven key lines of enquiry to help us answer the overall question: 'Are the arrangements for preventing and detecting fraud in the Welsh public sector effective?':

- Does the top tier demonstrate a commitment to counter-fraud and provide the necessary leadership to fight fraud?
- Does the organisation have a suitable structure and sufficient skilled resources to prevent and detect fraud?
- Does the organisation have a sound policy framework to support effective counter-fraud arrangements?
- Does the organisation have an effective fraud risk assessment together with appropriate responses to emerging issues?
- Does the organisation's internal control environment support effective arrangements for preventing and detecting fraud?
- Does the organisation have an appropriate response to fraud?
- Does the organisation have proper reporting and scrutiny in place to ensure its counter-fraud culture and framework is operating effectively?

The audit fieldwork was carried out by our local audit teams between November 2019 and February 2020. Their fieldwork included:

- structured interviews – interviews with key individuals in order to understand the counter-fraud arrangements in place at each audited body; and
- document reviews – where these existed, they typically included the counter-fraud strategy, risk assessment, work plans, corporate risk register, fraud response plan, Codes of Conduct, whistleblowing policy, guidelines and procedures for local fraud investigators and counter-fraud reports/updates provided to Audit Committee.

Teams also issued a core information request in order to gather some information directly from audited bodies.

The project team collated and reviewed the local findings to distil the key messages for inclusion in this report. Our audit teams have been providing tailored feedback on their local findings to relevant staff at each audited body.

The audited bodies included in this study are:

Local Government bodies:

- Blaenau Gwent County Borough Council
- Bridgend County Borough Council
- Caerphilly County Borough Council
- Cardiff Council
- Carmarthenshire County Council
- Ceredigion County Council
- Conwy County Borough Council
- Denbighshire County Council
- Flintshire County Council
- Gwynedd Council
- Isle of Anglesey County Council
- Merthyr Tydfil County Borough Council
- Monmouthshire County Council
- Neath Port Talbot County Borough Council
- Newport City Council
- Pembrokeshire County Council
- Powys County Council
- Rhondda Cynon Taf County Borough Council
- City and County of Swansea
- The Vale of Glamorgan Council
- Torfaen County Borough Council
- Wrexham County Borough Council

NHS Wales bodies:

- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Cardiff and Vale University Health Board
- Cwm Taf Morgannwg University Health Board
- Hywel Dda University Health Board
- Powys Teaching Health Board
- Swansea Bay University Health Board
- Health Education and Improvement Wales
- Velindre NHS Trust
- Public Health Wales Trust
- Welsh Ambulance Service NHS Trust

Central Government bodies:

- Welsh Government
- Welsh Revenue Authority
- Arts Council for Wales
- Higher Education Funding Council for Wales
- National Museums and Galleries Wales
- Natural Resources Wales
- National Library of Wales
- Sport Wales
- Senedd Commission

2 The Welsh Government's response to the July 2019 recommendations of the Public Accounts Committee

PAC Recommendation	Response from the Welsh Government's Permanent Secretary
We ask that the Welsh Government consider whether there is scope and potential to support a national counter fraud team to work across Wales to ensure that at least a basic level of counter fraud work is undertaken in each local authority area by suitably trained staff.	The Welsh Government recognises and fully supports local authorities addressing fraud within the £8 billion of their general revenue expenditure. As independent democratically led organisations, the prime responsibility for the detection and prevention of fraud is for each of the 22 councils themselves. As such, we would expect all to be fully engaged in this work and for local politicians to understand and provide leadership. To make sure that the recommendation is understood and given priority, officials will raise the matter with Ministers to secure an item on the Partnership Council agenda as well as its Finance Sub Committee. Subject to Ministers' agreement, we will agenda an item for the next possible meeting.
We ask that the Welsh Government consider whether there is scope and potential to support a national counter fraud team to work across Wales to ensure that at least a basic level of counter fraud work is undertaken in each local authority area by suitably trained staff.	I am supportive of any move to increase the understanding of fraud and the consistent application of best practice techniques across the Welsh Public Sector and there exists already a vehicle to bring together counter-fraud practitioners and other interested parties and drive forward a common understanding of this important area. The Welsh Government's Head of Counter-Fraud is Deputy Chair of the Wales Fraud Forum (WFF), which is a not-for-profit company run by a strategic board of volunteers. Its aims are to help prevent fraud in Wales by raising awareness in the public and private sectors and amongst individuals. In particular, its stated objectives include to: • bring the public and private sectors together to fight fraud and financial crime and to protect the economy of Wales;

PAC Recommendation

Response from the Welsh Government's Permanent Secretary

- promote fraud awareness amongst its membership, organisations and individuals throughout the region;
- create good practice cultures by encouraging and developing anti-fraud strategies for its membership to utilise;
- establish a best practice between its members for fraud prevention, investigation and detection; and
- promote an open and co-operative environment between the membership in both the public and private sectors.

The Forum is held in high regard; in 2017 the current First Minister gave the keynote address at its annual conference and outlined his support for effective counter-fraud arrangements across Wales. Forum membership includes the Audit Wales as well as a number of public and private sector organisations.

Therefore, I believe the Welsh Government can achieve the outcome desired by identifying strategies to support the work of the Forum, raising its profile within the Welsh Public Sector and seek a high level of commitment to support it. I will ask Officials to engage with the Forum to discuss strategies for strengthening its effectiveness by the end of the calendar year.

We agree there is potential in the use of data sharing between Welsh public bodies to improve the impact of counter-fraud activities. The introduction of the Digital Economy Act gives the Welsh Government and certain scheduled Welsh public bodies useful new powers to share data with each other compliantly to identify potential fraud. Officials are working on setting up the appropriate governance for taking forward the use of these new powers in Wales, and are aiming for a panel to be in place by the end of the financial year to consider potential uses of the powers.

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Report Title:	**Declarations of Interest, Gifts, Hospitality & Sponsorship**								
Meeting:	**Audit & Assurance Committee**						**Meeting Date:**	**9 September 2020**	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**	**X**	
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Risk and Regulation Officer**								

Background and current situation:

As previously agreed by the Audit & Assurance Committee an update on Declarations of Interest, Gifts, Hospitality and Sponsorship would be provided to each Audit Committee for information. This report provides an up to date position from the new financial year of April 2020.

Due to the ongoing COVID-19 situation, all planned Standards of Behaviour communication has been paused and will commence again in the coming months. Initial communications will tie in with the Health Board's Health Charity to remind all staff members of the need to declare gifts following the increase in donations over previous months. Thereafter communications will focus on key events and dates throughout the year to include Christmas and sporting events (as and when they resume).

In the event of any further spike in COVID-19 related activity an additional reminder will be circulated in anticipation of a further increase in informal donations, as has been experienced over the previous 5 months.

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

The following eight Declarations were received and included on the register from 1 April 2020. These have been RAG rated as follows:

- Two Declarations of Interest declared; one presented as a potential conflict and the other presented as no cause for concern
- Four Declarations of Interest with 'No Interest' declared which present no cause for concern
- Two Declarations of Gifts which present no cause for concern.

Level of Conflict Key:	
HIGH	High Conflict which needs managing
MEDIUM	Potential Conflict - Line Manager should be made aware and expectation that declaration is updated should conflict arise
LOW	No cause for concern

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 the ESR record keeping system 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.*

Report Title:	**Legislative and Regulatory Tracker Report**								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	8th Sepetember 2020	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

In January 2019 the organisation received a report on Legislative and Regulatory Compliance which provided a 'limited' assurance rating and made seven recommendations. These recommendations were all accepted by the Director of Corporate Governance. Four of the ratings were classed as high priority and three were rated as medium priority.

Good progress has been made on the development of a Legislative and Regulatory Tracker and the follow up internal audit report provided an assurance rating of 'reasonable' so 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:

Further work will be undertaken to improve the Regulatory and Legislative Compliance Tracker by the new Risk and Regulation Team which comprises a Head of Risk and Regulation plus two Risk and Regulation Officers (one of whom is yet to commence their employment). The onset of Covid-19 has temporarily stalled the Risk and Regulation Team's progress but it is hoped that the additional capacity secured will, moving forward, have the ability to further develop the 'Tracker' in addition to supporting the roll out of the departments Risk Management plans.

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
- 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 quarterly basis after been presented to HSMB.

Based on the information contained within the tracker there have been a further 21 inspections reported since the 3rd March 2020 (including inspections that had taken place prior to the 3rd March but have not previously been reported) as follows:

1) An inspection was undertaken by the All Wales Quality Assurance Pharmacist at Pharmacy SMPU on the 27th January 2020.

   Outcome – The inspection recommended a total of 166 Actions to be completed by the 31st December 2020.

2) An inspection was undertaken by the All Wales QUALITY Assurance Pharmacist at Pharmacy UHL on the 6th August 2020 – Further details of the outcome of the inspection are awaited.

3) An inspection was undertaken by Cardiff and Vale of Glamorgan Food Hygiene Ratings at the Teddy Bear Nursery on the 20th February 2020.

   Outcome: A food hygiene rating certificate of 5 was awarded.

4) An inspection was undertaken by Cardiff and Vale of Glamorgan Food Hygiene Ratings at Barry Hospital Kitchens on the 10th March 2020.

   Outcome: A food hygiene rating certificate of 5 was awarded.

5) An inspection was undertaken by Cardiff and Vale of Glamorgan Food Hygiene Ratings at the Teddy Bear Nursery on the 22nd May 2020.

Outcome: Due to COVID-19 an intelligence gathering exercise was undertaken and no matters of public health concern were identified.

6) An inspection was undertaken by Fire and Rescue Services at the Multi Storey Car Park, UHL on the 16th March 2020.

   Outcome: The inspection noted that the car park appeared to comply with the requirements of the Regulatory Reform Safety Order 2005

7) An inspection was undertaken by Fire and Rescue Services at Orthopaedic Centre, UHL on the 18th February 2020.

   Outcome: The inspection noted that the centre appeared to comply with the requirements of the Regulatory Reform Safety Order 2005

8) An inspection was undertaken by Fire and Rescue Services at Ward A6 on the 19th February 2020.

   Outcome: The inspection noted the following breaches: 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: Firefighting and fire detection: The fire detection is not adequate for the type and use of the premises.
   Article 17: Maintenance - Fire resisting doors are not adequately maintained

9) An inspection was undertaken by Fire and Rescue Services at Rookwood Hospital on the 10th February 2020.

   Outcome: The inspection noted the following breaches:
   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: Firefighting and fire detection: The fire detection is not adequate for the type and use of the premises.

10) An inspection was undertaken by Fire and Rescue Services at Vale Mental Health Services on the 27th January 2020.

    Outcome: The inspection noted the following breaches:

    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: Firefighting and fire detection: The fire detection is not adequate for the type and use of the premises.

11) An inspection was undertaken by Fire and Rescue Services at Vale Community Offices, Barry Hospital on the 27th January 2020.

Outcome: The inspection noted the following breaches:

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: Firefighting and fire detection: The fire detection is not adequate for the type and use of the premises.

12) An inspection was undertaken by Health Inspectorate Wales (HIW) at EU and AU UHW on the 10th and 11th March 2020.

Outcome - HIW have suggested that the UHB is required to provide HIW with details of the action it will take to ensure a system is in place to ensure all patients have a patient identification band to ensure staff can correctly identify patients and provide the right care. Improvement plans have been submitted to HIW.

13) An inspection was undertaken by HIW at the Sam Davies Ward, Barry Hospital 28th and 29th January 10th and 11th March 2020.

Outcome - HIW recommended that the service could improve discharge planning to avoid delayed transfers of care and provide a training matrix for staff. Improvement plans have been submitted to HIW.

14) An inspection was undertaken by HIW at Hafan y Coed (Maple and Elm Wards) on the 10th and 12th February 2020.

Outcome - HIW issued and immediate assurance letter on the 13th February 2020 which was followed by a next steps letter on the 13th March 2020. Improvement plans have been submitted to HIW.

15) An inspection was undertaken by the Information Commissioners Office at the Health Board's Information Governance Department (Woodland House) during February 2020.

Outcome – A total of 25 recommendations were made which are being monitored via the Health Board's Digital Health and Intelligence Committee.

16) An inspection was undertaken by the Medicines and Healthcare products Regulatory Agency at Blood transfusion (BSQR) on the 4th and 5th March 2020.

Outcome – 1 comment and 6 other notes were made following the inspection.

17) An inspection was undertaken by the Medicines and Healthcare products Regulatory Agency Pharmacy SMPU on the 18th February 2020.

Outcome – 1 major finding and 10other notes were made following the inspection.

18) An inspection was undertaken by Natural Resources Wales at Radiology and Theateres UHL on the 12th February 2020.

Outcome – 3 actions were noted and have been complied with.

19) An inspection was undertaken by UKAS at Biochemistry between the 12rd and 29th March 2020.

Outcome – 31 mandatory findings and 31 instances requiring evidence were noted. 11 actions were also recommended.

20) An inspection was undertaken by UKAS at Haematalogy/Lab Med between the 31st March to the 7th April 2020.

Outcome – 2 findings and 1 recommendation were made.

21) An inspection was undertaken by UKAS at the Institute of Medical Genetics on the 29th May 2020.

Outcome – No findings/Non-Conformances were raised.

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

1. The Fire and Rescue Service were due to undertake inspections under the Health and Safety at Work Act at Carys Ward ICU, Ward A5, Ward B5 and across a number of operating Theatres on the 1st September 2020.

2. UKAS were due to undertake an inspection at Perioprative Care on the 1st September 2020 and are scheduled to inspect Biochemistry between the 7th and 11th December 2020.

Recommendation:

For Members of the Audit Committee to:

(a) Note the inspections which have taken place since the last meeting of the Audit Committee in September 2020 and their respective outcomes.

(b) To note the continuing development of the Legislative and Regulatory Compliance Tracker.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

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

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

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

REGULATORY BODY REVIEW TRACKER - September 2019

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	Inspection outcome	inspection closure due by	inspection closure complete/ontrack? 1=Y 2=N
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	2
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy UHL	Quality Assurance of Aseptic Preparation Services	Stuart Walker	QSE Committee	Darrel Baker		06.08.2020				2
CD&T	Pharmacy	All Wales Quality Assurance Pharmacist	Pharmacy SMPU	Medicines Act 1968 (c.67) specific review of section 10	Stuart Walker	QSE Committee	Darrell Baker	365	01.11.2018	01.10.2019	High Risk - resourcing of an accountable pharmacist	01.11.2019	2
CD&T	Pharmacy	All Wales Quality Assurance Pharmacist	Pharmacy UHL	Medicines Act 1968 (c.67) specific review of section 10	Stuart Walker	QSE Committee	Darrell Baker	365	16.07.2019		High Risk - estate and PQS defciencies - link to MHRA inspection	01.01.2019	1
CD&T	Pharmacy			Falsifying Medicines Directive	Stuart Walker	QSE Committee	Darrell Baker	n/a	n/a	n/a	no inspection data as yet		
BRITISH STANDARDS INSTITUTE													
	Planning	British Standards Institute	Capital, Estates & Facilities	ISO - 14001 Environmental	Abigail Harris	Health and Safety	Jon McGarrigle	185 (Twice Yearly)	01.07.2019	01.01.2020	Minor non conformances which will be addressed by next audit		
CARDIFF AND VALE OF GLAMORGAN FOOD HYGIENE RATINGS													
	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		Due to COVID-19 an intelligence gathering exercise was undertaken. No matters of public health concern were identified.		
	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		10.03.2020		Food rating 5	30.04.2020	
	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	30.03.2020	
	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		Food rating 4		
	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		
	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		
	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		Food rating 5		
	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	30.09.2019	
	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Llandough Hospital	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety			19.09.2019		Food rating 5		
	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Hafan y Coed	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety			19.09.2019		Food rating 5		
FIRE AND RESCUE SERVICES													
Specialist Services Clinical Board	Capital and Asset Management	Fire and Rescue Services	C5 UHW	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	17.06.2019	01.06.2020	Failed to comply with requirements of safety order. Schedule of works required included: 3 x management	IN01: non-compliance but insufficient for enforcement notice. May return to check	1
Medicine Clinical Board	Capital and Asset Management	Fire and Rescue Services	B7 UHW	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	27.06.2019	01.07.2020	Failed to comply with requirements of safety order. Schedule of works required included: 3 x management 1 x compliance 1 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.	1
Surgery Clinical Board	Capital and Asset Management	Fire and Rescue Services	West 3 Anwen Ward UHL	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	09.07.2019	01.07.2020	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	1
Surgery Clinical Board	Capital and Asset Management	Fire and Rescue Services	Cerys Ward ICU	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	10.09.2019	01.09.2020	Failed to comply with requirements of safety order. Schedule of works required included: 1 x compliance 1 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been	1
Surgery Clinical Board	Capital and Asset Management	Fire and Rescue Services	Ward A5	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	19.09.2019	01.09.2020	Failed to comply with requirements of safety order. Schedule of works required included: 1 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check	1
Specialist Services Clinical Board	Capital and Asset Management	Fire and Rescue Services	Ward B5	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	19.09.2019	01.09.2020	Failed to comply with requirements of safety order. Schedule of works required included: 1 x compliance 1 x estates 1 x management	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.	1
Surgery Clinical Board	Capital and Asset Management	Fire and Rescue Services	Operating Theatres	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	30.09.2019	01.09.2020	Failed to comply with requirements of safety order. Schedule of works required included: 2 x compliance 1 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been	1
Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Rhydlafar Ward, St David's Hospital	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	21.01.2020	01.01.2021	Complied with the requirements of the Regulatory Reform Safety Order 2005	IN01: non-compliance but insufficient for enforcement notice. May return to check	1
Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Lansdowne Ward, St David's Hospital	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	21.01.2020	01.01.2021	Failed to comply with requirements of safety order. Schedule of works required included: 1 x management 1 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been	1
Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Sam Davies Ward, Barry Hospital	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	27.01.2020	01.01.2021	Failed to comply with requirements of safety order. Schedule of works required included: 2 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been	1
	Capital and Asset Management	Fire and Rescue Services	Multistorey Car Park, Llandough	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			16.03.2020		the standard of fire safety appeared to comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005.		
	Capital and Asset Management	Fire and Rescue Services	Orthopaedic Centre, Llandough	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			18.02.2020		the standard of fire safety appeared to comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005.		
	Capital and Asset Management	Fire and Rescue Services	Ward A6	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			19.02.2020		Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises. Aritcle 17: Maintenance - Fire resisting doors are not adequately maintained		
	Capital and Asset Management	Fire and Rescue Services	Rookwood Hospital, Artificial Limb Centre	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			10.02.2020		Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.		
	Capital and Asset Management	Fire and Rescue Services	Vale Mental Health Services, Barry Hospital	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			27.01.2020		Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.		

	Capital and Asset Management	Fire and Rescue Services	Vale Community Offices, Barry Hospital	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			27.01.2020		Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.		
HEALTH AND SAFETY EXECUTIVE													
		Health and Safety Executive		Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety							
HEALTH EDUCATION AND IMPROVEMENT WALES													
		Health Education and Improvement Wales											
HEALTH INSPECTORATE WALES													
Children & Women	Maternity	HIW	Maternity Services	HIW	Ruth Walker	QSE	Head of Midwifery				HIW are undertaking a national review of maternity services across Wales (Phase 2).	Details of community maternity sites sent to HIW 17.07.20 and self	
Medicine	Unscheduled Care	HIW	EU and AU, UHW	HIW	Ruth Walker	QSE	Director of Nursing, Medicine		10-11th March 2020		HIW have suggested that the UHB is required to provide HIW with details of the action it will take to ensure a system is in place to ensure all patients have a patient identification band to ensure staff can correctly identify patients and provide the right care. Six patients in the lounge area of the AU were not wearing wristbands; two patients were in receipt of intravenous medication.	Improvement plan to be returned by **19th March 2020.** Improvement Plan sent to CEO office to send to HIW on 18.03.20. Updated improvement plan sent to HIW 02.07.20. Assurance received 09.07.20.	**To be reported at August 2020 QSE**
Medicine			Sam Davies ward, Barry hopsital	HIW	Ruth Walker	QSE	Director of Nursing, Medicine		28-29th January 2020		HIW found overall that the ward provided a very good environment to support the care and treatment of the patients. The ward was well equipped, with a range of activities available to patients. The number of initiatives on the ward to improve patient outcomes is commended. Staff on the ward were committed to delivering a very good standard of patient care. There was very good management and leadership seen within the ward and staff felt supported by management. Patients reported a positive experience on the ward and were treated with dignity and respect. HIW recommended the service could improve discharge planning to avoid delayed transfers of care and provide a training matrix for staff.	Improvement plan to be returned by **24th March 2020** Improvement plan sent ot HIW 26.03.20. Letter received dated 27.03.20 advising inspection report has now been finalised and sent for publication and that sufficient assurance provided.	**To be reported at August 2020 QSE**
Mental health			Hafan Y Coed - Elm and Maple Wards	HIW	Ruth Walker	QSE	Director of Nursing, Mental Health		10-12 February 2020		Immediate assurance letter issued 13/02/2020 with a deadline for response 20th February which was not met due to a delay in the CEOs office. Extension requested. 04.03.20 - Immediate Assurance acceptance received from HIW. Inspection next steps letter issued 13/03/20 to 1. Review the inspection report; 2. Complete the improvement plan; 3. Send HIW our feedback. Deadline is 24.03.20.	**24.03.20** Improvement plan sent to 26.03.20. Final report published **21.07.20**	**To be reported at August 2020 QSE**
Mental health	Community Mental health	HIW	Cardiff North West Gabalfa Clinic CMHT	HIW	Ruth Walker	QSE	Director of Nursing, Mental Health		Due on 17th & 18th March 2020- postponed due to Covid		Pre inspection infromation to be submitted by March 9th. 29.01.20 HIW informed of two liaison members of staff to work with HIW team. **Inspection was cancelled due to Covid 19**		
PCIC	GP Practice	HIW	Llanishen Court Surgery	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		10.12.2019		HIW found that there were limited processes in place to support the safe recruitment and training of staff. They also found in the records of a sample of members of staff, there was no evidence that DBS checks had been undertaken.	Immediate improvement plan to be returned by 19.12.19	**To be reported at April 2020 QSE Committee**
Children & Women	Obs & Gynae	HIW	Maternity Unit, UHW	HIW	Ruth Walker	QSE	Director of Nursing, C&W		18,19&20/11.2019		Checks of equipment used in a patient emergency were insufficient. This is because checks were inconsistent and not all were recorded as being carried out appropriately in relation to neo-natal resuscitaires (daily checks), emergency resuscitation equipment (daily checks), difficult airway equipment (weekly checks). Also found was out-of-date equipment, including one airway and blood sample bottles, on one emergency trolley. Storage arrangements for the emergency resuscitation equipment, inlcuding a defibrilator was stored in a cluttered room with prevented ease of access in an emergency. Door to a treatment room on the Delivery ward was unlocked. The room contained stock, including epidural trolley and intravenous fluids. Immediate assurance plan submitted 28.11.19. **03.12.19 Assurance letter received.** 17.01.20 - draft report to Suzanne Hardacre to prepare response for RW by 28.01.20.	**Immediate assurance plan accepted 3/12/2019 Improvement plan submitted 30/1/20. Further assurance required in response to the improvement plan by February 19th. Not met due to a delay in the CEO office. Revised improvement plan sent 25th February**	**To be reported at February 2020 QSE Committee**
PCIC	GP Practice	HIW	Meddygfa Canna Surgery, Cardiff	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		31.10.2019		06.11.19 - HIW have written to Mr Williams at the practice to provide them with 1) a copy of their action plan in relation to the schedule of work required, as set out in their letter dated 04.11.19, 2) a full update once the schedule of work has been completed, 3) confirmation that they have informed C&VUHB of this inspection, and the findings and actions set to the practice by the South Wales Fire & Rescue Service. 07.11.19 - Draft response sent to Ruth Walker for amendments and comments. The practice are in the process of taking the actions required. 13.11.19 - Response sent.		
PCIC	Dental	HIW (Non-compliance notice)	Newport Road Dental Clinic	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		02.10.2019				
Specialist	Rehabilitation	HIW (Unannounced)	Rookwood Hospital	HIW	Ruth Walker	QSE	Director of Nursing, Specialist		02.10.2019		14.11.19 - Letter received from HIW for response with action plan by 29.11.19. Action plan submitted 29/11/2019. Response sent 29.11.19. Will be reported in February 2020 QSE Committee.	Final report to be published 3/01/20. To be reported in Febrauary 2020 QSE committee	
Medicine	Stroke Rehabilitation	HIW (Unannounced)	Stroke Rehabilitation Centre, UHL	HIW	Ruth Walker	QSE	Director of Nursing, Medicine		17 & 18/09/2019		Immediate assurance was required in relation to appropriate checks on resuscitation trolleys. Action plan completed. Improvement plan submitted 1/11/2019 and accepted by HIW. Immediate assurance action plan submitted 26/09/19		Reported to December 2019 QSE commitee
PCIC	Dental	HIW (Announced visit)	BUPA Dental Care, Canton	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		02.09.2019		Non-compliance notice issued regarding incorrect and hazardous storage of healthcare waste and innaccurate dental records. Improvement plan required by 11th September 2019.		
PCIC	Dental	HIW (Announced visit)	Family Dental Care (Cowbridge road west)	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		19.08.2019		Areas identified for improvement - Maintenance improvements in some clinical areas, radiology audits must demonstration whether image quality conforms to minimum standards, ensure verbal medical history checks undertaken with patients are recorded in patient records. Regulatory breaches regarding training (Dental Nurse had not undertaken the required number of hours (5) of verifiable training in radiology and radiation protection during their previous 5 year CPD cycle as recommended by the GDC, expired emergency drugs being sorted in draw next to in-date drugs which could potentially get mixed up in an emergency situation.		Final report published 20/11/2019

REGULATORY BODY REVIEW TRACKER - September 2019

PCIC	Dental	HIW (Announced inspection)	St Mellons Dental Practice (Restore Dental Group)	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		13.08.2019		There were no immediate assurance issues. Overall HIW found that systems were in place to capture patient feedback, comments and complaints. Patients who completed a HIW questionnaire rated the service provided at the practice as excellent or very good.Staff reported being happy in their roles and understood their responsibilities. Systems were in place to ensure staff were supported and had the necessary training to deliver their roles efficiently.The environment provided clinical facilities that were well-equipped,maintained and visibly clean and tidy. HIW recommended the service could improvethe following-aAn environmental risk assessment needs to be completed and any actions identified within the risk assessments need to evidence when they are completed. Medical histories need to be reviewed to ensure all patients complete one at every course of treatment, they are signed by the patient and countersigned by the dentist		Final report published 14/11/2019
PCIC	GP Practice	HIW (GP Announced visit)	Waterfront Medical Centre	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		Inspection due on March 23rd 2020				
PCIC	Dental	HIW	Cathays Dental Practice	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		05.08.2019		Non-compliance notice - storage of healthcare waste. Immediate improvement plan provided 8/8/2019.		Final report published 7/11/2019
PCIC	Dental	HIW	High Street Dental Practice, Cowbridge	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		23.07.2019		Non-compliance notice - The service must ensure healthcare waste is being stored appropriately and securely within the dental practice in line with best practice guidelines. HIW found evidence that the practice was not fully compliant with current regulations, standards and best practice guidelines		Final report published 24/10/2019
PCIC	GP Practice	HIW	Birchgrove Surgery	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		10.07.2019		Area of concern - Findings during the HIW inspection - they considered the pre-employment records of two non-clinical members of staff and there was no evidence that the relevant Disclosure and Barring Service (DBS) checks had been carried out. The Practice Manager confirmed that the DBS checks were not routinely undertaken for any non-clinical members of staff such as Practice management, administrative and reception staff. Improvement required. The Practice must implement a process to ensure that: Pre-employment checks for all staff include the need for a DBS check appropriate to their roles and all current members of staff have a DBS check undertaken urgently, appropriate to their roles. A record must be kept within the Practice.		Final report published 11/10/2019
PCIC	Dental	HIW (Announced visit)	Penarth Dental Healthcare	Penarth Dental Healthcare	Ruth Walker	QSE	Director of Nursing, PCIC		01.07.2019		HIW found evidence that the practice was not fully compliant with the regulations and other relevant legislation and guidance. HIW recommended improvements be made in the following; Provide more information to patients on how children and adults can best maintain good oral hygiene; the Fire Safety Officer must undertake training by a fire safety expert, make adjustments to the infection prevention and control procedures in place at the practice, provide a baby nappy bin and ensure the waste is disposed of appropriately, staff to receive training on the safeguarding of children and vulnerable adults, unused dental supplies need to be stored in a more secure cupboard, make adjustments to the arrangements for safe storage and use of the emergency drugs and emergency equipment available at the practice. HIW identified regulatory breaches during this inspection – whilst this has not resulted in the issue of a non compliance notice, there is an expectation that the registered person takes meaningful action to address these matters, as a failure to do so could result in non-compliance with regulations.		Final report published 2/10/2019
PCIC	Dental	HIW (Announced visit)	Llanederyn Dental Practice	Private Dentistry Regulations/All Healthcare Standards	Ruth Walker	QSE	Director of Nursing, PCIC		23.05.2019		HIW found some evidence that they were not fully compliant with Private Dentistry Regulations and all Health and Care Standards. The practice has been recently bought by its current owners and through discussions with them it was clear that they are keen to develop and improve the practice. There were a number of policies and procedures in place, but they were not dated, not version controlled, did not contain a review date and in the majority of instances did not include a staff signature		Final report published 26/08/2019
PCIC	Dental	HIW (Announced visit)	Tynewydd Dental Care	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		13.05.2019		HIW found some evidence that the practice was not fully compliant with Private Dentistry Regulations and all Health and Care Standards and a non compliance issue was issued. Copy of immediate assurance letter dated 24.05.19 received.		Final report published 14/08/2019
PCIC	Dental	HIW	Park Place Dental	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		01.05.2019		HIW recommend improvements could be made regarding advising patients of the results of their feedback and any changes. Review the management of emergency drugs and ancillary equipment.		Final report published 2/8/2019
PCIC		HIW (Clinical Review)	Her Majesty's Prison, Cardiff	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		01.05.2019		It was recommended that immediate steps are taken to review, monitor and improve the standards of note keeping in the medical records at HMP Cardiff. Formal Protocols should be devised for chronic disease management of all major chronic diseases as would be the case in community GP monitoring. Formal protocols should be devised for action to be taken after a period of nonattendance for dispensing of medications. A period of non-attendance should be obvious to the staff dispensing medication as they mark the medication charts accordingly. The protocol should include but need not be restricted to : ▪ Action to be taken to determine the cause of the non-attendance ▪ Note should be made of whether the non-attendance is a free choice made by a patient with full capacity or whether there is some hindrance affecting their ability to attend ▪ If there is any hindrance, as was the situation in this case, the nature of this hindrance should be documented ▪ Any action that needs to take place to overcome the hindrance should be documented. ▪ The situation should be reviewed after a reasonable length of time to ensure that the hindrance had been overcome. ▪ In the case of patients who choose not to attend, this should be addressed during routine chronic disease management appointments and opportunistically and should be documented. ▪ Appropriate Read Codes should be used for all of the above to enable accurate searches and recalls to take place. These should also allow for comparisons between episodes of a similar nature.		
PCIC	Dental	HIW (Announced visit)	Cathedral Dental Clinic	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		26.03.2019		Due to the CCTV cameras located within the practice, including the surgeries HIW have asked for CCTV signage to be clear and prominent to all patients and visitors attending the practice. Policies and procedures need to be updated to reflect current CCTV guidelines. The patient records HIWreviewed were detailed, but they identified some areas where improvement is required.		Final report published 27/06/2019
Medicine	Emergency Care	HIW (Unannounced)	Emergency Unit/Assessment Unit	HIW	Ruth Walker	QSE	Director of Nursing, Medicine		25.03.2019		28th March 2019 - immediate improvement plan required - letter; response 05-04-19; HIW response 11-04-19 - immediate assurance plan not accepted; 2nd UHB reponse 29th April 2019; HIW response accepting immediate assurance. Response sent 07.06.19. HIW assurance received 20.06.19.		Final report published 28/06/2019

Mental Health		HIW (Unannounced)	Hafan Y Coed	HIW	Ruth Walker	QSE	Director of Nursing, Mental Health		19-21/03/2019		HIW found the Health Board did not always meet all standards required within the Health and Care Standards (2015), the Mental Health Act (1983), Mental Health (Wales) Measure (2010) and the Mental Capacity Act (2005). HIW recommended that the service could improve upon: Areas of Mental Health Act documentation require improvement Garden areas on all wards are in need of maintenance and the responsibility for this, needs to be confirmed Inconsistency of information displayed for patients and relatives across the wards Page 7 of 34 HIW report template version 2 Areas of good practice employed on some wards are not shared with others to maintain consistency Some patients are sleeping out1 from their designated ward due to additional demand and clinical need		Final report published 8/7/2019
PCIC	Dental	HIW (Announced visit)	Danescourt Dental Practice	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		18.03.2019		The practice has conducted an internal audit and has addressed the gaps in fridge temperature readings by updating the record sheet used, and developed a process to handover responsibilities during staff absences. The Primary Care team has also audited fridge temperature logs and noted that temperatures were recorded on all working days.		Final report published 19/06/2019
PCIC	Dental	HIW (Announced visit)	Alison Jones, Barry	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		17.12.2018		HIW identified areas for improvement with regards to arrangements for checking of emergency drugs and equipment, first aid equipment and dental materials.Improvements were required with regards to some fire safety arrangements.More detailed patient records were needed in some areas to evidence the care and treatment provided to patients.The practice needed to implement a number of policies and procedures, and some were also in need of updating. Regular appraisals for staff needed to be introduced.		Final report published 5/4/2019
PCIC	Community	HIW	Mental Health Team, Western Vale	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		04.12.2018		Overall HIW/CIW found that service user feedback was generally positive.The environment was clean and tidy.Robust management of medicines processes were in place. There was provision of a support worker service that evidenced a positive and direct impact on service users. Application of Mental Health Act and Mental Health Measure (2010) and legal documentation was carried out well. Identification of a vision for the future of the service was supported by a passionate management team, and atrong integrated leadership model, supported at a senior management level. This is what HIW recommend the service could improve: Recruitment into key roles, such as psychiatrists and psychologists. Timeliness of transportation for services users to a place of safety and/or hospital. Organisation of outpatient and medication clinics. Completion of appropriate forms for service user capacity assessment by clinical staff. Clarity for staff regarding new processes and procedures following the merge of three teams.		Final report published 24/04/2019
PCIC	Dental	HIW (Announced visit)	Penylan Dental Practice	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		28.11.2018		HIW recommended that the practice move its emergency drugs and equipment to a place that is more accessible. Improvements recommended included: the practice are to ensure that all staff have completed appropriate safeguarding training, a feminine hygiene bin is to be installed in the staff toilet, emergency drugs with their appropriate algorithms to be stored in separate and labelled containers/bags. There were no areas of non compliance identified at this inspection		Final report published 01/03/2019
PCIC	GP Practice	HIW (Announced visit)	Pontprennau Medical Centre	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		05.11.2018		HIW found that the practice was not fully compliant with the Health and Care Standards in all areas of service provision. HIW did make a number of recommednations for improvements which included that they review and update written policies and procedures to ensure they all accurately reflect current arrangements at the practice, that they demonstrate that suitable staff recruitment checks have been conducted and ensure all staff have received up to date mandatory training and that records for this are kept within the practice. They further recommended that practice meetings should be formalised utilising agendas, and developing meeting minutes to aid communication throughout the teams.		Final report published 06/02/2019
PCIC	Dental	HIW	Windsor Road Dental Care, Cardiff	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		29.10.2018		This will be managed directly with the primary care contractor by HIW. We will only see final response from the practice when it is published with the report. We will however ask for specific assurance on this particular inspection when PCIC report to QSE Committee in December 2018.		
HEALTH AND SAFETY EXECUTIVE													
	Radiology	HSE	Radiology	The Ionising Radiations Regulations 2017	Martin Driscoll	Health and Safety	Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years		last inspections pre 2004, no inspeciton data currently available		
	Medical Physics	HSE	Medical Physics	Control of Artificial Optical Radiation at Work Regulations 2010	Martin Driscoll	Health and Safety	Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years		last inspections pre 2004, no inspeciton data currently available		
	Medical Physics	HSE	Medical Physics	The Control of Electromagnetic Fields at Work Regulations 2016	Martin Driscoll	Health and Safety	Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years		last inspections pre 2004, no inspeciton data currently available		
HUMAN TISSUE AUTHORITY													
Specialist Services	N&T	HTA	South Wales Transplant and NORS programme	Human Tissue Act	Fiona Jenkins	QSE Committee	Rafael Chavez	730	01/10/2019 - self assessment compliance update	01.10.2021	Number of areas of good practice noted from inspection in 2016/17. Self assessment compliance update provided in September 2019 which demonstrated evidence and compliance with the updated questions	n/a	1
CD&T	Haematology	HTA	South Wales BMT Programme	Human Tissue Act	Fiona Jenkins	QSE Committee	Xiujie Zhao	730	22-23/01/2019	no date set	1 minor	06.09.2019	1
CD&T	Haematology	HTA	Stem Cell processing Unit (HTA)	Human Tissue Act	Fiona Jenkins	QSE Committee	Alun Roderick/Sarah Phillips	730	22.01.2019	01.10.2021	1 major 4 minors	06.09.2019	1
CD&T	Cellular Pathology	HTA	Mortuary (Cell Path - HTA)	Human Tissue Act	Fiona Jenkins	QSE Committee	Adam Christian/Scott Gable	730	22.11.2018	no date set	3 criticals, 14 majors, 9 minor	31.01.2019	1
INFORMATION COMMISSIONERS OFFICE													
	Information Governance Dept	ICO									To ensure that the IGET covers all necessary topics during meetings the organisation should introduce a set of formal ToRs		
	Information Governance Dept	ICO									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.		
	Information Governance Dept	ICO									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		
	Information Governance Dept	ICO									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		

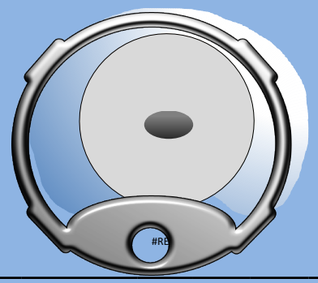
	Information Governance Dept	ICO									In order to ensure that specialised roles with IG responsibility have received appropriate training to carry out their role effectively, a training needs analysis for these roles should be undertaken. To ensure that training requirements for staff with specialised 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		
	Information Governance Dept	ICO									The organisation should provide detailed information about how compliance with data protection policies and procedures is to be monitored to give assurance regarding observance.		
	Information Governance Dept	ICO									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		
	Information Governance Dept	ICO									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.		
	Information Governance Dept	ICO									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.		
	Information Governance Dept	ICO									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.		
	Information Governance Dept	ICO									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		
	Information Governance Dept	ICO									The organisation should document its lawful bases for processing special category data is correct based on the requirements of Article 9 of the GDPR and Schedule 1 of the DPA 2018 to provide assurance that it has appropriately considered how a determination was reached.		
	Information Governance Dept	ICO									The organisation should ensure that there is an APD in place to define which schedule 1 conditions are relied on, so that the organisation is in compliance with the legislation. In order to ensure compliance with the legislation, the organisation should further: Create an APD which considers what procedures are in place to ensure compliance with the Article 5 principles of GDPR. Ensure the APD considers how special category data will be treated for retention and erasure purposes Ensure the APD defines a responsible individual for the processing activity		
	Information Governance Dept	ICO									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.		
	Information Governance Dept	ICO									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.		
	Information Governance Dept	ICO									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.		
	Information Governance Dept	ICO									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.		
	Information Governance Dept	ICO									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		
	Information Governance Dept	ICO									The organisation should ensure that all staff receive regular training and refresher training on fair processing policies and privacy information.		
	Information Governance Dept	ICO									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.		
	Information Governance Dept	ICO									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.		

	Information Governance Dept	ICO									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.		
	Information Governance Dept	ICO									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.		
	Information Governance Dept	ICO									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.		
	Information Governance Dept	ICO									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.		
JOINT EDUCATION ACCREDITATION 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	1
MHRA													
CD&T	Lab Med	MHRA	Blood transfusion (BSQR)	Blood and Safety Quality Regulations	Fiona Jenkins	QSE Committee	Andrew Gorringe/Alun Roderick	365	4-5/03/2020	no date set	6 others and 1 comment	31.03.2021	1
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	2

REGULATORY BODY REVIEW TRACKER - September 2019

	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	2
CD&T	Medical Physics	MHRA	Radiopharmacy	Good manufacturing practice (GMP) and good distribution practice (GDP)	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	730	23.07.2019	no date set	5 majors, 2 others	tbc with regulator	1
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	n/a
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	n/a
CD&T	Medical Physics	MHRA	Medical Physics	Managing Medical Devices 2015	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	ad hoc	05.01.2011	no inspeciton notified	no inspection to date in this area	n/a	n/a
NATURAL RESOURCES WALES													
CD&T	Radiology	NRW	Radiology UHL	Environmental Permitting (England and Wales) Regulations 2016 Permit HB3393NA (Sealed Source Cat 5)	Fiona Jenkins	QSE Committee	Andrew Gordon/ Lesley Harris	1461	12.02.2020		none	compliant n/a	1
CD&T	Radiology	NRW	Radiology UHL and Theatres (unable to seperate visit and report)	Environmental Permitting (England and Wales) Regulations 2016 Permit HB3393NC (Open	Fiona Jenkins	QSE Committee	Andrew Gordon/ Lesley Harris	730	12.02.2020		Radiology - 3 actions - completed 0 non compliance	13.03.2020	1
CD&T	Radiology	NRW	Radiology UHW, Medical Physics, Radiopharmacy, Pathology & InVitro Lab (unable to	Environmental Permitting (England and Wales) Regulations 2016 Permit ZB3793ND (Open	Fiona Jenkins	QSE Committee	Andrew Gordon/ Lesley Harris	730	30.04.2019		Radiology - 1 action, completed 1 recommendation, completed	01.05.2019	1
CD&T	Radiology	NRW	Radiology UHW, Medical Physics, Radiopharmacy, Pathology & InVitro Lab (unable to seperate visit and	Environmental Permitting (England and Wales) Regulations 2016 Permit CD9437 (Sealed Sources CAT 5)	Fiona Jenkins	QSE Committee	Andrew Gordon/ Lesley Harris	1461	30.04.2019		Radiology - None	Compliant n/a	1
OFFICE FOR NUCLEAR REGULATION													
	Medical Physics	Office for Nuclear regulation	Medical Physics	The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	185 (Twice Yearly)	17.03.2017		4 non conformances, 3 recommendaitons	01.05.2017	1
QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES													
Specialist Services	Immunology	Quality in Primary Immunodeficiency Services (QPIDS)	Immunology	Quality in Primary Immunodeficiency Services Standards	Stuart Walker	QSE Committee	Stephen Jolles/Richard Cousins	365		01.10.2019			
Specialist Services	Immunology	Quality in Primary Immunodeficiency Services (QPIDS)	Immunology	Quality in Primary Immunodeficiency Services Standards	Stuart Walker	QSE Committee			01.10.2019		Accreditation declined		
RESEARCH AND DEVELOPMENT													
	Haematology	Research and Development			Stuart Walker	QSE Committee							
UKAS													
Exec	Institute of Medical Genetics	UKAS	Institute of Medical Genetics, UHW	ISO 15189	Fiona Jenkins	QSE Committee	Lisa Grffiths		29.05.2020	no date set	No findings/non-conformances were raised, so there is no improvement action report		1
CD&T	Biochemistry	UKAS	Cellular Patholgy/ (Mortuary - UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Adam Christian Scott Gable Sally Jones	365	23-29/03/20	no date set	31 Mandatory findings 31 Evidence required 11 Action recommended	closed 2/8/20202	1
Specialist Services	ALAS	SGS/UKAS	ALAS (CAV)	ISO 9001:2015	Fiona Jenkins	QSE Committee	Paul Rogers	185 (Twice Yearly)		01.01.2020	2 x Major Corrective Actiions, 1 X Minor Corrective Action, Several Opportunities for Improvement	06.09.2019	1
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	1
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	1
Specialist Services	Haematology	SGS/UKAS	Haematology/Blood Transfusion (UKAS)	ISO 15189:2012	Fiona Jenkins	QSE Committee	Alun Roderick	N/A	06.11.2019	N/A	Accreditation extra visit: Action Mandatory x 2 Require Evidence to UKAS x 1 Action Recommended x 1	6.12.19	1
Specialist Services	Medical Genetics	SGS/UKAS		ISO 15189:2012	Fiona Jenkins	QSE Committee	Peter Thompson		2 and 5/11/19		Action Mandatory x 14 Require Evidence to UKAS x 14 Action Recommended x 5	5.12.19	1
CD&T	Haematology	UKAS	Phlebotomy (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Andrew Gorringe/Alun Roderick	365	31/03/20 - 7/04/20	19.04.2021	included in Haematology findings above	05/05/2019//	1
CD&T	Biochemistry	UKAS	Biochemistry (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Carol Evans/Nigel Roberts	365	04.12.2019	07/12/2020 to 11/12/2020	25 findings	16.02.2020	1
CD&T	Biochemistry	UKAS	Specimen Reception (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Carol Evans/Nigel Roberts	365	04.12.2019	07/12/2020 to 11/12/2020	2 findings and 1 reccomendation Included in findings of Biochemistry UKAS	16.02.2020	1
CD&T	Lab Med/Haematology	UKAS	Haematology/ Blood Transfusion laboratory	ISO 15189	Fiona Jenkins	QSE Committee	Alun Roderick Vicky Cummings Rachel Borrell	365	31/03/20 - 7/04/20	19.04.2021	4 mandatory findings 4 evidence required	18.05.2020	1
WELSH WATER													
		Welsh Water			Abigail Harris	Health and Safety							
WSAC													
	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	1
	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	1
	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	1
WEST MIDLANDS QRS													
Specialist Services	Haematology	West Midlands QRS	Red Cell Service (Clinical Haematology)	Published by Thalassaemia and Sickle Cell Society (2018)	Medical Director	QSE Committee	Jonathan Kell (Lead) Clare Rowntree (Clinical Director)	1095	01.10.2019	01.10.2022	In need of investment from WHSSC and ini stafff	01.12.2019	1

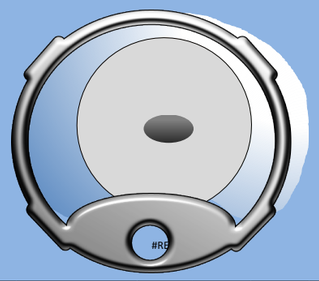
Regulatory and Accreditation Dashboard



Biochemistry ISO15189 inspection readiness

Improvement required on time of longest incident and CAPA.

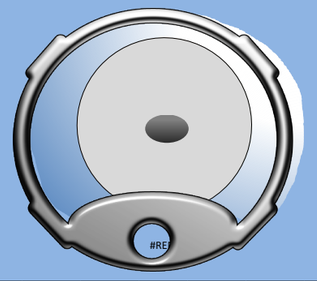
Low likelihood of inspection



Haematology ISO15189 inspection readiness

Significant delays in capa management

Last inspections held on 3 - 5th April and 1 - 2 May 2019



Cellular Pathology ISO15189 inspection readiness

Overdue CAPA and incident is of concern.

ISO inspection arranged for March 2020.

Radiopharmacy MHRA inspection readiness

Good improvement on audit and Capa closure

Without clear estates plan closure is likley

High likelihood of inspection

Cellular Pathology/Mortuary HTA inspection readiness

Whilst the previous inspection has been closed successfully, the current performance on timeliness of closing CAPA and incidents needs continued improvement

SMPU Pharmacy production MHRA

significnatly overdue incidents and capa, reflects current escalation postion with the regulator

UHL Pharmacy MHRA inspection readiness

significantly overdue incidents and CAPA

High likelihood of inspection

BLood Transfusion Laboratory MHRA inspection

Inspection outcomes recently closed, MHRA on bimonthly monitoring to test sustainability
Improvement required on time of longest incident
Low likelihood of inspection

Stem Cell Processing Unit HTA

long standing capa closure related to change controls

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	Inspection outcome	inspection closure due by	inspection closure complete/ontrack? 1=Y 2=N	Document review compliance	Audit compliance	Audit overdue by (days)	Overdue CAPA	CAPA overdue by (days)	Number of overdue incidents	incidents overdue by (days)	Critical Issue1=y 2=n
FIRE AND RESCUE SERVICES																					
	Capital and Asset Management	Fire and Rescue Services	Multistorey Car Park, Llandough	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			16.03.2020		the standard of fire safety appeared to comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005.										
	Capital and Asset Management	Fire and Rescue Services	Orthopaedic Centre, Llandough	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			18.02.2020		the standard of fire safety appeared to comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005.										
	Capital and Asset Management	Fire and Rescue Services	Ward A6	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			19.02.2020		Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises. Aritcle 17: Maintenance - Fire resisting doors are not adequately maintained										
	Capital and Asset Management	Fire and Rescue Services	Rookwood Hospital, Artificial Limb Centre	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			10.02.2020		Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.										
	Capital and Asset Management	Fire and Rescue Services	Vale Mental Health Services, Barry Hospital	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			27.01.2020		Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.										
	Capital and Asset Management	Fire and Rescue Services	Vale Community Offices, Barry Hospital	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety			27.01.2020		Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.										

REGULATORY BODY REVIEW TRACKER - September 2019

Critical Comment	completion	Documents	Audit Comliance	Audit overdue	CAPA	Capa overdue	incidents	Incident overdue	Critical	compliance score	Days since last inspection	Inspection liklihood Red	Inspection Liklihood Amber	Inspection liklihood green	Overall inspection liklihood

Bricknell,Helen
09/03/2020 08:30:14

REGULATORY BODY REVIEW TRACKER - September 2019

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	Inspection outcome	inspection closure due by	inspection closure complete/ontrack? 1=Y 2=N	Document review compliance	Audit compliance	Audit overdue by (days)	Overdue CAPA	CAPA overdue by (days)	Number of overdue incidents	incidents overdue by (days)	Critical Issue1=y 2=n	Critical Comment
		HIW	Llanishen Court Surgery	HIW	Ruth Walker	QSE Committee			10.12.2019		Limited processes were in place to support the safe recruitment and training of staff. There was no evidence that Disclosure and Barring Service (DBS) checks											
Specialist	Rehabilitation	HIW (Unannounced)	Rookwood Hospital	HIW	Ruth Walker	QSE Committee	Director of Nursing, Specialist		02.10.2019													
Medicine	Stroke Rehabilitation	HIW (Unannounced)	Stroke Rehabilitation Centre, UHL	HIW	Ruth Walker	QSE Committee	Director of Nursing, Medicine		17 & 18/09/19		Immediate assurance was required in realtion to appropriate checks on resuscitation trolleys. Action plan completed.											
PCIC	Dental	HIW (Announced visit)	BUPA Dental Care, Canton	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		02.09.2019		Non-compliance notice issued regarding incorrect and hazardous storage of healthcare waste and innaccurate dental records. Improvement plan required by 11th September 2019.											
PCIC	Dental	HIW (Announced visit)	Family Dental Care	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		19.08.2019		Areas identified for improvement - Maintenance improvements in some clinical areas, radiology audits must											
PCIC	GP Practice	HIW (GP Announced visit)	Waterfront Medicial Centre	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		12.08.2019													
PCIC	Dental	HIW	Cathays Dental Practice	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		05.08.2019		Non-compliance notice - storage of healthcare waste.											
PCIC	Dental	HIW	High Street Dental Practice, Cowbridge	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		23.07.2019		Non-compliance notice - The service must ensure healthcare waste is being stored appropriately and securely within the dental practice in line with best practice guidelines. HIW found evidence that the practice was not fully compliant with current regulations, standards and best practice guidelines											
PCIC	GP Practice	HIW	Birchgrove Surgery	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		10.07.2019		Area of concern - Findings during the HIW inspection - they considered the pre-employment records of two non-clinical members of staff and there was no evidence that the relevant Disclosure and Barring Service (DBS) checks had been carried out. The Practice Manager confirmed that the DBS checks were not routinely undertaken for any non-clinical members of staff such as Practice management, administrative and reception staff. Improvement required. The Practice must implement a process to ensure that: Pre-employment checks for all staff include the need for a DBS check appropriate to their roles and all current members of staff have a DBS check undertaken urgently, appropriate to their roles. A record must be kept											
PCIC	Dental	HIW (Announced visit)	Penarth Dental Healthcare	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		01.07.2019		HIW found evidence that the practice was not fully compliant with the regulations and other relevant legislation and guidance. HIW recommended improvements be made in the following; Provide more information to patients on how children and adults can best maintain good oral hygiene; the Fire Safety Officer must undertake training by a fire safety expert, make adjustments to the infection prevention and control procedures in place at the practice, provide a baby nappy bin and ensure the waste is disposed of appropriately, staff to receive training on the safeguarding of children and vulnerable adults, unused dental supplies need to be stored in a more secure cupboard, make adjustments to the arrangements for safe											

PCIC	Dental	HIW (Announced visit)	Llanederyn Dental Practice	Private Dentistry Regulations/All Healthcare Standards	Ruth Walker	QSE Committee	Director of Nursing, PCIC		23.05.2019		HIW found some evidence that they were not fully compliant with Private Dentistry Regulations and all Health and Care Standards. The practice has been recently bought by its current owners and through discussions with them it was clear that they are keen to develop and improve the practice. There were a number of policies and procedures in place, but they were not dated, not version controlled, did not contain a review date and in the majority of instances did not include a staff signature demonstrating that the policies and procedures had been read and understood. HIW recomended that the practice need to ensure that all staff are appropriately trained with evidence of this training held on file. HIW recommended a number											
PCIC	Dental	HIW (Announced visit)	Tynewydd Dental Care	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		13.05.2019		HIW found some evidence that the practice was not fully compliant with Private Dentistry Regulations and all Health and Care Standards and a non compliance issue was issued. Copy of immediate assurance letter dated 24.05.19 received.											
PCIC	Dental	HIW	Park Place Dental	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		01.05.2019		HIW recommend improvements could be made regarding advising patients of the results of their feedback and any changes. Review the management of emergency drugs and ancillary equipment.											
PCIC		HIW (Clinical Review)	Her Majesty's Prison, Cardiff	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		01.05.2019		It was recommended that immediate steps are taken to review, monitor and improve the standards of note keeping in the medical records at HMP Cardiff. Formal Protocols should be devised for chronic disease management of all major chronic diseases as would be the case in community GP monitoring. Formal protocols should be devised for action to be taken after a period of nonattendance for dispensing of medications. A period of non-attendance should be obvious to the staff dispensing medication as they mark the medication charts accordingly. The protocol should include but need not be restricted to : ▪ Action to be taken to determine the cause of the non-attendance ▪ Note should be made											
PCIC	Dental	HIW (Announced visit)	Cathedral Dental Clinic	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		26.03.2019		Due to the CCTV cameras located within the practice, including the surgeries HIW have asked for CCTV signage to be clear and prominent to all patients and visitors attending the practice. Policies and procedures need to be updated to reflect current CCTV guidelines. The patient records HIWreviewed were detailed, but they identified some areas where improvement is required.											
Medicine	Emergency Care	HIW (Unannounced)	Emergency Unit/Assessment Unit	HIW	Ruth Walker	QSE Committee	Director of Nursing, Medicine		25.03.2019		28th March 2019 - immediate improvement plan required - letter; response 05-04-19; HIW response 11-04-19 - immediate assurance plan not accepted; 2nd UHB reponse 29th April 2019; HIW response accepting immediate assurance. Response sent 07.06.19. HIW assurance received 20.06.19.											

REGULATORY BODY REVIEW TRACKER - September 2019

completion	Documents	Audit Comliance	Audit overdue	CAPA	Capa overdue	incidents	Incident overdue	Critical	compliance score	Days since last inspection	Inspection liklihood Red	Inspection Liklihood Amber	Inspection liklihood green	Overall inspection liklihood

Report Title:	**Internal Audit Recommendation Tracker Report**						
Meeting:	Audit Committee					**Meeting Date:**	8th September 2020
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	**Head of Risk and Regulation**						

Background and current situation:

The purpose of the report is to provide Members of the Audit Committee with assurance on the implementation of recommendations which have been made by Internal Audit by means of an internal audit recommendation tracking report.

The internal audit tracking report was first presented to the Audit Committee in September 2019 and approved by the Committee as an appropriate way forward to track the implementation of recommendations made by internal audit.

The tracker goes back 3 financial years and shows progress made against recommendations from 17/18 and18/19. It also show recommendations which have been made during 19/20.

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

As can be seen from the attached summary tables the overall number of outstanding recommendations has reduced from 226 individual recommendations to 164 for the period July 2020 to September 2020. This is due to a large number of recommendations having been completed during this period. However, it should also be noted that additional recommendations were added during this period.

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

A review of all outstanding recommendations has been undertaken since the last meeting of the Audit Committee where the internal audit tracker was presented (July 2020). Each Executive Lead has been sent the recommendations made by Internal Audit which fall into their remits of work. In addition to this the audits undertaken during the financial period 2019/20 have also been added to the tracker and progress reported.

The table below shows the number of internal audits which have been undertaken over the last three years and for the financial year 2019/20 and their overall assurance ratings.

	Substantial Assurance	Reasonable	Limited Assurance	Rating N/A	Total

		Assurance			
Internal Audits 17/18	7	25	5	-	37
Internal Audits 18/19	10	26	7	-	43
Internal Audits 19/20	10	25	2	2	39

Attached at Appendix 1 are summary tables which provide an update on the July 2020 position.

ASSURANCE is provided by the fact that a tracker is in place. This assurance will continue to improve over time with the implementation of quarterly follow ups with the Executive Leads.

Recommendation:

The Audit Committee Members are asked to:

(a) Note the tracking report which is now in place for tracking audit recommendations made by Internal Audit.
(b) Note that progress will be seen over coming months in the number of recommendations which are completed/closed.

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention	x	Long term		Integration		Collaboration		Involvement	

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

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2017/18 (September 2020 Update)

	Update September 2020				Update September 2020				Update September 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Complete												
Overdue under 3 months												
Overdue over 6 months under 12 months												
Overdue more than 12 months	5	2	3		10	1	8	1	7	3	2	2
Superseded												
Total	**5**	**2**	**3**		**10**	**1**	**8**	**1**	**7**	**3**	**2**	**2**

Total number of recommendations outstanding as on 1st September 2020 for financial year 2017/18 is **22** compared to the position in July 20 which was a total number of outstanding recommendations of **45**

INTERNAL AUDIT REPORT RECOMMENDATION FOR 2018/19

	Update September 2020				Update September 2020				Update September 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached											1	
Complete	8	8			11	11			6	6		
Overdue under 3 months												
Overdue by over 3 months under 6 months					3	1	1	1	1			1
Overdue over 6 months under 12 months	1			1	3		2	1				
Overdue more than 12 months	8		5	3	11	4	3	4	3	2		1
Superseded												
Total	**17**	**8**	**5**	**4**	**28**	**16**	**6**	**6**	**11**	**8**	**1**	**2**

Total number of recommendations outstanding as on 1st September 2020 for financial year 2018/19 is 39 compared to the position in July 20 which was a total number of outstanding recommendations of **104**

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2019/20

	Update September 2020				Update September 2020				Update September 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not specified	6		4	2	10		2	8	10		2	8
Date not reached	1			1	17		8	9	6		2	4
Complete	2	2			3	3			2	1	1	
Overdue under 3 months					8	1	3	4	2		2	
Overdue by over 3 months					4		2	2	1			1
Overdue over 6 months												
Overdue more than 12 months	1		1		4	1	2	1				
Superseded												
Total	**10**	**2**	**5**	**3**	**46**	**5**	**17**	**24**	**21**	**1**	**7**	**13**

Total number of recommendations outstanding as on 1st September 2020 for financial year 2019/20 is **77** compared to the position in July 20 which was a total number of outstanding recommendations of **77.**

Financial Year Fieldwork Undertaken	Audit Title	Executive Lead for Report	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update	Status of Report Overall
2017-18	WLI Payments Follow-Up	Chief Operating Officer	M	The UHB has produced a WLI Payments Policy /Procedure and this has been disseminated to Directorates, but has yet to be finalised and approved by the organisation. Additionally, there are no local Directorate procedures in place for the management of WLI payments as they will work to the UHB Payments Policy/Procedure (Finding 1 – Partially Actioned).	Not Provided	Chief Operating Officer	01/06/2018	pc	WLI Policy drafted but needs to be reviewed to ensure it aligns with the latest Welsh Consultant Contract.	Audit open over 30 months
2017-18	WLI Payments Follow-Up	Chief Operating Officer	M	Testing identified that whilst Cardiac Surgery make the appropriate checks and accurately record and approve submitted claims, they do not retain copies of the fully authorised WLI Claim Forms as they are sent directly to Payroll. Therefore, at the present time a full audit trail does not currently exist and it is ecommended that upon authorisation by the Clinical Board Director of Operations a copy should be taken and provided to Cardiac Surgery management for retention (Finding 10 – Partially Actioned).	Not Provided	Chief Operating Officer		c	SOP's drafted and hard copies available in the residences office.	Audit open over 30 months
2017-18	Residences	Director of Planning	L	The UHB should document future plans for the provision and utilisation of residences.	The UHB is currently embarking on a significant master planning exercise for the UHB site and an estate rationalisation programme across the UHB. The provision of accommodation will be considered as part of this exercise. This process will likely take in excess of 12 to 18 months. Progress will be reported as part of the verall master planning exercise.	Director of Finance		na	All rental arrears are addressed with tennats and payments are agreed.	Audit open over 30 months
2017-18	Residences	Director of Planning	L	The UHB should refer to the PFI contract/SLA to consider whether expectant vacant rooms must be communicated by Charter Housing to the Health Board within a certain timescale if void rents are to become chargeable.	Currently being reviewed by PFI Manager.	Director of Finance	01/04/2018	c	The contract requires Charter Housing to notify the UHB promptly on receipt of any notice terminating a tenancy. This requirement was highlighted to Charter representatives in early 2018 and they were advised that promptly should mean within a few working days.	Audit open over 30 months
2017-18	Surgery Clinical Board - Anaesthetist Rota Management	Chief Operating Officer	H	Standard Operating Procedure notes covering the administration of the CLW rota system should be developed and made available to all relevant staff.	It is accepted by the Directorate that there is no written SOP for staff, although all three rota masters currently in post have been formally and comprehensively trained by the CLWRota team to carry out processes within the system. The CLWRota team provide remote and on-site support as requested/required. The rota masters are overseen by the Clinical Director and Deputy Clinical Directors who are also rota masters. There is a workflow chart for writing a weekly rota currently in	Chief Operating Officer		c	Standard operating procedure developed and signed off by clinical board Feb 2018 and reviewed annually	Audit open over 30 months
2017-18	Pilot Model Ward Review	Director of Planning	L	For future projects the plans for financial costing should be more detailed within the project outline.	As this was a clear pilot and proof of concept. Costings were genuinely not known. We had agreed "success" criteria, which, we met for patients eating and drinking more. (Being hydrated and had improved nutritional status) This was always the main aim. The third one was improvement in patient flow. This could not be quantified over a period of 6 weeks (which was discussed). Only after the pilot, could we see what happened during this period and start to look at costs for further development and detailed costing for the elements the teams felt worthwhile keeping as part of the model. We changed and tweaked aspects of the model each week to ensure we made efficient use of resource whilst maximising patient experience and matched our success criteria. Only after a review following completion could we accurately sit down and look at lessons learnt and see what	Director of Planning		c	Recommendations noted for any future projects	Audit open over 30 months
2017-18	Pilot Model Ward Review	Director of Planning	L	For future projects a defined terms of reference that identifies membership, frequency of meetings, roles and responsibilities will be incorporated from the outset.	Agreed for applicable future projects.	Director of Finance		c	Recommendations noted for any future projects	Audit open over 30 months
2017-18	Wellbeing of Future Generations Act	Director of Public Health	M	The Health Board must ensure that its obligations in respect of the Act are appropriately communicated to all staff within the Health Board. We recommend that the Health Board develop a	The Chair of the Steering Group met with UHB Director Communications and the UHB Engagement Lead in March to discuss the approach to raising awareness within the UHB. Draft Communications Plan to be brought to the next Steering Group on 4 June.	Director of Public Health	01/06/2018	pc	The Director of Comms has confirmed 4.8.20 that the current comms plan is the formal plan, and will be subject to at least annual updates. This will be circulated to all WFG Steering	Audit open over 30 months
2017-18	Nurse Revalidation	Executive Nurse Director	M	The C&V UHB PADR form should be revised for Nursing Staff to include an appendix to ensure Nurse revalidation portfolio completion is discussed at each annual appraisal during the 3 year cycle.	The Senior Nurse for Nurse Education will work with the lead for PADR to create a section for revalidation for nurses within the pay progression document. Pay progression training continues, to assist nurses in the completion of documentation (through enhanced communication and coaching workshops).	Director of Nursing	01/03/2018	na		Audit open over 30 months
2017-18	Nurse Revalidation	Executive Nurse Director	L	Where nurses are using their line manager as their confirmer, the confirmers should be reminded of ESRs capability to make them aware that staff members in their hierarchy are approaching their nurse revalidation date.	An email via the Directors of Nursing will be issued to remind staff of ESR capability re revalidation/registration.	Director of Nursing	01/01/2018	na	system rules setup to overide early clocking in. If staff clocks in early and work overtime supervisers amend early clocking in.	Audit open over 30 months
2017-18	University Hospital of Wales Neo Natal Development	Director of Planning	H	The design for the MRI new build will be concluded and frozen as soon as possible, including affirmation of structural issues and design elements for the MRI installation, so that the total costs and affordability of the project can be confirmed.	The design solution has been informed, as far as is practicable, by considering the specification information provided by potential MRI suppliers.	Director of Finance	31/05/2018	c	MRI's installed and commissioned	Audit open over 30 months
2017-18	University Hospital of Wales Neo Natal Developme	Director of Planning	L	The Capital Procedures Manual should be revised to include the requirement for a Project Director's Acceptance Certificate signed by the Chief Executive and Project Director.	Agreed	Director of Planning	31/05/2018	pc	A review of the capital management procedure is due to be undertaken by internal audit in this financial year and the management will be updated to incorporate this and any other changes identified	Audit open over 30 months
2017-18	University Hospital of Wales Neo Natal Developme	Director of Planning	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	Agreed	Director of Planning	31/05/2018	pc	Ongoing	Audit open over 30 months
2017-18	Business Continuity Planning Follow-Up	Director of Planning	H	The significant, high priority, issue that remains from the original review can be summarised as follows: ⍰ The EPRR team have begun to accumulate BCPs from across the	Not Provided	Director of Planning		pc	This action will be included for all future reports as appropriate so is partially completed.	Audit open over 24 months

Financial Year Fieldwork Undertaken	Audit Title	Executive Lead for Report	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update	Status of Report Overall
2017-18	Mortality Reviews	Executive Medical Director	M	The Health Board must ensure that level 1 mortality reviews are completed for all inpatient deaths.	A review of the current paper trail will be undertaken and improved as necessary. Clinical Boards will be reminded of the need to complete the level one reviews at the time of death certification as acquiring the notes afterwards is often difficult due to the current process of managing case notes of deceased patients in medical records. A meeting will take place with the CD for Internal Medicine to review their processes as they have the most deaths in the UHB. The Medical Director will note the findings of the Internal Audit in the June HSMB Meeting to ensure the Clinical Boards are reminded of their responsibility to complete level one reviews.	Executive Medical Director	01/06/2018	pc	Approx 80% of inpatient deaths undergo level 1 review New process in development, superseeding this issue The MD is currently working with the AMD for patient safety and governance, and the patient safety team, to develop a new process for learning from death reviews. This will be aligned with the introduction of the National Medical Examiner process which is curently in development in Wales. The new delivery process has the same aspirations as outlined in this audit .	Audit open over 24 months
2017-18	Mortality Reviews	Executive Medical Director	M	The Universal Mortality Review form question pertaining to the need to trigger a Level 2 review should be revised and re-written to improve clarity and remove ambiguity as to its application.	The wording on the form and subsequent IT development was so that any 'yes' answer would trigger a level 2 review. The double negative was a calculated risk. Given this feedback we will review and revise it.	Executive Medical Director	01/07/2018	pc	Approx 80% of inpatient deaths undergo level 1 review New process in development, superceding this issue The MD is currently working wit the AMD for quality and safety, and the quality and safety team, to develop a new process for learning from new death reviews. This will be aligned with the introduction of the new Medical Examiner process which is curently in development in Wales. That new process has the sam aspirations as outlined in this audit with a new delivery process. At the UHB level, a Mortality review group has been set up with representation from all the CB's.	Audit open over 24 months
2017-18	RTT Performance Reporting	Director of Transformation and Informatics	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	Director of Transformation & Informatics	01/09/2018	pc	performance reporting is being reviewed with input from the COO's office	Audit open over 24 months
2017-18	RTT Performance Reporting	Director of Transformation and Informatics	M	The Health Board should consider validating data of patients that are 'in target' due to the potential that these patients may have incorrectly applied suspensions and thus overall understating the amount of breaches.	We accept the point made in the context that data quality audits should extend to reported cancer waiting times – periodic audit of RTT pathways does already occur. Validation of all cancer pathways open and closed does occur at the weekly tracking meetings, and teams are reminded of the requirement to ensure that all management actions are accurately captured on the PMS system. A periodic audit, which will not be monthly, of data quality for cancer patients will be put in place as part of the new member of the cancer services team.	Director of Transformation & Informatics	01/11/2018	pc		Audit open over 24 months
2017-18	RTT Performance Reporting	Director of Transformation and Informatics	M	The Performance Report should include a note next to the SCP compliance figures to ensure the Board understands that these figures are not necessarily accurate and are not a true reflection of performance as data collection systems are currently not fit for purpose and data sets have not been defined.	Accepted	Director of Transformation & Informatics	01/05/2018	pc	the overall performance report is being reviewed for Qtr 4 2020/21	Audit open over 24 months
2017-18	RTT Performance Reporting	Director of Transformation and Informatics	L	The Performance Report should include data on the related Cancer patient volumes in addition to percentage compliance as this will be a useful metric to aid the Board's understanding of scope (eg. Total number of USC/Non-USC and corresponding number of patients 'in target' and 'breached')	The reporting of volumes occurs infrequently. There is a balance to be had in the detail presented within the board report. The board have asked that they receive less granular information on the operational performance of the board and more detail on the strategic and tactical performance of the board. As such we will partially accept the recommendation and provide an infrequent update on volumes, unless of course it is a material factor in explaining performance	Director of Transformation & Informatics		pc	the overall performance report is being reviewed for Qtr 4 2020/21	Audit open over 24 months
2017-18	Costing Review	Director of Finance	H	Management will look to increase the level of clinical engagement throughout the costing process.	The PCB platform provides the UHB with an effective dashboard for analysing costing data at a component level. Whilst the UHB can make greater use of the PCB tool, its utilisation is complex, requiring statistical, financial and service knowledge and the associated resource to support this level of analysis. Data and analysis outputs are used by the organisation to inform the transformation and CRP opportunities agenda and our IMTP. Evidence of this is available. The new osting system and efficiency framework provides the opportunity to re-engage with interested clinicians and efforts are ongoing to achieve this this through evised performance management processes. Finance delivery unit dashboard	Director of Finance	01/04/2018	pc	There is an increased level of engagement with regard to the benchmarking and costing data. Working groups have been established with the transformation team and clinical boards. These have currently been suspended due to COVID-19 Bob Chadwick, Director of Finance, will lead dissemination of Costing info including highlighting areas for potential improvement. This should lead to greater Clinical Engagement	Audit open over 24 months
2017-18	Internal Medicine Directorate Mandatory Training and PADRs	Chief Operating Officer	H	Management should ensure that all staff within Internal Medicine undertake a PADR, which is completed in full with both organisational and personal objectives agreed by the reviewing manager and employee. Management should create a personal development plan for each employee to help achieve each objective set. Management must ensure that when completing the annual review with staff they are completing the latest and most up to date version of the PADR format.	The Directorate has developed a Project Outline Document to support ward areas to complete PADR. This POD included timelines. The directorate has provided a trajectory of expected completion of PADRs. The directorate will share best practice to ensure learning. Bi-weekly operational meetings will now include PARD compliance as a standing agenda item. Implementation of Tier 1 target meetings chaired by Lead Nurse, this will include a robust discussion of actions required. Senior Nurses will support this robustly. *Note –the Directorate Team feels that the actual current position with regard to PADR compliance, since completion of the audit, is now more positive than the results of the sample testing within the report indicate.	Chief Operating Officer	01/03/2018	c	Update August 2020 - Monthly IM Directorate Performance Review meetings are held on a monthly basis. There has been a challenge for the past four months with increased covid activity causing staff to be off sick and shielding. The Directorate plan has been developed by the Lead Nurses for the completion of all VBA and statutory and mandatory training to be completed by the end of the 2020 calendar year.	Audit open over 30 months
2018-19	Performance Reporting Data Quality - Non RTT	Director of Public Health	M	Consideration should be given to aligning the Performance Report and Tier 1 scorecard to the NHS Delivery Measures.	Discussions at a national level are happening between Welsh Government and the NHS in Wales to ensure that the Health Boards are sighted on the data being submitted to Welsh Government to report on the Q&D framework targets. This is not the case at the moment and there is no mechanism other than via the NHS	Director of Transformation & Informatics		c		Audit open over 18 months
2018-19	Performance Reporting Data Quality - Non RTT	Director of Public Health	L	The Performance Report working spreadsheet should be linked to data sources and SOPs in order to aid collation and ensure the on-going robustness of the process.	As identified above – not all the data is available to achieve this. The UHB is actively contributing, via membership of WG & NHS Wales committees to changing and improving data flows and making the required data available.	Director of Transformation & Informatics		pc	work in progress to ensure accurate reporting is in apce for Q4 2020/21	Audit open over 18 months
2018-19	Performance Reporting Data Quality - Non RTT	Director of Public Health	L	Consideration should be given to re-formatting the Performance Report to improve usability.	Accept	Director of Transformation & Informatics		c		Audit open over 18 months

Financial Year Fieldwork Undertaken	Audit Title	Executive Lead for Report	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update	Status of Report Overall
2018-19	Strategic Planning/IMTP	Director of Planning	M	Management should ensure that the plans for Clinical Boards are produced on a timely basis to enable the Clinical Boards to report on their projects in a consistent manner and allow them to monitor them appropriately.	A revised monitoring process for reporting clinical board progress on IMTPs will be in place for 2019/20. This will utilise the Shaping Our Future Wellbeing- Annual Plan (X-Matrix) methodology to provide clarity on performance and accountability arrangements. Progress against key IMTP priorities as captured in the annual plan document will be reported to Management Executives on a monthly basis as agreed at Management Executives on 09/05/19.	Director of Planning	01/07/2019	na		Audit open over 12 months
2018-19	Dental CB – Theatre Sessions	Chief Operating Officer	H	The Dental administration staff should ensure that Patient Dental files contain copies of all necessary documentation relating to the procedures undertaken.	Urgent meeting to be arranged with Clinical Lead and Peri-Operative Care Manager to define a process to manage documentation	Chief Operating Officer	01/09/2018	pc	This action is partially complete and will now be reaudited when green, amber zones are created in SSSU and main theatre - completion will be in September 2020	Audit open over 24 months
2018-19	Environmental Sustainability Report	Director of Planning	M	Future Sustainability Reports should only report on water supply costs. This may be achieved by: using different subjective codes to pay water and sewerage charges; by maintaining a manual record of the split between water and sewerage charges; or by apportioning annual costs based on a sample of paid water and sewerage charges.	Future Sustainability reports will include water supply costs, but will be determined on an apportionment basis from the invoices we receive from Welsh Water. The calculations will be determined from a limited sample of Welsh Water invoices.	Director of Finance	01/04/2019	c	Recommendation adopted where possible	Audit open over 24 months
2018-19	Environmental Sustainability Report	Director of Planning	L	Future Sustainability Reports should include references / links to where further sustainability and estate management performance is published. For example this could include links to information such as the Estates Strategy, EMSG Terms of Reference and selected meeting minutes, ISO Certificate and audit reports / ISO website, Cost Reduction Programme, Re:fit programme, further information on CHP units and Solar PV Schemes and the Sustainable Travel Plan.	Consideration will be given to include references / links to where further sustainability and Estate management performance is published depending on its relevance.	Director of Finance	01/04/2019	c	Business manager assigned to oversee pilot, reporting suite developed and final evalution on completion	Audit open over 24 months
2018-19	National Standards for Cleaning in NHS Wales Follo	Director of Planning	M	The Health Board should ensure that there is a Multi- Disciplinary Group in place in line with the requirements of the 'National Standards for Cleaning in NHS Wales' or that the Healthcare Environment Steering Group referred to in the Cleaning Strategy is reconvened.	Formerly add the Cleaning Standards requirement into one of the existing forums described above into the same agenda. This will save additional meetings and labour resources.	Director of Finance	01/01/2018	c	The Healthcare Environment Steering Group has been re-established and has met on two occasions (27/11/19 and 18/02/20), where the Terms of Reference and membership was agreed. The next meeting is scheduled for 23/09/20. The Group reports to the Infection Control Committee. A shared folder is available for ward managers to access C4C reports weekly.	Audit open over 18 months
2018-19	PCIC CB – District Nursing Rotas	Chief Operating Officer	L	District Nurses should work in conjunction with the Rosterpro team to ensure details in Rosterpro are correct to enable use of the automated generation of rotas. Rotas should be entered into Rosterpro prior to shifts being worked.	District Nursing sisters will be expected to use Rosterpro to roster all staff, this will be reviewed through regular 1-1's with them and the Locality senior nurse.	Chief Operating Officer	28/11/2019	c	The PCIC clinical Board can be assured that rosters are prepared; managed and authorised in line with rostering policy. There continues to be periodic reminders to the district nursing service of the importance of recording shortfalls on the rota and allocation of annual leave.	Audit open over 18 months
2018-19	PCIC CB – District Nursing Rotas	Chief Operating Officer	L	District Nurse Sisters should ensure rotas are prepared on a timely basis. Where rotas are prepared manually, these should be formally signed and the date of preparation recorded.	District Nursing sisters will be expected to use Rosterpro to roster all staff, rosters will be audited quarterly to ensure that rosters are provided 4-6 weeks in advance, and signed off, this will be reviewed through regular 1-1's with them and the Locality senior nurse	Chief Operating Officer	28/11/2019	c	The PCIC clinical Board can be assured that rosters are prepared; managed and authorised in line with rostering policy. There continues to be periodic reminders to the district nursing service of the importance of recording shortfalls on the rota and allocation of annual leave.	Audit open over 18 months
2018-19	Renal IT system	Chief Operating Officer	H	Both UNIX and MySQL should updated to a more recent, supported version.	Early investigations have taken place between Vitalpulse and Summerside. Monies will need to be found to either see how viable the MySQL version 5.7 is with a more recent AIX version. It may not be compatible and a Windows or Linux infrastructure (Live and DR) will need to be considered. Whilst the appropriate Hardware and Software vendor companies, who are contractually obliged to support and maintain the renal IT infrastructure (Summerside Computers Ltd and Vitalpulse Ltd respectively) review and consider the viable options available, we are unable to action any immediate change, either as a HB or as part of the WRCN. We will continue to monitor and review until a suitable solution is identified and can be implemented.	Chief Operating Officer	01/06/2019	c	There has been ongoing discussions following the audit with both C&V UHB and with the Welsh Renal Clinical Network to move away from a UNIX/AIX environment, to Windows. Funding has been agreed through Transformation Funds with WAG to merge the two Renal IT Systems used in Wales and in order to accommodate this, a new IT infrastructure will need to be evaluated and implemented. Recognition that the merging of two established systems will take some time and estimated for 2021, it was agreed that C&V UHB will proceed with this recommendation in parallel. This was progressed and put in place from April 2020.	Audit open over 18 months
2018-19	Renal IT system	Chief Operating Officer	M	The minimum password length should be set to 8 and all users have a forced password change enacted.	The minimum length has now been amended to 8. With regard to forced change, this will be required when VitalData v1.7 is implemented across Wales this financial year. v1.7 has Active Directory authentication, which will mean Users will be required (and forced) to change their VitalData password every 90 days – the same as is required with User's everyday NADEX domain login.	Chief Operating Officer	01/06/2019	c	Action completed - see management response	Audit open over 18 months
2018-19	Renal IT system	Chief Operating Officer	M	The DR plan should be revised to include contact details of support organisations, user departments and management. The DR plan should be tested and subject to subsequent review.	Dialogue with the Vendor parties has already started regarding the failback process. Action is underway to test and resolve, and identify an appropriate timetable for follow-up to ensure regular review. The BCP will be revised with immediate attention	Chief Operating Officer	01/04/2019	pc	The BCP and DR plan have been revised. A new plan will be devised and tested following implementation of a new IT infrastructure, expected by July 2020	Audit open over 18 months
2018-19	Kronos Time Recording System - Estates	Director of Planning	H	Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system.	Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system.	Director of Finance	01/06/2019	pc	Interface requires testing to complete pilot	Audit open over 18 months
2018-19	Kronos Time Recording System - Estates	Director of Planning	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	The issue will be considered as part of the system review although all overtime is authorised and recorded therefore the risk is low. Kronos has been updated to include overtime reasons.	Director of Planning	01/06/2019	na		Audit open over 18 months

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2018-19	Kronos Time Recording System - Estates	Director of Planning	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 update	Staff clock in on arrival on site but are not paid from this point, unless authorisation is given for overtime. Staff will be advised not to clock in as suggested and this will be monitored but the risk associated with this practice is considered low.	Director of Finance	01/03/2019	na	system rules setup to overide early clocking in. If staff clocks in early and work overtime supervisers amend early clocking in.	Audit open over 18 months
2018-19	Medicine CB - Sickness Absence Management	Chief Operating Officer	M	Management should ensure that all current ward managers are provided with appropriate training to enable them to effectively manage sickness absence. A robust process should also be implemented to ensure that timely training is provided to any new ward managers. Regular information on sickness absence levels should be consistently provided to all ward managers.	Within Stroke Services, engaged with Human resources to provide further training for all members of the Leadership team. Discussed with HR and now regularly circulating sickness data. HR currently undertaking deep dives with high rate areas to provide useful supportive information about absence.	Director of Planning	22/05/2020	c	All supervisory managers are provided with support from HR and their line managers to manage sickness in an effective way. Covid has bought an increaase focus and scutiney on sickness and levels are decreassing within the directorate.	Audit open over 18 months
2018-19	CRI Safeguarding Works	Director of Planning	M	Progression at risk should be fully documented, approved and recorded at the risk register (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Planning	22/05/2020	na	Included on the project risk register	Audit open over 18 months
2018-19	CRI Safeguarding Works	Director of Planning	L	A Project Execution Plan should be prepared at the outset of a project, in accordance with the Capital Projects Manual and best practice (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Planning	22/05/2019	c	all projects have a project execution plan developed at the outset and reveiwed and revised at the relevant stages	Audit open over 18 months
2018-19	CRI Safeguarding Works	Director of Planning	M	Sufficient contractual arrangements should be in place to safeguard the Health Board interests (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Planning	01/06/2019	c	all projects have a project execution plan developed at the outset and reveiwed and revised at the relevant stages	Audit open over 18 months
2018-19	CRI Safeguarding Works	Director of Planning	L	4) Project benefits should be clearly identified and documented in the business case, including: Baseline value; Method of measurement; Target improvement; Timing of when the benefit would be achieved; and Lead responsibility for the benefit (D). (This recommendation being for implementation at future projects). Post project evaluations should be delivered in accordance with agreed Business Case requirements, or a revised approach should be appropriately approved (O).	Agreed. **ALL FUTURE PROJECTS**	Estates Manager	01/05/2019	na		Audit open over 18 months
2018-19	CRI Safeguarding Works	Director of Planning	L	5) The required approach to post project evaluation and benefits assessment should be agreed with the Welsh Government, in relation to the CRI afeguarding project and wider investment at the CRI site (O).	Agreed.	Estates Manager	01/04/2020	na		Audit open over 18 months
2018-19	Commissioning	Director of Transformation and Informatics	H	Strategic Commissioning Group Terms of Reference document should be revised and updated to state the quorate attendance level and its current membership. Additionally, its membership should include representation from the Clinical Boards to ensure a broad contribution and as such an improved strategic approach in full alignment with the Group's Terms of Reference.	The Strategic Commissioning Groups Terms of Reference, including membership was reviewed at a facilitated workshop on 20th Feb 2019. The first draft of a refreshed Terms of reference is scheduled for discussion at the May 2019 meeting of the Strategic Commissioning and Finance Group. Clinical Board representation will be fully considered.	Director of Transformation & Informatics	01/04/2019	na		Audit open over 18 months
2018-19	E IT Training	Director of Transformation and Informatics	L	An impact assessment process should be introduced in order to gather and evaluate the feedback from training attendants after they have had the opportunity to use the relevant systems. The feedback emails should be reviewed on a regular basis.	An impact assessment process is in draft but has been suspended due to the Work Life Balance absence of the WCP trainer. This and the regular review of feedback emails will recommence once the trainer has returned to post.	Director of Planning	30/06/2019	c		Audit open over 18 months
2018-19	E IT Training	Director of Transformation and Informatics	L	The training material should be updated to include a range of options for post learning support other than just helpdesk contact information. The need for refresher sessions should be reviewed in conjunction with	It would not be appropriate to provide Service Coordinator details since these will be subject to change at effectively no notice. Training materials include contact information for the "IT User Support" team which is managed by the IT Trainers and Implementation Officer. Both e-mail and telephone contact details are included. Users are able to contact for advice, refresh and support to	Director of Planning	30/06/2019	c		Audit open over 18 months
2018-19	Water Safety	Director of Planning	M	Attendances of the Water Safety Group should be reviewed, with staff reminded of their responsibilities to attend, to ensure key groups are appropriately represented (O).	Agreed	Director of Finance	30/07/2019	c	CEF representatives agreed and attend scheduled meetings	Audit open over 12 months
2018-19	Water Safety	Director of Planning	M	The current position in respect of the backlog of remedial jobs, should be routinely reported to the Water Safety Group (O).	Agreed	Director of Finance	30/06/2019	pc	Ongoing discussions at scheduled meetings	Audit open over 12 months
2018-19	Water Safety	Director of Planning	M	Training should be updated for all key staff with assigned water management responsibilities (O).	Agreed	Director of Finance	30/07/2019	na		Audit open over 12 months
2018-19	Water Safety	Director of Planning	M	a) An audit trail should be maintained where routine checks are not completed, in cases where risk-based decisions dictate alternative monitoring/testing schedules will be applied. b) Key person dependency should be reviewed and removed, where possible, to facilitate the timely identification and completion of	Agreed	Director of Finance	01/11/2019	pc	Statutory inspections ongoing, information being entered into MiCad, live database	Audit open over 12 months
2018-19	Water Safety	Director of Planning	H	a) For those clinical boards identified in this audit as being non-compliant with required flushing practices, the Chair of the WSG should request assurance from the clinical boards that practices have been improved.	Agreed	Director of Finance	01/11/2019	na		Audit open over 12 months
2018-19	Water Safety	Director of Planning	H	The risk assessment process, including preparation of appropriate prioritised action plans to address the identified risks, should be completed as soon as possible (D).	Agreed	Director of Finance	30/07/2019	na		Audit open over 12 months
2018-19	Water Safety	Director of Planning	M	Progress, including highlighting of any delays, should be regularly reported to the Water Safety Group (O).	Agreed	Director of Finance	31/10/2019	na		Audit open over 12 months
2018-19	UHB Core Financial Systems	Director of Finance	M	Management should inform responsible staff to promptly notify eEnablement of changes to the Purchasing Oracle hierarchy list. The required forms should be completed to process updates.	Recommendation Accepted. The UHB's current procedure will be updated to clarify the responsibility to review approvers at the Clinical Board level and within Corporate Finance.	Director of Finance	31/07/2019	pc	A list of actions were agreed with NWSSP Procurement eEnablement on the 21st June 2019. Actions included the establishment of a revised Oracle User Form which would include ESR position numbers which could be linked to Oracle responsibilities. On the 15.06.2020 NWSSP confirmed that	Audit open over 12 months

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2018-19	UHB Core Financial Systems	Director of Finance	M	Management should ensure that a standard procedural guide is produced to support staff in the maintenance of the Oracle Purchasing hierarchy. The guide should also state an appropriate agreed period for the review of the hierarchy.	Recommendation accepted. The UHB's current procedure will be updated to clarify respective responsibilities at the Clinical Board level and within Corporate Finance. The minimum expectation is that purchasing hierarchies will be reviewed quarterly.	Chief Operating Officer	01/04/2020	pc	A list of actions were agreed with NWSSP Procurement eEnablement on the 21st June 2019. Actions included the establishment of a revised Oracle User Form which would include ESR position numbers which could be linked to Oracle responsibilities & an agreement to investigate whether	Audit open over 12 months
2018-19	UHB Core Financial Systems	Director of Finance	M	Management should ensure that the required forms are completed, signed and forwarded to eEnablement for all additions to the Oracle Hierarchy. Management should also liaise with eEnablement to ensure there is an organised system for storing the Financial limit forms so they can be easily retrieved here an audit trail is required.	Recommendation accepted. The UHB's revised procedure will be updated to clarify respective responsibilities for establishing approvers and maintaining appropriate records for additions to the Oracle Hierarchy.	Chief Operating Officer	31/08/2019	pc	AA list of actions were agreed with NWSSP Procurement eEnablement on the 21st June 2019. Actions included the establishment of a revised Oracle User Form which would include ESR position numbers which could be linked to Oracle responsibilities & an agreement to investigate whether Finance staff could be provided with read only access to hierarchies. The read only access to hierarchies was	Audit open over 12 months
2018-19	Specialist Services Clinical Board – Medical Finance Governance	Chief Operating Officer	H	Management should carry out a comprehensive review of the current and future consultant staffing levels to ensure that the Critical Care service can be sustainably delivered in the future. This should include review of the current service model.		Chief Operating Officer	01/04/2019	pc	Active recruitment taking place and plan to be fully recruited to existing capacity by Nov 2020 succession planning being identified and models of care being reviewed	Audit open over 12 months
2019-20	Legislative/Regulatory Complaince	Director of Corporate Governance	H	The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Agreed	Director of Corporate Governance	01/02/2019	pc	It should be recognised that the current all Wales FRA tool used by all Welsh Health Boards and managed by SSP does not evidence completion of actions making evidance of	Audit open over 18 months
2018-19	Legislative/Regulatory Complaince	Director of Corporate Governance	H	The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers.	Agreed	Deputy CEO & Executive Director of Workforce and OD	30/06/2019	na	This action if for the Fire Safety Manager to be followed up by end of June	Audit open over 18 months
2018-19	Information Governance: General Data Protection	Director of Transformation and Informatics	H	The UHB should consider establishing a GDPR group with representation from all clinical boards. The function of the group should be to ensure appropriate compliance actions are taken and to provide assurance that the UHB has good processes to ensure compliance with the GDPR.	The UHB has adapted the all Wales IG policy. As part of the process to formal adoption, consultation and impact assessment will be taking place through which we anticipate identification of all clinical board requirements and prioritised action. The UHB sees placing responsibility and accountability as close as possible to the operational front line as the key to having an empowered and engaged workforce. Thus we see that the role of the corporate IG department is to design delivery of compliance and to provide specialist advice, rather than co-ordinate and deliver. It is accepted that as resources and expertise accumulate in line with expectation, there is more the central team can do on communication and engagement including	Director of Transformation & Informatics	01/03/2019	c	IG representation at CB Q&A groups being trialed to ensure pertinent principles of the GDPR are being adhered to. The Digital Service Management Board has responsibility for delivering the digital transformation, supported by an Information Governance group that includes representation from clinical boards.	Audit open over 18 months
2018-19	Information Governance: General Data Protection	Director of Transformation and Informatics	H	The resource requirement for the Information Governance team should be fully assessed and resource provided appropriately.	In the context of the UK wide economy growing at a lower rate than: patient expectation, demand and health care cost inflation, the UHB has had to take business decisions in order to deliver a financially balanced plan. We recognise these have had significant consequences on many of our staff and resulted in high levels of sickness which have only made the position harder for all.	Director of Transformation & Informatics	30/09/2019	c	The IG function has been increased and strengthened as part of the Digital & Health Intelligence directorate restructure.	Audit open over 18 months
2018-19	Information Governance: General Data Protection	Director of Transformation and Informatics	H	A revised Subject Access Procedure should be completed, placed on the intranet and flagged to all staff.	Accepted	Director of Transformation & Informatics	ational Implementati	c	SAR procedure live	Audit open over 18 months
2018-19	Information Governance: General Data Protection	Director of Transformation and Informatics	M	The IG webpages should be updated to ensure they present current, accurate information.	The contact details will be updated shortly. As noted above the department has been short staffed and there has needed to be a prioritisation between designing and mitigating significant risks to noncompliance and making general information available. The UHB has engaged widely on the DPA 2018 and is intending to use the consultation on the IG policy as a further vehicle for promoting awareness and setting out	Director of Transformation & Informatics	01/03/2019	c	Website has been updated	Audit open over 18 months
2018-19	Information Governance: General Data Protection	Director of Transformation and Informatics	M	The UHB should seek to ensure all staff complete the IG training module.	Management Response Accept – The UHB is engaged nationally in the development of the e-learning package and has licenses for its use. We intend to make use of this national initiative in line with its roll out plan.	Director of Transformation & Informatics	30/09/2019	c	This has been consolidated into a single IG action plan which is being updated in preparation for the Digital & Health Intelligence Committee meeting on 3 December 2019	Audit open over 18 months
2018-19	Information Governance: General Data Protection	Director of Transformation and Informatics	M	Training on GDPR should be enhanced and provided to all staff acting in an IAO or IAA role. Further information should be passed to Directorates on the specific actions to be undertaken following GDPR.	Training is via the mandatory training route described in recommendation 5. The UHB will take actions to ensure we have asset registers and awareness of GDPR within dermatology and across the medicine clinical board as an early priority. Within clinical boards there will be further emphasis and engagement on the responsibilities and requirements for IAO/IAA roles, in order to enable appropriate senior staff to be allocated/trained, following implementation of enhanced training programme	Director of Transformation & Informatics	30/09/2019	c	IAR completed. TNA should be undertaken as recommended by recent ICO audit.	Audit open over 18 months
2018-19	Surgery Clinical Board – Medical Finance Governance	Chief Operating Officer	H	The Directorate should ensure that consultants carry out all planned sessions wherever possible and appropriate reasons are recorded for the cancellation of clinics and theatres. Colorectal Consultants should ensure that they cover and backfill the other Consultants lists if they are unable to carry out the planned session.	A new system to accurately record consultant activity in theatre is being developed with a clear desktop procedure. Through job planning each consultants expected activity will be agreed in weeks and monitored accordingly by the Directorate Expectation around backfill sessions will be agreed and signed by consultants and a system to monitor this will be managed by the Directorate team Systems will be put in place by end of March 2019	Chief Operating Officer	30/03/2019	pc	Theatre sessions reviewed on a weekly basis by the specialty manager for General Surgery. Improve annual leave data base has been developed for General Surgery which includes reason for absence. Joint job planning meeting is scheduled for the end of August, at which discussions will be held in relation to backfilling. The Directorate have seen improvements in terms of backfilling.	Audit open over 18 months
2018-19	Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up	Chief Operating Officer	H	Management should ensure that all members of staff within the directorate are fully compliant and up to date with their mandatory training. If staff members believe that ESR is not tracking when a module is completed, staff should print out the certificate available to provide proof and store it within their personal file.	Improved compliance for 85% of staff with completion of 100% mandatory and statutory training modules (44% improvement over 6 months). Staff to be allocated onto study leave planner and compliance monitored monthly via ESR and discussed with ward managers at 121s.	Director of Transformation & Informatics	01/07/2019	pc	Work has commenced to cleanse ESR which will mean that Ward Managers receive accurate monthly data from workforce. Ward Managers are held to account for the training compliance of their team and this is discussed monthly with the Senior Nurse Plan to be compliant by Sept 2020	Audit Open over 18 months
2018-19	Cyber Security	Director of Transformation and Informatics	H	A review of the resources available within IM&T and the requirements of the organisation should be undertaken to ensure that the department can appropriately meet the demands. Additional investment should be considered in order to provide a cyber security function.	A review of the current IT and Information departments has been completed and a restructure proposal created. This includes additional cyber security resources to manage and deliver the NESSUS and SIEM requirements, utilising the additional funding being made available by Welsh Government.	Director of Transformation & Informatics	01/09/2019	c	In anticipation of receiving WG funding, resources are being procured by a framework agency on a temporary basis, pending recurrent funding.	Audit open over 12 months
2018-19	Cyber Security	Director of Transformation and Informatics	H	An active monitoring process which feeds into KPI reporting should be developed and maintained within IM&T.	The restructure of the directorate includes additional resource to manage cyber security issues. A key role for this function will be the development of a monitoring system that supports the KPI reporting against cyber security.	Director of Transformation & Informatics	01/09/2019	c	Additional temp reources are being procured to manage the cyber security performance indicators	Audit open over 12 months
2018-19	Cyber Security	Director of Transformation and Informatics	H	Resources should be provided to allow for a cyber security role to be properly defined and operating appropriately.	The restructure of the IT and information functions being proposed will result in the establishment of cyber security roles which will monitor and respond to cyber incidents and will develop policy, processes and procedures to reduce the likelihood of a cyber security incident	Director of Transformation & Informatics	01/09/2019	c	In anticipation of receiving WG funding, resources are being procured by a framework agency on a temporary basis, pending recurrent funding.	Audit open over 12 months
2018-19	Cyber Security	Director of Transformation and Informatics	H	Active monitoring should be established. A Cyber response plan should be developed.	The creation of new cyber security roles in the restructured directorate will mean that a proactive stance on monitoring of cyber security is created as part of a wider Cyber response plan, which will also incorporate use of the NESSUS and SIEM solutions.	Director of Transformation & Informatics	01/09/2019	c	In anticipation of receiving WG funding, resources are being procured by a framework agency on a temporary basis, pending recurrent funding.	Audit open over 12 months
2018-19	Cyber Security	Director of Transformation and Informatics	M	A formal, resourced plan for the removal of old software and devices should be established.	A formal plan is in the early stages of production and will address removal of aged and insecure software as well as devices. This will be implemented by the cyber security team proposed in the new directorate structure.	Director of Transformation & Informatics	01/07/2019	c	A contract is in place with incumbent supplier which documents the processes and form the basis of the plans	Audit open over 12 months

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2018-19	Cyber Security	Director of Transformation and Informatics	M	A formal patch management procedure should be developed that sets out the mechanisms for patching / updating all items within the Health Board.	Patching of PCs is being investigated as time allows to identify the scale of the risk. A patch management procedure will be developed to address patching of all devices. This procedure will describe how patches and updates will be managed, with reference to the national standards and alerts managed through NWIS.	Director of Transformation & Informatics	01/09/2019	c	A deployment programme is underway and patching / updates are included as part of this programme.	Audit open over 12 months
2018-19	E-Advice	Director of Transformation and Informatics	M	Management should undertake an exercise to review and quantify benefits from the ongoing use of the e-Advice system to ensure benefits are maximised and the system is sufficiently supported and resourced.	With the resource available an exercise will be carried out to review and quantify the original key benefit identified in the project outline document 'a minimum of 10% avoidance of attendance in Outpatients is likely to be achieved by GPs implementing an e-advice service'. As part of the restructure process of the wider Digital team, we will look to increase our capacity for benefits realisation and evaluation. A wider benefits review will be carried as our service users recognise the benefits that e-Advice brings.	Director of Transformation & Informatics	01/07/2019	c		Audit open over 12 months
2018-19	E-Advice	Director of Transformation and Informatics	M	Management should document the approach to testing and implementing changes. This should include documentation of requirements around change categorisation, the extent of testing required, the approval process, the approach to rolling back changes, and criteria to be used when assigning a severity to changes.	There are processes in place to manage testing, approvals, roll back and assigning a severity to changes which allow for a quick response. It is recognised that these processes have lacked some formality due to the resource available. However work has already started on formal cumentation to support ease of handover to other members of the department. This will be light-touch, with minimum documentation, aimed at supporting the change and testing process without being overly bureaucratic.	Director of Transformation & Informatics	01/06/2019	c		Audit open over 12 months
2018-19	E-Advice	Director of Transformation and Informatics	M	A regular, at least annual, exercise should be undertaken to confirm the validity of user accounts and ensure any leavers accounts are identified and disabled.	A report to identify account inactivity of 90 days will auto-run daily following which inactive accounts will be closed. Accounts can be reactivated on request.	Director of Digital and Health Intelligence	24/05/2019	c		Audit open over 12 months
2018-19	E-Advice	Director of Transformation and Informatics	L	Management should consider the use of local e-Advice super users.	The team are looking at ways to relieve the administration workload on them. A service announcement will be sent out to all super users reminding them of the actions that they can carry out e.g. authorising of accounts, closing accounts. New users are now able to self-register. Super users will be encouraged to take an increased role in user acceptance testing.	Director of Digital and Health Intelligence	30/09/2019	c		Audit open over 12 months
2018-19	UHB Transformation Process	Director of Digital and Health Intelligence	M	The Transformation Enabler Steering Group should consider including nominated Clinical Board Leads to contribute directly into each Enabler where appropriate and actively inform the development of progress.	Each enabler task and finish group links with Clinical Boards and have involvement of staff . We will review this with the Boards in order to improve engagement. We will consider whether a lead or link person from each Board would improve engagement.	Director of Digital and Health Intelligence	24/05/2019	c	this work is being managed by the recently formed Digital Service Management Board, which reports into the DHIC and ME.	Audit open over 12 months
2018-19	UHB Transformation Process	Director of Digital and Health Intelligence	M	The Accessible Information Enabler should implement a formal Task and Finish Group that oversees and provides governance of delivery of the Enabler's objectives and interfaces with the Transformation Enablers Steering Group.	The Accessible information enabler work is being reported to a number of different groups, which ensures oversight and assurance. These include HSMB, the "signals from Noise" steering group chaired by the CEO and the new Digital Design Group being established in October 2019 which will include membership from the Executive Management team and Clinical Boards. In addition, the accessible information enabler work will be reported into the new Digital & Health Intelligence committee, a new formal committee of the Board.			c	this has been incorporated into the work programme being monitored by the Digital and Health Intelligence Committee.	Audit open over 12 months
2019-20	Standards of Business Conduct (DoI & GH&S) Follow-up	Director of Corporate Governance				Director of Planning	30/09/2019	c		
2019-20	Carbon Reduction Commitment	Director of Planning	M	The UHB should ensure that the strategy is agreed as soon as possible so that the surplus allowances can be sold for the best achievable price.	The UHB will be agreeing the strategy regarding the course of action to be adopted for surplus allowances during August 2019.	Director of Planning	16/08/2019	na	The surplus CRC allowances were advertised to be sold via procurement however there were no bids therefore no sale was made.	Audit open over 12 months
2019-20	Mental Health Clinical Board - Sickness Management Follow-up	Chief Operating Officer	H	Management should ensure that the sickness triggers are being managed correctly with informal discussions and formal sickness interviews being carried out in accordance with the All Wales Sickness Policy.	Directorates to send "trigger table" out to all managers, reminding them to check with line managers if they have any doubt or queries with individual cases. Senior Nurse Managers to conduct random sickness file checks as part of 1:1 with managers.	Director of Planning	31/10/2019	c	Action complete - see management response	Audit open over 12 months
2019-20	Legislative / Regulatory Compliance	Director of Corporate Governance	M	The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Agreed	Deputy CEO & Executive Director of Workforce and OD	01/02/2019	pc	It should be recognised that the current all Wales FRA tool used by all Welsh Health Boards and managed by SSP does not evidence completion of actions making evidance of closure a laborious resource intensive task. However CEF intend to develop an alternative electronic system to enable closure of actions to be carried out by the responsible person attributed to each action resulting in evidence that is both current and auditable.	Audit open over 12 months
2019-20	Legislative / Regulatory Compliance	Director of Corporate Governance	M	The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers.	Agreed	Deputy CEO & Executive Director of Workforce and OD	01/05/2019	pc	This action if for the Fire Safety Manager to be followed up by end of June	Audit open over 12 months
2019-20	Legislative / Regulatory Compliance	Director of Corporate Governance	M	The Corporate Team should re-evaluate the Report to ensure that all the necessary information required to maintain a comprehensive list is in place. The Corporate Team should also review the standard email that is sent out to ensure that all the required information is requested. They should also pursue those who have not provided the relevant information.	Recommendation agreed	Director of Corporate Governance		c	This action is complete and the report and more detail was presented to the Committee for the first time in September 2019	Audit open over 12 months
2019-20	Sustainability Reporting	Director of Planning	M	Evidence of the retrospective approval of the sustainability report by the Environmental Steering Group / Health & Safety Group and sign off by the Director of Capital Estates and Facilities should be provided to audit each year. The documented procedural guidance should be updated to reflect the actual review and approval process currently in place.	Future Sustainability reports will be approved and signed off at the Capital Estates and Facilities Health & Safety Group. Depending on timescales retrospective approval may need to be provided, however the approval and sign off of the report shall be documented in the relevant minutes of the group.	Director of Planning	16/08/2019	c	The SDR will be tabled at the departmental Health and Safety meeting for retrospective approval.	Audit open over 12 months
2019-20	Sustainability Reporting	Director of Planning	M	Management should draw up a timetable each year to help ensure appropriate time is allocated for the sustainability report preparation, review process, audit, approval and submission to the Communications Team. The requirement to produce a timetable each year should be incorporated into the procedural guidance.	Once the timescale for the Sustainability report submission is known an indicative timetable will be developed. Timings however may change depending on when information is available for inclusion in the report and the availability of Officers to verify and audit information and data.	Chief Operating Officer	01/06/2020	c	The SDR timescales were modified in light of Covid 19	Audit open over 12 months
2019-20	Claims Reimbursement	Executive Nurse Director				Executive Medical Director	01/11/2019	na		Audit open over 6 months
2019-20	Consultant Job Planning Follow-up	Executive Medical Director	H	Clinical Boards must ensure that all consultants complete a job plan or have their existing job plan reviewed on an annual basis.	1. Processes are in place to support the completion and reporting of job planning activity. There is monthly reporting of the annual job planning process via the Clinical Board Performance reviews. There has been recent improvement in a small number of Clinical Boards. Immediate steps will be taken by the Medical Director and the Director of Workforce to target those Clinical Boards with poor performance and those not significantly improving (5 out of 8) to request an improvement plan which will ask for reported improvement in annual job planning review rates over a period of three months. Clinical Board Directors should ensure that the Clinical Directors take responsibility for these being undertaken and have internal Clinical Board systems to monitor improvement.	Executive Medical Director		pc	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system.	Audit open over 6 months

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2019-20	Consultant Job Planning Follow-up	Executive Medical Director	H	The UHB job planning guidance should require consultants to use the standard Job Plan template contained within the guidance unless they can provide a valid reason for not doing so. Job Planning documentation should be completed in full and should include full details of the activities to be undertaken in each session. Line managers should ensure that the number and split of sessions recorded in ESR agrees to and is supported by a fully completed job plan.	1. Clinical Board Directors and Clinical Directors should ensure that summary job plans data are submitted to the Medical Workforce Team on a regular basis so that updates can be made in the ESR system. This will be recognised by implementation of actions in Management Recommendation 1 in terms of outcomes. 2. Medical Workforce to update ESR system with summary job plan data – this has been already reviewed by the Medical Director and Director of Workforce recently and there is no back-log of data to currently input into the system (maximum wait two weeks). Clinical Directors/DM will be able to submit to ESR and their data will be entered in a timely way. The previous guidance issued	Executive Medical Director		pc	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system.	Audit open over 6 months
2019-20	Consultant Job Planning Follow-up	Executive Medical Director	H	Clinical Board management must ensure that all consultants complete the outcome measures template contained within the UHB Job Planning guidance as part of the job planning process.	1. Review of job planning guidance with regard to job plan template and re-issue to Clinical Board Senior Teams for cascade to their Clinical Directorates. 2. The Medical Director and Workforce Director will present to the HSMB in June 2018 the outcome of the Internal Audit Report - outlining the actions to be taken and re-emphasise the information available to the Clinical Boards and Clinical Directorates.	Executive Medical Director		pc	24/08/2020: First draft of procedure sent out to BMA for comments and to all CBDs and CDs for comments.Awaiting comments, this procedure will then go out for 28days consultation prior to approval. Procedure includes the need to complete the outcome forms	Audit open over 6 months
2019-20	Consultant Job Planning Follow-up	Executive Medical Director	H	In accordance with the guidance, Clinical Board management should ensure that individual, personalised schedules are completed for all consultants that are on Team or Annualised Hours Job Plans.	Review of job planning guidance with regard to job plan template and re-issue to Clinical Board Senior Teams for cascade to their Clinical Directorates. This will emphasise the need for all members of a team to complete individually the team job plan.	Executive Medical Director		pc	24/08/2020: First draft of procedure sent out to BMA for comments and to all CBDs and CDs for comments.Awaiting comments, this procedure will then go out for 28days consultation prior to approval. Procedure includes annualised job plans, with the annual job plan cycle aligned to the financial year. Please see procedure for details	Audit open over 6 months
2019-20	Consultant Job Planning Follow-up	Executive Medical Director	L	The UHB should consider developing additional methods of communication and / or training for both line managers and consultants to improve the completion rate and quality of consultant job plans.	A planned schedule for training should be refreshed and communicated, including sources of information available to Clinical Directors. **Implemented.** Evidence was provided to confirm that a series of training sessions detailing the findings from the original audit was delivered by the Assistant Medical Director (Medical Workforce and Revalidation).	Executive Medical Director		na	24/08/2020: Training has been provided by the AMD for Workforce and implemented. In line with the implementation of the e-JP system, a revised training plan will be developed to update all CDs with how this will work with the new system.	audit open over 6 months
2019-20	Consultant Job Planning Follow-up	Executive Medical Director	M	All completed job plans must be signed by the Consultant and the clinical manager responsible for agreeing them. The standard Job Plan documentation included in the UHB Job Planning guidance should be updated to incorporate the use of digital signatures.	1. The job plan review does not require an actual signature but there does need to be a record of the job plan being agreed by all parties and signed. 2. An electronic job planning system will be trialled in Cardio Thoracic should provide a seamless and electronic system solution in the future, pending evaluation of the pilot and consideration of costs. This will include the ability for electronic sign off.	Executive Medical Director		na	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system. The system will make use of digital signatures. Within procedure and system, noted that no response will be taken as assumed acceptance of JP.	Audit open over 6 months
2019-20	Tentacle IT System	Director of Transformation and Informatics	L	Brief user guides should be developed for the system.	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.	Director of Transformation & Informatics		c	Tentacle system on PMS - access controlled	audit open over 6 months
2019-20	Budgetary Control	Director of Finance	M	Delegated Budget Holders should sign-up to their delegated budget annually.	This specific issue was considered as part of the Deloitte's Financial Governance review and was not supported due to anticipated unintended consequences.	Director of Finance	not applicable	c	Not applicable	Audit open over 18 months
2019-20	Brexit Planning	Director of Planning	H	The business continuity arrangements within Mental Health should be further reviewed, scrutinised, approved and embedded within the Clinical Board	Draft business continuity plans completed and circulated within Mental Health, and shared with EPRR Team. The Clinical Board is holding a Business Continuity Exercise for mental health leads, facilitated by	Director of Finance		na		audit open over 6 months
2019-20	Brexit Planning	Director of Planning	M	Management information surrounding areas of lower compliance should be distributed to the clinical/service boards and staff should be encouraged to complete the nationality section on ESR.	Work will continue to address the information gap by encouraging Clinical and Service Boards to encourage their staff to update their information. The Head of Workforce Governance will provide, if required, information on a Directorate or	Director of Finance		na		audit open over 6 months
2019-20	Brexit Planning	Director of Planning	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	Director of Finance		na		audit open over 6 months
2019-20	Brexit Planning	Director of Planning	L	Going forward, if there is a requirements for daily reporting in the future; all required areas of the Health Board should complete the required forms.	UK/Welsh Government reporting focussed on the key areas of Medical Devices/Clinical Consumables, General Supplies and Workforce. As such – the key areas for concern were primarily Clinical Boards – hence the requirement for daily reporting. However, the recommendation is noted.	Director of Finance		na		audit open over 6 months
2019-20	Freedom of Information	Director of Transformation and Informatics	H	The Health Board should take steps to ensure the continuity of the FoI management function, and that all necessary knowledge and expertise currently being utilised is able to be retained, especially if/when personnel	Both of the fixed term contracts are being addressed and are being made permanent in the new Digital structures.	Director of Transformation & Informatics		c	JDs agreed - recruitment to permanent positions was planned for early Summer (Covid-19 caused delay). Roles being advertised internally.	Audit open over 6 months
2019-20	Freedom of Information	Director of Transformation and Informatics	L	FoI certification or additional FoI training should be available for team members whose role involves processing and answering FoI requests.	FOI lead in discussion with NWIS re national approach to training.	Director of Transformation & Informatics		pc	potential training opportunities discussed at local and national level;	audit open over 6 months
2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	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	UHB Study Leave procedure document will be reviewed and strengthened in the areas outlined in the report. This will require agreement with the Local Negotiating Committee (LNC) of the UHB.	Director of Workforce and Organisation Development	01/07/2020	pc	UHB procedure document has been reviewed and strengthened, including negotiation with the LNC regarding funding gap. To go to LNC on 26th November.	audit open over 6 months
2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	M	Pro-forma procedures for administering consultants study leave and annual leave should be drawn up and shared with Directorates for them to customise to their particular circumstances. Such procedures could also include good practice, dos & don'ts and other useful advice as well	Enhanced Guidance will be provided for Directorates on interpretation of types of leave and their level and status of approval. This can then be consistently applied and adapted to local circumstances and will need to be agreed with the LNC.	Director of Workforce and Organisation Development	01/07/2020	c	Categories of leave are on Intrepid. Certain types of leave need approval by the Assistant Medical Director.	audit open over 6 months
2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	M	Directorate administrative arrangements should be reviewed and strengthened in line with the revised Health Board Procedure and as a part of producing local operational procedures, particularly the recording of clinical authorisation on Intrepid. Procedures should	Comprehensive Review of local processes Directorate by Directorate will take place to ensure consistency of process with UHB Procedures and guidance	Director of Workforce and Organisation Development	01/09/2020	pc	Email sent out to the HR leads for the clinical boards listing 'finding 3' administration practices. Requested comments back from directorates to confirm processes and guidance. Asked for responses by end of	audit open over 6 months
2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	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.	Director of Workforce and Organisation Development	01/09/2020	pc	Currently under discussion with the LNC, pending agreement. LNC meeting 26th November.	audit open over 6 months
2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	M	Assess and review the use of Intrepid as a tool for managing activities other than junior doctors and formulate a plan going forward.	Intrepid approval system enables approver to view a 'team' leave view that facilitates approval only where cover for clinical services can be managed and Intrepid will not allow leave application unless cover has been agreed by a named colleague. The UHB is currently considering options for e rostering of Medical Staff etc within the Medical Productivity Project alongside e job planning	Director of Workforce and Organisation Development	01/12/2020	pc	The Allocate E Job planning software has been procured. There are options to review the E Rostering facility. Ongoing options (no date as yet).	audit open over 6 months

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2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	M	Develop the Intrepid User Group to co-incide with the introduction of the updated Health Board Procedure and local operational procedures. Besides regularising practices, the group could be a forum to identify development opportunities and good practice. The ability of the system to generate 'team views' and reports should be considered as well. Once updated, the authorisations should be checked annually. A Terms of Reference should be put in place and all meetings should have minutes and action plans.	Intrepid User Group will be refreshed with revised TOR and membership. Minutes of meetings and associated Action plans will be reviewed by the Medical Workforce Advisory Group	Director of Workforce and Organisation Development	01/07/2020	pc	Membership of the Intrepid User Group has been reviewed. This group is seeking nomination for a member of the LNC to join. TOR currently under review. To be signed off by MWAG group on 21st October.	audit open over 6 months
2019-20	Control of Contractors	Director of Finance	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.	Director of Finance	01/03/2020	na		audit open over 6 months
2019-20	Control of Contractors	Director of Finance	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.	Director of Finance	01/10/2020	na		audit open over 6 months
2019-20	Control of Contractors	Director of Finance	M	Induction content should be reviewed and updated to reflect current practice (O)	Accepted. The presentation will be updated to reflect current practice. The audit-visual presentation will be audible version of the induction will be removed from use until any ambiguities in the narrative have been addressed. In the interim, physical presentations by UHB staff will be undertaken.	Director of Finance	01/03/2020	na		audit open over 6 months
2019-20	Control of Contractors	Director of Finance	M	The functionality of the Backtraq system should be reviewed for the timeliness and detail of the management information provided. (D).	Accepted. Initial discussions have been held with the software provider re: potential enhancements to the existing system. However, it is accepted that a standalone system for sign in/out would be more effective.	Director of Finance	01/09/2020	na		audit open over 6 months
2019-20	Control of Contractors	Director of Finance	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.	Director of Finance	01/03/2020	na		audit open over 6 months
2019-20	Control of Contractors	Director of Finance	M	Management should collate the output of the contractor monitoring forms for reporting to an appropriate forum; for actions to be taken where required. (O)	Accepted. In the role of Framework Manager, the Head of Discretionary Capital & Compliance, will initially hold six-monthly review meetings with all contractors addressing the recommendation requirements; and subsequent frequency will be dependent on how often the contractor is used by the UHB. However, all will have an annual review meeting.	Director of Finance	01/09/2020	na		audit open over 6 months
2019-20	Control of Contractors	Director of Finance	M	Formal post completion review meetings of contractor performance should be undertaken in accordance with HSE guidance (O)	Accepted, as per the response to recommendation 9.Accepted, as per the response to recommendation 9.	Director of Finance	01/09/2020	na		audit open over 6 months
2019-20	Control of Contractors	Director of Finance	M	An annual audit of compliance with the policy should be completed and reported to an appropriate forum. (O)	Accepted. Discussions will be held with the Head of Health & Safety with a view to enhance the data that is reported to the Health & Safety Committee within the Annual Report.	Director of Finance	01/06/2020	na		audit open over 6 months
2019-20	CD&T Clinical Board - Laboratory Turnaround Times	Chief Operating Officer						na		audit open over 6 months
2019-20	Core Financial Systems	Director of Finance	L	The FCP should be reviewed and updated to reflect it has been reviewed until any best practice arising from the TAG is identified.	The FCP will be reviewed and updated. Future reviews will reflect any best practice arising from the TAG.	Director of Finance	01/06/2020	pc	Current FCP to be reviewd in September 2020. TAG to be asked for an update on All Wales work,	audit open over 6 months
2019-20	Core Financial Systems	Director of Finance	M	Although responsibility for removing Oracle user access is the responsibility of NWSSP. We recommend that the Health Board undertakes a periodic comparison of its current Oracle Users against its leavers report to ensure that access does not remain open after the employee has left the Health Board or is accessed after the leave date. Managers should be reminded of their responsibility to update the NWSSP Eenablement team of any leavers or change in roles.	The Health Board will undertake a periodic comparison of its current Oracle Users against its leavers report to ensure that access does not remain open after the employee has left the Health Board or is accessed after the leave date.	Director of Finance	01/06/2020	pc	Hierarchy Report available on Oracle. Clinical Boards to be reminded to compare list of leavers against report during September 2020.	audit open over 6 months
2019-20	Risk Management	Director of Corporate Governance	M	We recommend that the risk management training framework is finalised and detailed training materials are developed for roll out across the health board.	A detailed plan will be developed but due to activities which Clinical Boards are dealing with in relation to COVID 19 the roll out of that programme will be delayed.	Director of Corporate Governance	07/2020 - 12/2020	pc	Contact has been made with Clinical Boards to establish risk leads and a training programme is scheduled to be rolled out during October. A new risk and regulation officer is scheduled to commence work in October 2020 and will be tasked with progressing the training regime from the date of appointment.	audit open over 6 months
2019-20	Risk Management	Director of Corporate Governance	M	We recommend that training initiatives include the distinction between risks and issues and that the latter are addressed through an alternative allied management oversight activity.	Agreed – this will be picked up through the detailed training programme referenced above.	Director of Corporate Governance	01/07/2020	na	To be addressed in training programme	audit open over 6 months
2019-20	Risk Management	Director of Corporate Governance	M	We recommend that going forward the weaknesses observed in the recording of risk mitigating actions are addressed.	Agree this will initially be addressed through the training programme and then there will be a continuous review and support to ensure the weaknesses do not reoccur.	Director of Corporate Governance	01/07/2020	na	To be addressed in training programme	audit open over 6 months
2019-20	Risk Management	Director of Corporate Governance	L	We recommend that going forward the weaknesses observed and recorded in the Board Assurance Framework reporting are addressed.	Agree	Director of Corporate Governance	01/07/2020	pc	Adequate cross referencing between the BAF, Strategic objectives and CRR to be included in time for the September Board meeting.	audit open over 6 months
2019-20	UHW Neonatal Development	Director of Planning	L	The UHB should ensure KPI / performance management submissions are completed as per Framework guidance (O).	Agreed. Management will ensure that the Project Manager provides reminders to the key officers at the UHB facilitate submission of the KPIs as per the Framework guidance.	Director of Planning	At Future Projects	pc	ongoing until the end of the prorject	audit open over 3 months
2019-20	UHW Neonatal Development	Director of Planning	L	Assurances should be provided by the Cost Adviser that source documentation is reviewed routinely, not limited to final account, in confirming calculations of staff / labour costs attributed to the project (O).	Agreed. Management will write to the Cost Advisers setting out the requirements to provide assurances that source documentation has been appropriately reviewed prior to the sign off of the monthly certificates.	Director of Planning	At Future Projects	pc	ongoing until the end of the project	audit open over 3 months
2019-20	Service Improvement Plan Team	Director of Finance						na		audit open over 3 months
2019-20	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	M	Management, in consultation with their advisers, should seek approval of plans for financing the shortfall in the 2020/21 financial year. Continued scrutiny will be applied of the reasonableness for further changes requested / required to the project. (O)	Agreed. Any changes to the project are routinely scrutinised by Project Board. The potential project overspend has been reported at every Capital Management Group so Executives are fully aware of the position. This will continue to be monitored as the project moves towards closure with the expectation that any shortfall will be met from the UHB's discretionary capital programme.	Director of Planning	ongoing to end of project	pc	ongoing to the end of the project. Changes to be agreed with project board and capital management group due to the UHB financial position	audit open over 3 months
2019-20	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	M	The risk register will be updated to extend consideration of mitigation actions for the ten open risk identified; and consideration will be given for new risks as they arise. (O)	Agreed. The Project Director will write to the Project Manager as custodian of the project risk register to ensure: a) It is completed appropriately; and b) It is considered at all progress meetings.	Director of Planning	01/05/2020	pc	ongoing. Risk register reviewed at regular project team and project board meetings	audit open over 3 months
2019-20	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	M	All payments should be made in accordance with the terms of the contract. (O)	Agreed. The Capital Planning leads will be reminded to process payments within seven days of receipt of the Project Manager's certification.	Director of Planning	01/05/2020	pc	Continuing monitoring of payments in accorance with the terms of the contract	audit open over 3 months
2019-20	Surgery CB - Enhanced Supervision	Chief Operating Officer	M	Surgery Clinical Board should introduce an overarching procedure/guidance provided for Ward Managers that formalises the governance arrangements relating to the use, monitoring and reporting of enhanced supervision of patients.	The Surgery Clinical Board agreed with the above recommendation. The Surgery Clinical Board will (via a task and finish group) review the reporting of enhanced monitoring booklet and its suitability for use within Surgery Clinical Board. A supporting document/ guidance can be developed and produced to assist in use of the enhanced supervision document. This updated document will be agreed via the Surgery Nursing Board formal meeting structure	Chief Operating Officer	01/09/2020	pc	Action due to be completed Sept 2020	audit open over 3 months

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2019-20	Surgery CB - Enhanced Supervision	Chief Operating Officer	M	Specialling Risk Assessment Forms should be completed by Ward Managers and authorised by Senior Nurses for all patients that commence enhanced supervision so as to formally record and justify its use.	The enhanced supervision document will be reviewed by Surgery Clinical Board and updated to ensure that a risk assessment is included and that there is a section which documents and records agreement to commence enhanced supervision by the Senior/ Lead Nurse. This updated document will be agreed via the Surgery Nursing Board formal meeting structure	Chief Operating Officer	01/09/2020	pc	Action due to be completed Sept 2020	audit open over 3 months
2019-20	Surgery CB - Enhanced Supervision	Chief Operating Officer	M	All patients that receive enhanced supervision should retain a fully completed Specialling Care Plan, medical review, 'Read about Me' - Life style Questionnaire, Falls Risk Indicator Assessment and DoLs Proforma (if applicable). Specialling Risk Assessments must be retained on the patient's notes and regularly reviewed and scored to justify ongoing use of enhanced supervision.	After updating the Enhanced supervision document Surgery Clinical Board will re audit the use of the document and how the document is used alongside 'Read about Me' - Life style Questionnaire, Falls Risk Indicator Assessment and DoLs Proforma (if applicable). The results will be reported to Surgery Clinical Nursing Board Formal meeting.	Chief Operating Officer	01/11/2020	pc	Action due to be completed Sept 2020	audit open over 3 months
2019-20	Surgery CB - Enhanced Supervision	Chief Operating Officer	M	Behaviour Monitoring Charts must be completed for 7 days, evidencing the hourly review of the level of enhanced monitoring and a formal written assessment of need for continuation of enhanced monitoring carried out by a registered nurse on a daily basis. Care Plans should be	A guidance document will be developed to support the Enhanced supervision document by Surgery Clinical Board which will help support what the requirement is for recording engagement by all members of the MDT.	Chief Operating Officer	01/09/2020	pc	Action due to be completed Sept 2020	audit open over 3 months
2019-20	Surgery CB - Enhanced Supervision	Chief Operating Officer	M	Hourly reviews during the period of enhanced supervision, and formal written assessments should be carried out by registered nurses on a daily basis to support justification to continue the supervision. Communication of risks to all members of the multi-disciplinary team	A guidance document will be developed to support the Enhanced supervision document by Surgery Clinical Board which will help support what the requirement is for recording engagement by all members of the MDT.	Chief Operating Officer	01/09/2020	pc	Action due to be completed Sept 2020	audit open over 3 months
2019-20	Surgery CB - Enhanced Supervision	Chief Operating Officer	L	Enhanced Supervision Patient Record Booklet should be revised to include early indicator requirement 'triggers' which would aid the nurses' decision making process as to whether to commence enhanced supervision.	The enhanced supervision document will be reviewed by Surgery Clinical Board and updated to ensure that a risk assessment is included and that there is a section which documents and records agreement to commence enhanced supervision by the Senior/ Lead Nurse. This updated document will be agreed	Chief Operating Officer	01/09/2020	pc	Action due to be completed Sept 2020	audit open over 3 months
2019-20	Surgery CB - Enhanced Supervision	Chief Operating Officer	L	Ward Managers should be provided with training relating to the use of theenhanced supervision facility on Clinical Workstation as it would provide 'real time' information and aid the active monitoring and management of patients	Awareness will be raised on the use of the icon on the Clinical Work station via professional nursing forums and by local communication routes	Chief Operating Officer	01/09/2020	pc	Action due to be completed Sept 2020	audit open over 3 months
2019-20	Infection Prevention and Control	Executive Nurse Director	M	All out of date Infection Prevention and Control policies and procedures should be reviewed and updated, and any bad links reinstated. The C & V Infection Prevention and Control intranet pages should be updated to reflect the list of current policies and procedures submitted to the IPC	Infection Prevention and Control policies and procedure are reviewed, updated and ratified as required by the core IP&C team and the Infection Prevention and Control Group. Since a member of the IP&C team with administrative rights for the Intranet left the organisation in July 2018 we have been unable to get anyone	Executive Director of Nursing	01/09/2020	na		audit open over 3 months
2019-20	Infection Prevention and Control	Executive Nurse Director	M	The IPCG Terms of Reference and membership list should be reviewed, updated and formally approved by the Group. In particular, the Estates Department should be requested to ensure they provide a regular representative for the Group.	The TOR will be reviewed by the Infection Prevention and Control Group as a priority. This was on the agenda for February 2020 before it was impacted by COVID-19; there is a plan to re-agenda in 2020.	Executive Director of Nursing	01/06/2020	na		audit open over 3 months
2019-20	Infection Prevention and Control	Executive Nurse Director	M	The IP & C Annual Programme should be updated to reflect the period it covers, and all references to it being a draft document should be removed. The IP & C	The Annual Programme for IP&C will be uploaded to the Intranet.	Executive Director of Nursing	01/09/2020	na		audit open over 3 months
2019-20	Infection Prevention and Control	Executive Nurse Director	L	The minutes of each IPCG meeting should be presented to the Health Board Quality, Safety and Experience Committee for information and monitoring purposes. The IP & C Senior Nurse should prepare update reports for the Q, S & E Committee on a more regular basis. We would suggest half yearly	IPC reports to QSE bi-annually as part of the Health and Care Standards selfassessment and follow up report. Exception reports are brought as appropriate. Reporting mechanisms to QSE currently under review and future IP&C reporting will align with the output of that review.	Executive Director of Nursing	01/09/2020	na		audit open over 3 months
2019-20	Infection Prevention and Control	Executive Nurse Director	M	The IP & C Team should consider how the number of IP & C audits undertaken can be increased. An annual programme of planned IP & C audits should be drawn up with targets set for the number of audits to	The IPC Team are now at full complement which will allow for more audits to be undertaken. This was a priority set for 2020 but has been impacted by COVID-19; we will be	Executive Director of Nursing	01/12/2020	na		audit open over 3 months
2019-20	Infection Prevention and Control	Executive Nurse Director	M	Staff completing RCA investigations should be reminded that they should be undertaken jointly by Nursing and Medical staff.		Executive Director of Nursing		na		audit open over 3 months
2019-20	Infection Prevention and Control	Executive Nurse Director	M	Management should put checks in place to ensure that the data recorded in the Incident Log matches the details recorded in the Outbreak Tables.	This will be reviewed routinely in the future	Executive Director of Nursing		na		audit open over 3 months
2019-20	Infection Prevention and Control	Executive Nurse Director	M	lead nurse from the IP & C team should be assigned to each Clinical Board IP & C group and Q, S & E group. Where possible the designated lead nurse or arepresentative from the IP & C team should attend all Clinical Board IP & C and Q, S & E meetings.	There is an IP&C nurse assigned to each Clinical Board who attends the Clinical Board Q&S meetings where possible. In future if they cannot attend they will send a representative on their behalf.	Executive Director of Nursing	01/09/2020	na		audit open over 3 months
2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	H	The UHB should ensure policies are reviewed and updated within appropriate timescales.	A plan will be put in place to review all out of date policies and to contact document owners to update their policies. Due to activities which colleagues are dealing with in relation to COVID 19 the roll out of that plan will be delayed until Health Board staff have substantially returned to a business as usual position.	Director of Corporate Governance	01/12/2020	na		audit open over 3 months
2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	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	A plan will be put in place to review the register for completeness and to consider that document alongside the written control documents available on the intranet and internet. It is assumed that not all documents available on the intranet and	Director of Corporate Governance	01/12/2020	na		audit open over 3 months
2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	M	1. Review the readability of documents to make ways to write clearer, especially those available through internet to wider audience. From register, 372 out of 393, recorded as published on internet.	Recommendations are noted and agreed. A plan will be put in place to action the recommendations and circulate appropriate messages to document owners to address the issues raised.	Director of Corporate Governance	01/12/2020	na		audit open over 3 months
2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	L	Review of record keeping process for when a request is made to create new written control document; from receipt of request to create, to issue of draft for consultation. Review of record keeping process for the consultation process; from request made, publishing and any feedback received.	Recommendations are noted and agreed. A plan will be put in place to action the recommendations and put in place appropriate processes.	Director of Corporate Governance	01/12/2020	na		audit open over 3 months
2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	L	Review of record keeping process for notifying stakeholders of new, amended and exiting policies.	Review of record keeping process for notifying stakeholders of new, amended and exiting policies.	Director of Corporate Governance	01/12/2020	na		audit open over 3 months
2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	H	Temporary Staffing Management should revise their current pre-employmentchecks procedures. The following highlighted areas should be considered for revision:				na		audit open over 3 months
2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	M	Health Board managers should be reminded that internal applicants cannot commence in post prior to pre-employment checks being fully completed. Managers should also be reminded to take notice of the weekly Trac update				na		audit open over 3 months
2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	M	Temporary Staffing Department management to familiarise themselves with the NHS Employment Checks Standards and implement appropriate procedural guidance, ensuring it satisfies all requirements/criteria of the Standards.				na		audit open over 3 months
2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	M	Management to review the process for Consultant reference checks to ensure it adheres to the relevant guidance.				na		audit open over 3 months

Financial Year Fieldwork Undertaken	Audit Title	Executive Lead for Report	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update	Status of Report Overall
2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	L	Management to review the Employment Services SLA.				na		audit open over 3 months
2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	L	Management to review Internal and External Recruitment Process Flowcharts and determine if their content is relevant.				na		audit open over 3 months
2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	L	Management to review the apparent contradicting information found in the NHS Reference Standard and the NWSSP Reference Guidance and determine which is more relevant. Management should consider updating the guidance if necessary.				na		audit open over 3 months
2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	L	NWSSP Recruitment and Health Board recruiting managers to be reminded of the importance of considering validity of references when undertaking and approving pre-employment checks.				na		audit open over 3 months
2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	L	Management should review all supporting policies/procedures listed in the CVU Recruitment Policy. Management should review and consider updating the Secondment Policy to include the requirement for pre-employment checks to be completed before an employee can commence in a secondment post. Management should review the Recruitment of Locum Doctors and Dentists Policy, ensuring all terminology is relevant.				na		audit open over 3 months
2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	L	Temporary Staffing Department management to review the standard letter sent with the conditional offer and ensure it complies with the Identification Check NHS Standard.				na		audit open over 3 months
2019-20	Strategic Planning - IMTP	Director of Planning	M	Management should ensure that the business case procedural document (flowchart) is up to date and reflects the current system in place regarding the processing of projects/ schemes from the point of						
2019-20	Strategic Planning - IMTP	Director of Planning	M	Management should ensure that all key staff required to sign the business case complete and evidence sign off at the required stage.						
2019-20	Strategic Planning - IMTP	Director of Planning	M	Management should ensure that the due process and documentation required to document decisions of business cases are adhered to.						
2019-20	Strategic Planning - IMTP	Director of Planning	L	Management should ensure the ToR are reviewed and updated as required.						

Report Title:	**External Audit Recommendation Tracking Report and Regulatory Tracker Report**								
Meeting:	Audit Committee						**Meeting Date:**	8th September 2020	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

The purpose of the report is to provide Members of the Audit Committee with assurance on the implementation of recommendations which have been made by Wales Audit Office by means of an external audit recommendation tracking report.

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

The External Audit tracker is demonstrating that actions are being completed with a further 29.5% of outstanding recommendations completed since July 2020. However, there are also 29.5% of recommendations where there has been no action and 41% where the recommendation is partially completed. Of all the actions 49% are over 1 year old and 41% are over 6 months old.

Following a re-organisation of work within the Corporate Governance team, it is hoped that additional support will be available to Executive and Operational Leads to ensure that actions are progressed and completed in a timelier manner moving forward.

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

A review of all outstanding recommendations has been undertaken since July 2020 and this will now continue and will be reported to the Audit Committee each quarter providing a quarterly update in movement of recommendations completed.

The Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken in **17/18, 18/19 and 19/20** as at 1st September 2020.

Reports will, in future, be discussed at Management Executives and HSMB which includes the entire leadership team of the organisation. This has not been taking place over recent months due to COVID 19 however, the organization is now returning to a more business as usual situation.

Recommendation:

The Audit Committee Members are asked to:

(a) Note the progress which has been made in relation to the completion of WAO recommendations.

(b) To note the continuing development of the WAO Recommendation Tracker.

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

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

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

External Audit (WAO) Recommendations 2017/18 – 2019/20 (July 2020)

External Audit	Complete	No action	Partially complete	< 3 mths	> 3 mths	+6 mths	+ 1 year	Grand Total
Structured Assessment 2018	8	-	6	-	-	5	9	
Clinical Coding Follow Up	-	3	-	-	-	-	3	
Discharge Planning	-	-	1	-	-	-	1	
Review of Medical Equipment	-	-	2	-	-	-	2	
Audit of Financial Statements	1	-	2	-	-	-	3	
Structured Assessment 2019	1	-	1	-	-	-	2	
Implementation of the Wellbeing of Future Generations Act	-	7	2	-	-	9	-	
Total	**10**	**10**	**14**	**-**	**-**	**14**	**20**	**34**

From the above table it can be seen that since the last report to Committee in July 2020 29.5% of outstanding WAO recommendations from July 2020 have been completed. It can also be seen that there are a further 29.5% of recommendations where there has been no action a further and 41% where the recommendation is partially completed. Of all the actions 59% are over 1 year old and 41% are over 6 months old.

Financial Year Fieldwork Undertaken	Final Report Issued on	Audit Title	Executive Lead for Report	Rec No.	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Operational Lead for Recommendation	Agreed Implementation Date	Committee Implementation Monitored by	Please confirm if completed (c), partially completed (pc), no action taken (na)
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R1/11	The Health Board should complete our 2017 structured assessment recommendations by the end of 2019.	Agreed and these will be monitored to ensure this happens through Management Executives and reported to Audit Committee	Director of Corporate Governance	Head of Corporate Governance	Dec-19	Audit and Assurance Committee	pc
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R1b/11	R2 [2017] To ensure compliance with the NHS planning framework, the Health Board needs to ensure that the Strategy and Engagement Committee regularly scrutinises progress on delivery of the Annual Operating Plan, and subsequent three	The new S&D Committee's work plan includes scrutiny of key elements of the Annual Operating Plan, 10-year strategy and transformation programme. The Committee and the Board still need to receive appropriate	Director of Corporate Governance	Head of Corporate Governance	Dec-16	Audit and Assurance Committee	c
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R1c/11	R3 [2017] To enable effective scrutiny, the Health Board needs to improve the quality of its papers to Board and Committees by ensuring that the length and content of	The length of Board and committee papers has improved compared to last year, but inconsistencies and variation remain. The Health Board's introduction in September 2018 of a	Director of Corporate Governance	Head of Corporate Governance	Dec-16	Audit and Assurance Committee	c
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R1f/11	R6 [2017] 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: updating the information governance strategy; putting in place arrangements for monitoring compliance of the primary care information governance toolkit;	Progress to date: An up-to-date Information Governance strategy does not yet exist. The Health Board has drafted its strategic approach in the Information Governance Policy. The Health Board plans to agree and implement this approach later in 2018. NWIS has developed the information	Director of Transformation and Informatics		Dec-16	Audit and Assurance Committee	c
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	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	Overall this recommendation has been partly addressed. The S&D Committee continues to receive a high-level performance dashboard, which is less detailed than the performance report received by the Board. Since September 2018, the S&D Committee receives six-monthly updates against the workforce plans, including key workforce metrics.	Director of Transformation and Informatics		Dec-16	Audit and Assurance Committee	pc
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R1h/11	R9 [2017] To ensure resilience to security issues, such as cyber-attacks, the Health Board should consider identifying a dedicated resource for managing IT security.	In early 2018, the Health Board received an external review of cyber security arrangements. The review recommended improvements to cyber security arrangements. In response the Health Board is developing a formal cyber security improvement action plan. It plans to bring in specialist cyber security skills in early 2019 to address these recommendations and	Director of Transformation and Informatics		Dec-19	Audit and Assurance Committee	c
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R1i/11	R10 [2017] To improve scrutiny of the Health Board's informatics service, the Health Board should expand the range of key performance indicators relating to informatics to include the cause and impact of informatics incidents.	The Health Board plans to review in early 2019 the structure and governance of its information and information technology functions to deliver the digital strategy.	Director of Transformation and Informatics		Dec-16	Audit and Assurance Committee	c
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R3b/11	b. Review and update the Standing Orders and Standing Financial Instructions, ensuring these documents are reviewed and approved on an annual basis;	Agreed and timetabled to be undertaken on an annual basis going forward	Director of Corporate Governance		Mar-19	Audit and Assurance Committee	pc
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R3d/11	d. Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date;	Agreed	Director of Corporate Governance		Oct-19	Audit and Assurance Committee	pc
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R4/11	The Health Board should update its performance management framework to reflect the organisational changes that have taken place since 2013.	We accept that the performance management framework should be reviewed to ensure it fully supports the organisational business.	Director of Transformation and Informatics		Sep-19	Audit and Assurance Committee	pc

2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R7/11	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.	CAV UHB is committed to continually improving mitigation of its risks of non-compliance. We are taking an improvement approach in line with the rest of Wales and in regular discussion with the ICO's office. Progress has been made on the registering of major assets and new flows of information. We intend to progress the assessment of our existing significant flows, adopting a risk based approach.	Director of Transformation and Informatics		Jun-19	Audit and Assurance Committee	c
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R8/11	The Health Board should achieve full compliance with the General Data Protection Requirement by May 2019.	Delivery of the CAV UHB's updated action plan will reduce the risks we carry in relation to noncompliance with GDPR. Prioritisation of risks and mitigating actions are part of our continuous improvement plan, aimed at achieving full GDPR compliance during 2019.	Director of Transformation and Informatics		Dec-19	Audit and Assurance Committee	c
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R9/11	The Health Board should improve its response times to requests for information from Freedom of Information Act and Data Protection Subject Access Requests.	CAV UHB has recently appointed additional staff resulting in a positive impact on response times for FOI and Subject Access Requests. This will be monitored as we continue to move towards achieving fully compliant response times.	Director of Transformation and Informatics		Mar-19	Audit and Assurance Committee	c
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R11/11	The Health Board should routinely update IT Disaster Recovery plans after key changes to IT infrastructure and networks and at scheduled intervals and test plans to ensure they are effective	The CAV IT Disaster Recovery plan is reviewed annually at a minimum and in response to specific circumstances. Testing is undertaken (both Check list and Technical) and multiple system restores are performed successfully annually. Additional infrastructure and software have been put in place to improve this process. A schedule of testing is being developed as part of the technical roadmap work.	Director of Transformation and Informatics		Mar-19	Audit and Assurance Committee	pc
2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science	R3/8	R3 Review medical equipment risk management throughout the organisation, ensuring alignment between the corporate and operational approach.	Ensure CBs capture medical equipment risks as part of their risk management processes. These will be monitored via MEG, and escalated through relevant strategic committees, eg Strategy and Resources/Capital Management/QSE/Management Executive as	Director of Therapies & Health Science	Deputy Director of Therapies & Health Science	Apr-19	Strategy and Delivery	pc
2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science	R7/8	R7 Ensure all relevant service areas collaborate, consult and engage on medical equipment issues. It should give particular attention to the arrangements in place for maintenance and replacement of beds and hoists.	Monitor attendance and engagement of CB MSDOs and other members at MEG, escalate non-attendance or lack of engagement. Monitor progress of action plan developed by Health and Safety Advisor following the Arjo Proact 2017 survey Health and Safety Committee 18/005 minute (25 January 2018). Maintain hoists within the Clinical Engineering Department at the end of external supplier contract. Ensure Clinical Engineering is represented at the Bed Management Group	Director of Therapies & Health Science	Deputy Director of Therapies & Health Science	Dec-18	Strategy and Delivery	pc
2017-18	Dec-17	Discharge Planning	Chief Operating Officer	R4a	Explore developing an e-learning course for discharge planning which ward staff may find more accessible.	Work is ongoing with LED colleagues to develop a discharge planning focused e-learning resource.	Chief Operating Officer	Head of Integrated Care	Dec-18	Strategy and Delivery	pc
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					Digital Health Information	na

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)					Digital Health Information	na
2019-20	Jun-19	Clinical Coding Follow-up From 2014 not yet completed	Director of Transformation and Informatics	R3	Board Engagement: Build on the good level of awareness of clinical coding at Board to ensure members are fully informed of the Health Board's clinical coding performance. This should include: c) raising the awareness amongst Board members of					Digital Health Information	na
2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	R1	**1: the 'retire and return' arrangements require strengthening** The Health Board should strengthen its current guidance so that it clearly sets out all the key elements of the DoH guidance. The revised guidance should include all the DoH's employer-checks, which the Health Board should always apply and clearly evidence when assessing a business case for an employee to retire and return. The Health Board should ensure that its updated guidance is shared with all Clinical Boards and	The Health Board is currently reviewing the Retire and Return Procedure in partnership with Trade Unions. The purpose of this review is to reduce inconsistencies in the way that it is applied across the UHB by reducing the level of manager's discretion involved and ensuring that applications can only be rejected for robust business reasons. Reference will be made to the DoH guidance and checklist as appropriate. Reference will also be made to the other flexible retirement options to raise awareness of the			Feb-20	Audit and Assurance	pc
2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	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			Mar-20	Audit and Assurance	pc
2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	R6	**6: some of the arrangements around the year-end stocktake require improving** The Health Board should ensure that all officers who undertake and record stock counts are regularly trained so that they fully understand the procedures and key requirements that are in in place.	Your findings will sent out with the annual stock taking instructions at the end of January 2020, with clear instructions that all Clinical Boards comply with your recommendation.			Mar-20	Audit and Assurance	c
2019-20	Nov-19	Structured Assessment	Chief Executive Officer	R1	**Committee meeting frequency and timing** R1 We found scope to review the timings and frequency of some committee meetings to support members to scrutinise current information more often. Reviewing timings will also allow maximum attendance at meetings. The Health Board should: a) Review the frequency of Audit Committee meetings to close the gap between the May and September meeting. b) Review independent member's capacity and timings of committee meetings where there is	Agree this can be achieved an additional meeting will be added in for July which will also coincide with other meetings taking place in July 2020. This is already under review with the change in Chair and Vice Chair. Current proposals include increasing the membership of each Committee to ensure the meetings are quorate.		Director of Corporate Governance Director of Corporate Governance / Interim Chair of the UHB	Dec-19	Audit and Assurance Committee	c
2019-20	Nov-19	Structured Assessment	Chief Executive Officer	R2	**Performance Management Framework** R2 We found that performance monitoring at an operational level is sound, but some information received by the Board and its committees need to be improved. When the Health Board restarts its performance framework review it should be extended to include: • Monitoring IMTP delivery on a quarterly basis and reporting the wholescale position to the Strategy and Delivery Committee and Board. We have previously suggested presenting the committee with a summarised version of the IMTP progress reports available at clinical board performance reviews. • Ensuring that the Strategy and Delivery Committee receives, the same or more, detailed performance information than that received by the Board.	Agree to recommendation. The flash report which is used for Performance Reviews will be sent to Strategy and Delivery of a quarterly basis. December 2019 we will start from the beginning of the New Year and send to the S&D Committee in January 2020 Agree to the recommendation. The performance information is currently under review alongside other performance information to the		Director of Planning Director of Digital and Health Intelligence	Jan-20	Audit and Assurance Committee	pc

2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R1	**Long-term** Further enhance the profile of primary care by building upon the successes of existing promotional campaigns.	We will continue to build on the Primary Choice campaign to promote Primary Care.		Director of Operations, PCIC	Ongoing	Strategy and Delivery	na
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R2	2 Develop a campaign to educate the public about what types of services will be available at each of the centres and hubs.	We have an active engagement programme for each of the Wellbeing Hubs and Health and Wellbeing Centres, we will continue to evolve our engagement working with local organisations, public health colleagues and community groups to promote the services in each centre.	Director Planning		Dec-21	Strategy and Delivery	na
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R3	3 Use examples of successfully moving services from secondary to community and primary care to promote and sustain a shift in resources from other services that could be provided closer to home.	Supporting services to move to community delivery is a core element of the Health Board's Integrated Medium Term plan. Through this process we are celebrating and promoting examples of good practice.	Director Planning		Ongoing	Strategy and Delivery	na
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R4	4 Develop a model to monitor and review the impact and benefits of the centres and hubs. Use a blended approach that includes outcome measures, data, exemplar projects and patient stories to show not only cost effectiveness but also the positive impact on patient experience.	The Regional Partnership Board is developing an Outcomes Framework which will provide a tool to support the evaluation of the impact of Health and Wellbeing Centres and Wellbeing Hubs.	Director Planning		Jul-20	Strategy and Delivery	na
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R5	**Prevention** 5 Undertake needs assessments on an ongoing basis and continually review services to ensure that centres and hubs remain current and fit for purpose.	Primary Care Clusters are required to produce plans to meet the needs of their populations, this will include considerations of Wellbeing Hub services once established. These plans will take into account evidence from wider needs assessments including future updates to the population assessment required under the Social Services and Wellbeing Act and the Wellbeing Assessment required under the WFG Act		Director of Operations, PCIC	Annually	Strategy and Delivery	na
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Planning	R6	6 Develop a clear plan to agree finances prior to centre and hub services commencing to prevent duplication of resources.	This will form part of the operating model of the Wellbeing Hubs.	Director of Planning		Nov-21	Strategy and Delivery	na
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R7	**Integration** 7 Undertake a community services mapping exercise for each of the localities to identify services it could signpost patients to if they fall outside of the services delivered by centres and hubs.	We will be undertaking this mapping on a locality and cluster basis in partnership with existing tools and services such as Dewis Cymru.	Director of Planning		Oct-21	Strategy and Delivery	pc
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R8	**Collaboration** 8 Develop some overarching principles for the centres and hubs operating model which allow for some local variation based on community need.	We will establish an overarching operating model for the Health and Wellbeing Centre and Wellbeing Hubs focussed on operating as single assets and supporting community ownership.	Director of Planning		Oct-21	Strategy and Delivery	pc
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R9	**Involvement** 9 Explore the best vehicles to engage marginalised citizens both in terms of planning future centres and hubs and in ensuring they are accessible to all when in operation. For example, by finding community leaders to help roll out key messages and engage with these groups on an ongoing basis.	We will ensure this forms part of the engagement plan for each project.	Director of Planning		Oct-21	Strategy and Delivery	na

Cardiff and Vale University Health Board

Annual Quality Statement

Final Internal Audit Report

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Ruth Walker, Executive Nurse Director
Distribution:	Carol Evans, Assistant Director Patient Safety and Quality Ann Jones, Patient Safety and Quality Assurance 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

The review of the 2019/20 Annual Quality Statement has been completed in line with the Internal Audit Plan. The review seeks to provide Cardiff and Vale University Health Board (the 'Health Board') with assurance regarding the process for the production of the Annual Quality Statement.

The relevant lead Executive Director for the review is the Executive Nurse Director.

The Health Board is required to publish an Annual Quality Statement (AQS) by the revised date of 30th September 2020 reporting on the 2019/20 year. The AQS is a statement from the Board to the public.

2. Scope and Objectives

The overall purpose of the review was to assist the Health Board with accuracy checking, including the triangulation of data and evidence, before the publication of the Annual Quality Statement.

The scope was limited to assisting the Health Board to ensure that the Annual Quality Statement is accurate, complete and consistent with information reported to the Board over the period. In addition, consideration was given to compliance with Welsh Government guidance for 2019/20.

The areas that the review sought to provide assurance on were:

- The AQS is compliant with the relevant Welsh Government guidance;
- Planned developments and stated challenges identified in the 2018/19 AQS are appropriately reported in the 2019/20 submission;
- The timetable for the production and publication of the AQS is appropriate;
- There has been appropriate stakeholder engagement in the production and review of the AQS;
- Performance information / data demonstrating 2019/20 achievements and challenges is appropriate and consistent with our knowledge of the Health Board; and
- Performance indicators detailed in the AQS are accurate and can be validated back to source information. We tested a sample of two performance indicators detailed in the AQS.

3. Associated Risks

The potential risks considered in this review were as follows:

- Failure to follow Welsh Government guidance;

- The public is not clearly informed of any improvement and challenges experienced in the range of services provided, as well as improvement priorities for the forthcoming year; and
- The information detailed in the AQS is incomplete and / or incorrect.

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 Annual Quality Statement is **Substantial 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
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.

Our review of the Annual Quality Statement has confirmed that the UHB has robust processes in place to ensure that the Statement is produced and published in line with the required timetable set by Welsh Government.

The Health Board has worked to the revised deadline this year and at the time of review they were on track to publish the document by the required date of 30th September 2020.

The draft statement that we reviewed is presented in a clear and user friendly format that should be easily understood by its audience. The AQS provides a clear assessment of how well the Health Board is doing, identifies areas that require improvements and effectively reports on the progress it has made year on year.

The detail of the UHBs achievements and challenges are effectively communicated within the AQS through the key themes that are in line with

the Health and Care Standards for Wales and the Health Boards Quality Safety and Improvements (QSI) Framework.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	The AQS complies with WG guidance				✓
2	2019/20 developments and challenges are appropriately recorded				✓
3	The AQS timetable is appropriate				✓
4	There has been appropriate stakeholder engagement				✓
5	There is appropriate data to support 2019/20 achievements and challenges is appropriate and consistent with our knowledge of the Health Board				✓
6	Performance indicators detailed in the AQS are accurate and can be validated back to source information.			✓	

** 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 Annual Quality Statement.

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 Annual Quality Statement.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise any significant findings made during our audit fieldwork. The full detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: The AQS is compliant with the relevant Welsh Government guidance.

The following areas of good practice were noted:

- The AQS provides a clear assessment of how well the Health Board is doing, identifies areas that require improvements and reports on the progress it has made year on year. This is communicated through the key themes that are in line with the Health and Care Standards for Wales and the Health Boards Quality Safety and Improvements (QSI) Framework.
- The AQS contains a mixture of case studies and patient stories that is based on this year's theme 'Mental Health in the community' and uses infographics in a meaningful way to present the information clearly to the public;
- The AQS continues to provide signposts to key documents, links to detailed information and YouTube clips of the in-year successes;
- The AQS is written in plain English that would be understandable to those with no knowledge of the subject matter, and refrains from using terminology that is NHS specific.

There were no significant findings under this objective.

Objective 2: Planned developments and stated challenges identified in the 2018/19 AQS are appropriately reported in the 2019/20 submission.

The following areas of good practice were noted:

- The planned developments and stated challenges identified in the 2018/19 AQS are part of the Quality and Safety Improvement Framework

2017-2020, which can be found on pages 54-57 of the 2019/20 AQS report.

- The majority of the developments and challenges progressed within the year had been updated through the narrative of the relevant quality theme.

There were no significant findings under this objective.

Objective 3: The timetable for the production and publication of the AQS is appropriate.

The following area of good practice was noted:

- Throughout each stage of the production of the report we could evidence that the deadlines set in the timetable had been met, therefore confirming that the timeframe was realistic and manageable to ensure that the report will be finalised in line with the Welsh Government deadline of 30/09/20.

There were no significant findings under this objective.

Objective 4: There has been appropriate stakeholder engagement in the production and review of the AQS:

The following areas of good practice were noted:

- Appropriate engagement took place with a range of internal and external stakeholders in the development and review of the AQS;
- The AQS had been discussed at length at the Stakeholder Reference Group that was attended by key staff;

There were no significant findings under this objective.

Objective 5: Performance information / data demonstrating 2018/19 achievements and challenges is appropriate and consistent with our knowledge of the Health Board.

The following areas of good practice were noted:

- A review of the draft AQS has confirmed that performance information / data relating to successes and challenges across the Health Board are recorded within each of the themes e.g. Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Treating People as Individuals; and Staff Resources.
- In reviewing the recorded performance information / data we did not identify any areas that were inconsistent with our knowledge of the Health Board.

There were no significant findings under this objective

Objective 6: Performance indicators detailed in the AQS are accurate and can be validated back to source information.

The following areas of good practice were noted:

- The performance indicators detailed in the AQS have been used appropriately to support improved performance detailed within the narrative for each quality theme.
- Review of the performance indicators relating to Safe Care confirmed that the figures were accurate and could be traced back to source data.

There were no significant findings under this objective.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**0**	**2**	**2**

Finding 1 - Compliance with Welsh Government Guidance (Operating effectiveness)	Risk
The draft AQS report incorporates the majority of the key requirements of the Welsh Health Circular that was issued by the Welsh Government in December 2019. However, details of how the public could provide feedback to the Health Board was not included. This oversight was acknowledged by the Patient Safety and Quality Assurance Manager and we have been informed that it will be adjusted in the final report.	Failure to follow Welsh Government guidance.
Recommendation	**Priority level**
Management should ensure that all Welsh Government guidance is followed and incorporated in the report.	**Low**
Management Response	**Responsible Officer/ Deadline**
A survey monkey link has been inserted at the end of the document. This invites the reader to provide feedback on the quality and visual appeal of the document as well as suggestions for improvement.	Patient Safety and Quality Assurance Manager -**Immediate**

Finding - 2 - Performance Indicators (Operating effectiveness)	Risk
A sample of seven performance figures from the Effective Care theme were verified back to the source information to ensure the data entered into the draft AQS was accurate. During this process it was identified that one of the seven figures shown had been calculated incorrectly. The discrepancy related to the number of pieces of NICE guidance reviewed during the year and occurred due to human error. The differences were discussed at the time of our audit fieldwork with the Patient Safety and Quality Assurance Manager who confirmed that the necessary amendments would be made to the final report.	The information detailed in the AQS is incomplete and / or incorrect.
Recommendation	**Priority level**
The department should consider incorporating an accuracy check of all data into the AQS timetable, which should be done as late as possible in the AQS process.	**Low**
Management Response	**Responsible Officer/ Deadline**
Accuracy checks are already carried out several times throughout the production of the document, however a final check will be introduced immediately prior to the date of submission to the Internal Audit department and will be verified by a second person within the Patient Safety department.	Patient Safety and Quality Assurance Manager- **Immediate**

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.

Strategic Planning / IMTP

Final Internal Audit Report

2019/20

Cardiff and Vale University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Abigail Harris, Executive Director of Planning
Distribution:	Marie Davies, Deputy Director of Strategy & Planning Lynne Aston, Senior Assistant Finance Director Julie Casley, Deputy Director of WOD
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 review of the Cardiff and Vale University Health Board (the UHB or the 'Health Board') Strategic Planning / Integrated Medium Term Plan (IMTP) processes was completed in line with the 2019/2020 Internal Audit Plan.

The UHB has a statutory duty to operate within the bounds of a Welsh Government approved IMTP. Reviewed annually, the NHS Planning Framework sets out the core content expected within the IMTP.

The IMTP is the key planning document for the UHB and sets out the milestones and actions they are taking and the expected outcomes, in order to progress implementation of Shaping Our Future Wellbeing, the UHB's ten year strategy.

The UHB 2019-22 IMTP was formally approved by Welsh Government. This is the first occasion that the Health Board has had its IMTP approved, having previously been subject to an annual planning process as it was unable to submit a balanced IMTP.

The processes for developing and implementing the UHB's IMTP have been covered as part of previous Internal Audit reviews. The current review will therefore focus on the processes for the development, review and approval of business cases (BCs) for key service developments included within the Health Board and individual Clinical Board IMTPs.

The relevant lead Executive Director for this review is the Executive Director of Planning.

2. Scope and Objectives

The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of Strategic Planning /IMTP processes, in order to provide assurance to the Health Board Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The scope of the audit was to establish if robust processes are in place for the development, evaluation and approval of business cases to ensure that appropriate key developments included within IMTPs are progressed.

The main areas that the review sought to provide assurance on are:

- The Health Board has appropriate and up to date business case procedures and standard documentation in place;
- Clinical Boards undertake a robust process for the development of business cases, in accordance with any Health Board procedures and utilising any standard documentation;
- The Health Board has a robust process for evaluating and approving submitted business cases; and

- Approved business cases are subject to on-going monitoring / review of outcome measures to determine if the service changes are delivering the anticipated objectives.

In order to assess the robustness of the system, the following 2 business cases were selected for review:

- **Diabetes Enhanced Service BC**: This is a Welsh Government allocation for 2019/20 - A Healthier Wales, in response to the long term plan for Wales. The development of the business case and specification for the service was dictated by Welsh Government. There was a requirement for the health board to perform a quality and assurance review rather than the usual approval as required of a typical business case.
- **Overseas Nurse Recruitment BC**: This was led corporately, however owned by staff in the Medicine and Surgery Clinical Boards. As the two major clinical boards with the highest level of vacancies they were required to provide business cases which were integrated into one business case. The recruitment of the overseas nurse's scheme came up as a part of the objectives of the Project 95 group. This was developed over three years ago for the continual recruitment of band 5 staff. Some of the group's objectives involved the recruitment, retention and constant monitoring of nursing staff numbers.

3. Associated Risks

- Business cases are not developed in a consistent format and / or to the required standard;
- Inappropriate service changes / developments are implemented; and
- Service changes do not achieve the anticipated objectives.

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 Strategic Planning / IMTP 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 current review has identified that there are generally good processes and controls in place for managing the risks associated with the development, evaluation approval and implementation of business cases.

There is a Health Board Business Case flow chart in place, however this needs to be updated to reflect the current practices of the system.

There was evidence that Clinical Boards and key staff responsible for the preparation of the business cases were being adequately supported by the corporate planning team.

The two sampled business cases had relevant backing and supporting documentation which explained the basis and need to fund the project. Although the selected copy of the business case documents were either not signed or only partly signed by key staff, they were found to be comprehensive having relevant fields to ease review and enable the Business Case Approval Group (BCAG) to reach an appropriate decision.

Adequate processes are in place for monitoring the on-going delivery of the developments and service changes that have been approved and funded through the business case process.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Appropriate Procedures			✓	
2	Robust development of Business Case			✓	
3	Robust Evaluation Process of Business Case			✓	
4	Clinical Board On-going Monitoring				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted 1 issue that is classified as weakness in the system control/design for Strategic Planning / IMTP.

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 Strategic Planning / IMTP.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: The Health Board has appropriate and up to date business case procedures and standard documentation in place

The following area of good practice was noted:

- There is a Health Board Business Case flowchart in place which provides guidance on the stages and standard documents to be used for the production and approval of business cases.

The following significant finding was noted for this objective:

- On review of the Business Case flowchart, it was observed that it required updating and improved positioning for easy accessibility on the intranet.

Objective 2: Clinical Boards undertake a robust process for the development of business cases, in accordance with any Health Board procedures and utilising any standard documentation

The following areas of good practice were noted:

- The sampled business cases have been appropriately developed having backing documents to support why the business cases should be approved. Key persons were engaged and supported within relevant Clinical Boards. Input from (and not limited to) the following staff were used in the compilation of the business cases.
  - GPs;
  - Clinicians;
  - Finance; and
  - Procurement.
- Each business case has key leads. The Diabetes Enhanced Service BC was led by a key staff member in the Primary, Community and Intermediate Care (PCIC) Clinical Board while the Overseas Nurse Recruitment BC was led corporately, however owned by staff in the Medicine and Surgery Clinical Boards.
- IMTP Workshops are usually held and localities were asked for their input. In relation to 2019/20, there were two main types of IMTP session/ workshops held in the PCIC Clinical Board.
  - IMTP Development Sessions for the IMTP 2020-2023; and
  - IMTP Progress Sessions for the IMTP 2019/20 Priorities.
- The following actions were undertaken to help inform the production of a business case for overseas nursing staff:
  - There was a review of the position of the nurse staffing levels against the expected forecast at the corporate level. An update was presented to the Management Executive Team, the outcome from the review showed that all areas except the Medicine and Surgery Clinical Boards had exceeded the substantive filling of the band 5 posts.
  - A check was also done on the level of staff retention on the last round of recruitment where it was found that there was a higher level of retention rate of Nurses from Non EU Nurses.

The following significant finding was noted for this objective:

- On review of the business cases it was observed that they had not been appropriately signed off.

Objective 3: The Health Board has a robust process for evaluating and approving submitted business cases.

The following areas of good practice were noted:

- A standard process is followed, however, this is usually based on the nature and type of business case as some are initiated corporately/ at the Clinical board level while some schemes are externally funded;
- The Corporate Planning team meets with the Clinical Boards and Executive leads where they work through the IMTP priority list;
- There is a Business Case Approval Group (BCAG) which meets monthly. The group is made up of members of staff representing the relevant areas with the required level of specialisation. They come together to scrutinise business cases and they also undertake assurance reviews particularly relating to external funding;
- The Corporate Strategic Planning lead sends emails out to the Clinical Boards with a list of business cases and key events with deadlines;
- The BCAG works using an action plan document, all business cases (both approved and unapproved) are stated within this document. It summarises the business cases to be reviewed for the period indicating the dates these reviews should take place, dates they have taken place (if already undertaken) and states the cost implication; and
- A BCAG decision report is prepared and presented at the Management Executive meeting.

The following significant finding was noted for this objective:

- The decision report was not used to document the position of one of the two business cases reviewed.

Objective 4: Approved business cases are subject to on-going monitoring / review of outcome measures to determine if the service changes are delivering the anticipated objectives.

The following area of good practice was noted:

- There are reasonable measures in place regarding the monitoring of the outcome of the approved business cases in relation to the nature and level of completion of the two selected business cases.

There was no significant finding noted under this objective.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**2**	**2**	**4**

Finding 1 - Update of Business Case Guidance document (Control design)	Risk
The available business case guidance document is in a flow chart format. The flow chart was noted to have been produced in April 2016 showing the various stages and documents used for the preparation of a business case which feeds into the IMTP. The flow chart was reviewed to establish its relevance to the current system in operation. Below are some of the findings: • The 'Health System's responsibility' stated within the flow chart should actually be the 'Management Executive responsibility' • The development of PODs was still included as one of the documents to be completed during the process. This document has been taken out of the current process as it is seen as a duplication of the business case. • The BCAG decision report was not referenced within the flowchart. Also, at the documentation of the system / process stage, a '1 page pro forma' document was mentioned during discussion with the Corporate Strategic Planning Lead as being essential. However, this was not used as a part of the process during the period under review, although it was said to be used previously and going forward. Use of this pro forma was also not stated within the flow chart, indicating that further update of the guidance/ flowchart is required. It was observed that the flowchart guidance document can be found in the following locations:	Business cases are not developed in a consistent format and / or to the required standard

• On the intranet, where it is located as an appendix within the BCAG Terms of Reference (ToR). • Within a shared drive which is only accessible to the BCAG, Finance and the Planning team. These locations do not ensure that the guidance document is easily accessible to all staff.	
Recommendation 1	**Priority level**
Management should ensure that the business case procedural document (flowchart) is up to date and reflects the current system in place regarding the processing of projects/ schemes from the point of inception down to the stage of approval. Each stage/ document/ process within the flow chart should be individually reviewed for relevance and where required elements should be added or removed. Management should also ensure that the business case flowchart is made available in a location easily assessable to other members of staff.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Business Case procedural flowchart updated accordingly. Standard business cases template universally adopted and embedded within all clinical boards.	Marie Davies /Complete

Finding 2 - Business Case (Operating effectiveness)	Risk
In order to ensure that the business cases go through a robust process during development in accordance with the Health Board procedures and utilising any standard documentation, two business cases which had been approved for funding were selected for review. The business case document has a section which requires an approval sign off from the Clinical / Service Board Director or Departmental Director and Chair of the BCAG. Below are the findings of the business cases which were selected for review to ensure that they were adequately signed off as required: • **Diabetes Enhanced Service BC** was led by the PCIC Clinical Board. The business case form was not signed by BCAG chair. • **Overseas Nurse Recruitment BC** which was led corporately by Workforce but owned by Medicine and Surgery Clinical board. The business case form was not signed by the required signatories.	Business cases are not developed in a consistent format and / or to the required standard
Recommendation 2	**Priority level**
Management should ensure that all key staff required to sign the business case complete and evidence sign off at the required stage.	**Medium**
Management Response	**Responsible Officer/ Deadline**
This is a requirement in completing the business case proforma and it checked prior to business case submission for formal consideration to BCAG.	Marie Davies/Complete

Finding 3 - BCAG Decision Report (Operating effectiveness)	Risk
The BCAG meet monthly to review the business cases as outlined in the already agreed action plan for the period. The outcome from the decisions made regarding the business cases are documented within the BCAG decision report. This states if the business case has been approved (or not) with any added note for the decision made. A Business Case Approval Group decision report is prepared for presentation at the Management Executive meeting. On request of the BCAG decision report for the 2 selected business cases, it was observed that one (Corporate - Overseas nurse recruitment) which was approved by the Chair's action was not captured within the BCAG decision report as required.	Inappropriate service changes / developments are implemented.
Recommendation 3	**Priority level**
Management should ensure that the due process and documentation required to document decisions of business cases are adhered to.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Each BCAG decision report and any required actions formally reported to Management Executive. Programme oversight for IMTP period continuously maintained.	Bob Chadwick & Marie Davies /Complete

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**
Review of TOR due in Sept 2020 with scheduled annual review process now included in proposed TOR.	Marie Davies/Sept 2020

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

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

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.