Audit and Assurance Meeting - 9 February 2021

Tue 09 February 2021, 09:00 - 12:30

MS TEAMS

Agenda

1. Welcome and Introductions

John Union

2. Apologies for Absence

John Union

3. Declarations of Interest

John Union

4. Minutes of the Committee meeting held on 17th November 2020

John Union

4 Unconfirmed Minutes SR.NF 17 Nov 2020.pdf (12 pages)

5. Action log following meeting held on 17th November 2020

John Union

5 Public Audit Action Log - 17.11.2020.pdf (2 pages)

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

John Union

7. Items for Review and Assurance

7.1. Internal Audit Progress and Tracking Reports

Ian Virgill

7.1 - Internal Audit Progress Cover Report.pdf (2 pages)
7.1 - Internal Audit Progress Report Feb 21.pdf (20 pages)

7.2. Internal Audit Plan to Complete 2020/2021

Ian Virgill

7.2 - Internal Audit Plan to Complete 2020-21.pdf (13 pages)

7.3. Audit Wales Update

Wales Audit

7.3 - Audit Wales Update (February 2021).pdf (12 pages)
7.3 - Letter from Auditor General for Wales.pdf (2 pages)

7.4. Doing it Differently, Doing it Right? Governance in the NHS During the COVID-19 Crisis

Wales Audit

7.4 - Doing it Differently, Doing it Right.pdf (19 pages)

7.5. Follow-up of Operating Theatres

Wales Audit

7.5 - Follow Up of Operating Theatres.pdf (16 pages)

8. Items for Approval / Ratification

8.1. Declarations of Interest and Gifts and Hospitality Tracking Report

Nicola Foreman

8.1 - Declarations of Interest and Gifts and Hospitality Tracking Report.pdf (5 pages)
8.1 - Declarations of Interest Register 2020 - 21 (February 2021).pdf (2 pages)

8.2. Regulatory Compliance Tracking Report

Nicola Foreman

8.2 - Regulatory Compliance Tracking Report.pdf (4 pages)
8.2 - Regulatory Heat Map - February 21.pdf (12 pages)

8.3. Internal Audit Tracking Report

Nicola Foreman

8.3 - Internal Audit Tracking Report February 2021.pdf (3 pages)
8.3 - Internal Audit Tracker - Jan 21 v1.pdf (7 pages)
8.3 - Appendix 1 Internal Audit Summary Tables.pdf (4 pages)

8.4. Audit Wales Tracking Report

Nicola Foreman

8.4 - Audit Wales Tracking Report.pdf (2 pages)
8.4 - Audit Wales Tracker Jan 21 v2.pdf (2 pages)
8.4 - Appendix 1 External Audit Summary Table.pdf (1 pages)

8.5. Final Accounts Timetable And Plans

Christopher Lewis / Nicola Foreman

8.5 - Final Accounts Timetable and Plans.pdf (3 pages)
8.5 - Appendix 1 Timetable for Annual Report.pdf (2 pages)

8.6. Review Committee Terms of Reference

Nicola Foreman

8.6 - Review Committee Terms of Reference.pdf (2 pages)
8.6 - Audit Committee TOR 2021-22.pdf (9 pages)

8.7. Audit Committee Annual Report

Nicola Foreman

- 8.7 - Audit Committee Annual Report.pdf (2 pages)
- 8.7 - Annual Report of Audit and Assurance Committee.pdf (8 pages)
- 8.7 - Appendix 1.pdf (1 pages)
- 8.7 - Appendix 2.pdf (3 pages)
- 8.7 - Appendix 3.pdf (1 pages)

8.8. Annual Work Plan

Nicola Foreman

- 8.8 - Annual Work Plan Covering Report.pdf (2 pages)
- 8.8 - Audit Committee Work Plan 2021.22.pdf (1 pages)

8.9. Agree Audit Wales 2021 Audit Plan

Wales Audit

- 8.9 - Audit Wales 2021 Audit Plan.pdf (18 pages)

8.10. Audit Wales Annual Report

Wales Audit

- 8.10 - Audit Wales Annual Report.pdf (22 pages)

9. Items for Information and Noting

Ian Virgill

9.1. Internal Audit reports for information:

Ian Virgill

9.1.1. Mental Health Outpatient Clinic Cancellations

- 9.1.1 - Mental Health Outpatient Clinic Cancellations.pdf (18 pages)

9.1.2. Specialist CB – Patient Assessment and Provision of Equipment by ALAS

- 9.1.2 - Specialist CB Patient Assessment and Provision of Equipment by ALAS.pdf (14 pages)

9.1.3. Asbestos Management

- 9.1.3 - Asbestos Management.pdf (27 pages)

9.2. Update on Governance arrangements

Nicola Foreman

- 9.2 - Update on Governance Arrangements.pdf (3 pages)

10. Review and Final Closure

10.1. Items to be deferred to Board / Committee

John Union

10.2. To note the date, time and venue of the next Committee meeting: Tuesday 6th April 2021 at 9.00am

Unconfirmed Minutes of the Public Audit and Assurance Committee
Held on Tuesday 17th November 2020 09:00am – 12:00am
Via MS Teams

Chair		
John Union	JU	Independent Member – Finance
Present:		
Eileen Brandreth	EB	Independent Member – ICT
Dawn Ward	DW	Independent Member – Trade Union
In Attendance:		
Anthony Veale	AV	Audit Wales
Charles Janczewski	CJ	UHB Chair
Chris Lewis	CL	Interim Executive Director of Finance
Craig Greenstock	CG	Counter Fraud Manager
Darren Griffith	DG	Audit Wales
Ian Virgil	IV	Head of Internal Audit
Martin Driscoll	MD	Executive Director of Workforce & OD / Deputy Chief Executive Officer
Nicola Foreman	NF	Director of Corporate Governance
Stuart Walker	SW	Executive Medical Director
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		
Len Richards	LR	Chief Executive Officer

AAC 20/11/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting. CC also welcomed Darren Griffiths and Mike Usher's replacement Anthony Veale – Engagement Director, Audit Wales.	**ACTION**
AAC 20/11/002	**Apologies for Absence** Apologies for absence were noted.	
AAC 20/11/003	**Declarations of Interest** There were no declarations of interest.	
AAC 20/11/004	**Minutes of the Committee meeting held on 8th September 2020** **Resolved that:** (a) The Committee approved the minutes of the meeting held on 8th September 2020 as a true and accurate record.	
AAC 20/11/005	**Action Log following the Meeting held on 8th September 2020** The Committee reviewed the action log and the following updates were provided: **AAC 20/09/007** – Was on the agenda	

	AAC 20/09/008 – Clinical Coding was on the agenda, update on TTP to be provided at February 2021 meeting **AAC 19/12/015** – Was on the agenda **AAC 20/03/008** – Was on the agenda **AAC 20/04/005** – The Head of Internal Audit (HIA) and Executive Medical Director (EMD) would provide an update at the March 2021 meeting **AAC 19/12/012** – Would be on the agenda for February 2021 **AAC 20/05/005** – Was on the agenda **Resolved that:** (a) The Committee reviewed and noted the action log and the updates provided.	
AAC 20/11/006	**Any Other Urgent Business** There were no items raised.	
AAC 20/11/007	**Internal Audit Progress and Tracking Reports** The HIA highlighted section 2.1 within the report, which outlined six planned audits that had not been completed in time for the November Committee meeting and the following reasons were provided. 1) Asbestos management – Was now finalized and agreed with Estates and Facilities with the final report being issued a week prior to the Committee meeting. 2) Specialist Clinical Board – Initial responses received from management would be finalized shortly. 3) Four remaining audits were delayed due to a combination of issues related to Covid-19, availability of managers to engage with the audits and availability of Internal Audit resources. The HIA also referred to section 3 within the report and the finalisation of six audits since the last meeting. He highlighted that the pre-employment checks audit from the 2019/20 Internal Audit plan was received by Committee at the end of 19/20 and the Reasonable assurance report fed into the opinion for 19/20. Management responses to finalise the report were awaited. Five reports were finalised from the current audit plan, all had positive outcomes and Reasonable assurance. These five reports were on the agenda for noting. The HIA highlighted issues reported within the Surgery Clinical Board report which looked at sickness management within theatres with an overall rating of Reasonable assurance. Five out of six departments had good processes in place. One department lacked any management	

process of sickness, a lack of completed required forms and lack of ongoing monitoring of long term sickness. A specific issue raised was that ebbs of long term sickness were being managed via social media which was deemed inappropriate. The HIA provided assurance that an overall Reasonable assurance was given although there were significant high priority issues within the report; these had been raised with management at the time of completion of the audit and actions put in place to address these issues.

The HIA also highlighted a report relating to work done with the RPB and how the Health Board carried out its duties around its role in relation to the RPB. This was a positive report with Reasonable assurance at the higher level. Areas where the governance arrangements could be strengthened further were highlighted and there were steps in place to look at these processes.

The Committee was reminded that it had agreed the Internal Audit plan for 2020/21 in April. Section 4.3 highlighted the proposed ten audits to be removed from the plan, these were areas considered low risk and had been agreed by the Management Executive. This was considered a sensible approach and it was confirmed that these would be added to the next annual plan and consideration given to overall risk and what needed to be prioritised at that time.

The HIA also highlighted that they were looking to include two additional audits to the 2020/21 plan; UHW Surge Facility and Post Contract Audit of DHH Costs.

The HIA confirmed that there would be enough information to give an end of year audit opinion for the health board and that this year an overall opinion would be provided rather than one for each domain. He added that there were discussions taking place with the Director of Audit Assurance to build in contingencies should they not be able to deliver on all 35 audits.

The HIA highlighted that the Health Board had introduced an Internal Audit recommendation tracker. He confirmed that validation work had been done on the 2017/18 recommendations detailed within the tracker which had been presented to the September Audit Committee. The overall position was summarised as follows:
The tracker included a total of 22 recommendations from 2017/18

- A sample of 13 of the recommendations was selected for validation;
- Evidence was obtained to confirm that the stated progress for 11 of the 13 sampled recommendations was accurate;
- Evidence for the remaining 2 recommendations was to be supplied.

Resolved that:

a) the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports be considered;

	b) the proposed amendments to the Internal Audit Plan for 2020/21 be approved.	
AAC 20/11/008	**Audit Wales Update** Audit Wales (AW) highlighted exhibit 3 within the report that showed work currently underway. AW aimed to bring reports relating to this work to the February meeting; two of the projects related to local pieces of work, follow-up of previous IM&T recommendations and follow-up of operating theatres. The other pieces of work were National and it was confirmed that the Orthopaedic Services follow-up would set out the local position of each Health Board. The final piece of work in exhibit 4 was highlighted, a follow-up of radiology services which was an additional piece of work to be taken up locally, scoping was currently taking place. **Resolved that:** (a) the Audit Wales Update be noted.	
AAC 20/11/009	**Annual Structured Assessment Report** AW advised that the work undertaken was in the context of the pandemic and had been reshaped and re-focused to concentrate on 3 areas in particular: • Governance Arrangements; • Managing Financial Resources; • Operational Planning. AW thanked the health board for its full cooperation and assistance. AW advised that in terms of Governance Arrangements, it found the revised governance arrangements were set up quickly and supported responsive decision-making and effective operational management, but public scrutiny and assurance at Board-level could have been enhanced during the pandemic. Board business was found to be conducted in an open way but there was scope for more detailed reporting in some areas. The Board maintained effective communication with its stakeholders during the pandemic and was stable during the period but opportunities to support and enhance development of the Board members could have been pursued in full. In terms of Managing Financial Resources, it found that effective financial controls, monitoring and reporting had been maintained throughout the pandemic and arrangements were put in place to track Covid-19 expenditure. In regards to Operational Planning, it was informed by robust data modelling and developed in a timely way and the health board responded quickly to ensure sufficient resources to deliver its planning commitments.	

	AW made one recommendation which was to encourage learning from the pandemic to strengthen future governance arrangements. It was confirmed that the report had been seen by the Independent Members and that the Executives had accepted the recommendations. **Resolved that:** (a) the Audit Wales Annual Structured Assessment Report be noted.	
AAC 20/11/010	**Management of Clinical Coding Across Wales** AW stated that this was a national report where local work had been undertaken in 2018/19 and its aim was to highlight the current challenges and opportunities for clinical coding, including the potential to use COVID-19 related changes to working practices to secure new and more sustainable ways of delivering coding work. It was agreed that this report be part of a future Board Development Session. AW stated that the report was well received by Welsh Government and it was actively working with them to progress the 10 opportunities and ensure consistency with the messaging and approach across the sector. IM-ICT felt a refresh on clinical coding would be helpful and agreed to take to a DHIC meeting to discuss. **Resolved that:** (a) the Audit Wales Management of Clinical Coding Across Wales Report be noted.	**NF** **EB**
AAC 20/11/011	**10 Opportunities for Planned Care** AW stated that this was based on follow up work assessing progress against its 2015 report on waiting times for elective care. AW advised that it reframed its findings and key messages in the context of Covid-19 to inform emerging plans for restarting planned care and wider discussions on what a post COVID-19 NHS needed to look like. The report contained ten key opportunities made up of five longer-term opportunities and five immediate opportunities to restart the system. This was again a national report and health bodies were encouraged to consider the report as part of their ongoing planning arrangements for recovery and restarting. AW suggested that this report be taken to the Strategy and Delivery Committee to ensure that the 10 Opportunities were considered as part of the Health Board's planning arrangements. **Resolved that:** (a) the Audit Wales 10 Opportunities for Planned Care Report be noted.	**NF**
AAC 20/11/012	**The National Fraud Initiative (NFI) in Wales 2018-20**	

	AW stated that it reported the outcomes achieved since the last report of October 2018. It highlighted the importance of maintaining robust controls to minimise the risk of fraud during the pandemic. Recommendations were provided for Welsh Government as well as local Audit Committees to consider. **Resolved that:** a) the National Fraud Initiative in Wales 2018-20 be noted.	
AAC 20/11/013	**Welsh Community Care Information System** AW stated that this was a national study that examined the latest position relating to the implementation and rollout of the Welsh Information System. Section 2.6 of the report set out the Health Board's position. As part of the work, it identified that the current version of the information system would not meet the Health Board's requirements and also considered that it offered less in terms of its functionality and provided a significantly more costly option compared to existing arrangements. The Interim Executive Director Finance (IEDF) commented that this would be a cost pressure to the Health Board if taken forward. IM-ICT mentioned that this had been discussed in DHIC and that she supported the view of the Director of IM&T that our existing combined system had better integration from a health perspective and better functionalities than the system being developed and rolled out. She also highlighted that the new open architectural approach that Welsh Government ratified did allow the Health Board not to take this system provided there was an alternative and she considered that a decision by the Health Board of that nature would be appropriate. The IM-ICT suggested that the report be taken to DHIC to ensure its consideration by that Committee. The UHB Chair commented that in terms of the decision making, it would be for the Management Executive team with input from IT and other parties to arrive at a recommendation for the Board. **Resolved that:** (a) the Welsh Community Care Information System Report be noted.	**EB**
AAC 20/11/014	**Declarations of Interest and Gifts and Hospitality Tracking Report** The DCG stated that the report provided the updated position in regards to DOIs. Following the last meeting, a communications plan had been developed to increase awareness resulting in 100 more declarations since the last meeting and a further 400 declarations since the 8A chaser in November. These were not yet included within the tracker but would be reflected in time for the February meeting.	

	The DCG also advised that the team had now expanded and was split between Risk and Regulation and Corporate Governance so there would be more time invested in maintaining all trackers. The CC was pleased to see very few were rated red or amber and were seen as more low risk. **Resolved that:** a) the ongoing work being undertaken within Standards of Behaviour be noted b) the update in relation to the Declarations of Interest, Gifts, Hospitality & Sponsorship Register be noted.	
AAC 20/11/015	**Regulatory Compliance Tracking Report** The DCG stated that the report updated the Committee on overall inspections. She advised that a number of inspections were stalled due to Covid-19. She highlighted that 9 further inspections had been done and added to the tracker with a summary of the outcomes of those inspections. The CC commented that the report was useful and it was good to see outcomes as well. IM-TU queried the progression of the Clinical Board plan. The DCG responded that the outcomes of these inspections and assurance that recommendations are implemented and follow up work done would be brought to the Committee. **Resolved that:** a) the inspections which have taken place since the last meeting of the Audit Committee in September 2020 and their respective outcomes be noted b) the continuing development of the Legislative and Regulatory Compliance Tracker be noted.	
AAC 20/11/016	**Internal Audit Tracking Report** The DCG informed the Committee that the report contained three financial years of data. In terms of the Internal Audit 2017/18 position, there were now only 15 recommendations outstanding, the Risk and Regulation Team were meeting those with outstanding recommendations to ensure: • The recommendations were being completed • If not, to establish why and • To check if they were obsolete or superseded by other recommendations. The HIA had provided assurance around the progress reported. The DCG added that at the time of the Audit Wales Structured Assessment, there were 200 recommendations outstanding but this had significantly reduced over the last few months and continuous	

	improvement would be seen in this area as work picked up and chasers issued. The UHB Chair commented that there needed to be Executive ownership of this area and that he would like to see assurance for future meetings that Executives had bought into the process and supported recommendations being dealt with in an appropriate timescale. The DCG confirmed that the report was provided to the Management Executive to reinforce its importance. CC was pleased to see the recommendations drop from 164 to 111 but was mindful that Internal Audit would now deliver a number of new reports and recommendations which could increase that number. **Resolved that:** (a) the tracking report which is now in place for tracking audit recommendations made by Internal Audit be noted (b) progress would be seen over coming months in the number of recommendations completed/closed.	
AAC 20/11/017	**Audit Wales Tracking Report** The DCG highlighted an error in the report in that 3 recommendations added since last time were not showing on the pdf version and 1 recommendation in relation to TTP was an administrative error as the report had not yet been received. Apart from that the report provided a status update on the Audit Wales recommendations CC queried whether there were 28 or 22 recommendations outstanding. The DCG confirmed that 24 had been brought forward and 3 had been added since as the TTP was not a recommendation so 27 in total. **Resolved that:** a) the progress made in relation to the completion of Audit Wales recommendations be noted b) the continuing development of the Audit Wales Recommendation Tracker be noted.	
AAC 20/11/018	**Review Losses and Special Payments** The IEDF advised that under the Standing Financial Instructions, the Committee was required to approve the write offs of losses and special payments. To support it in this process, there was a Losses and Special Payments Panel that met twice a year and last met on 23rd October. He referred to the assessment area of the report that set out those items recommended for write off. The IEDF highlighted 2 items: • **Bad Debt Write-offs** – this was particularly small for the first 6 months of the year as they had stopped referring to the debt collection agency given the hardship people were facing during the pandemic but this process was now restarting.	

	• **Treforest Flood** – there was over £2.0M in damage. As this was above the Committee's delegated limit, this had gone for Welsh Government specific approval which had been granted. The CC queried the amounts that the Committee was asked to approve relating to criminal negligence. The IEDF confirmed that there was a bigger amount written off and a smaller amount as a cost to the Health Board as it was written off by the Welsh Risk Pool but the total losses needed to be recorded at the Committee. IEDF confirmed a mistake in the headings and would amend. CC queried whether clinical negligence claims was down since last year. IEDF responded that with the Welsh Risk Pool, a certain amount of money was set aside and if the total claim exceeded that, a mechanism was in place where each of the Health Boards paid a contribution. There was a set fixed figure of £2.1M that the Health board would have to contribute this year, £1.5M was set aside in the original plans and the topping up was factored into the financial forecast so the liability was covered. **Resolved that:** a) the write-offs outlined in the Assessment Section of the report be approved.	
AAC 20/11/019	**Proposed Changes to Governance Arrangements** The DCG advised that she had worked closely with the UHB Chair on pulling this piece of work together. Independent Members had already seen it via the Board Governance Group. The recommendations section picked up the outputs from the Audit Wales Structured Assessment and Internal Audit work. She also highlighted the KPMG report which was in the private part of the meeting at the request of KPMG as it was commissioned by Welsh Government, this contained recommendations for both the Health Board and Welsh Government. Appendix 1 provided a summary of Governance arrangements and proposals to strengthen the Governance around the pandemic and to respond to recommendations made. Appendix 2 was a template report put in place to ensure the following key areas were covered off: • Quality • Workforce • Governance • Public Health • Operations The DCG added that the ToR for the Board Governance Group had been revised to include all Independent Members rather than only Independent Members required for Chair's actions which was the case previously.	

	The DCG concluded that the governance structure had not changed vastly but now included the Committees which would continue should we need to stand down others but confirmed that we were not yet in that position. AW commented that this was a very good piece of work which picked up the different layers of assurance and recommendations and that there had been a timely response to recommendations. **Resolved that:** a) the proposed amendments to governance arrangements (Appendix 1) be approved; b) the changes to the Board Governance Group Terms of Reference (Appendix 2) which extends the Membership to include all Independent Members be approved; c) the COVID-19 Report Template (Appendix 3) covering the key areas of Quality and Safety, Workforce, Governance, Operational Framework, Governance and Public Health be approved; d) the first 90 minutes of future Board Development sessions be in public demonstrating that the Board is meeting in public every month; e) the revised Governance Structure ensuring appropriate reporting to the Committees of the Board during the second wave (Appendix 4) be approved.	
AAC 20/11/020	**Items for Information and Noting - Internal Audit reports for information** The Committee received the following 6 reports: 1. Pre-Employment Checks – Reasonable assurance 2. Surgery CB – Theatres Directorate Sickness Absence Management – Reasonable assurance 3. Regional Partnership Board – Reasonable assurance 4. Sustainability Reporting – Reasonable assurance 5. Management of Serious Incidents – Reasonable assurance 6. Governance During COVID-19 – Advisory **Resolved that:** (a) the Internal Audit reports be noted.	
AAC 20/11/021	**Business of other Committees and Review of Inter-relationships** The DCG stated that this had been a useful exercise to be able to look back at what: • was in place • was not in place • had been done and • had not been done. It also provided the Committee with assurance regarding what had been completed since 2019-2020 and where it was headed. The purpose of the review was to enable the Audit Committee to provide further assurance to the Board that the other Committees were in place and operating effectively, and in particular that: • ToR were in place • Annual reports on ToR provided and	

	• Effectiveness reviews carried out. The DCG highlighted that this year some of these items had slipped due to some Committees being stood down due to Covid-19, and the aim for the end of the year was to ensure that all these outstanding areas were addressed and processes in place for the next year. UHB Chair commented that this was a very good piece of work and suggested that it be shared with the other Committees for information so that the linkages were understood. **Resolved that:** (a) the outcome of this review to provide 'independent' assurance to the Board that the Board assurance requirements were appropriately aligned be noted (b) the areas of development within the report to provide further assurance to the Board on the Inter relationships between the Committees particularly in the areas of Risk, Regulatory Tracking, Performance Monitoring and Audit recommendations be noted (c) the outputs of the Committee self-assessment and the action plans in place to improve effectiveness of the Committees and that where the self-assessments were not undertaken that they will be undertaken before the end of the year be noted (d) approval be recommended to the Board that the Health and Safety Committee administration moves to the Directorate of Corporate Governance to align end of year reporting and independence from the Health and Safety function of the Health Board.	**NF**
AAC 20/11/022	**Self-Assessment of Committee Effectiveness** The DCG advised that self-assessment was undertaken last year with most Committees and actions followed up where the response was "adequate", "needs improvement" or "no". The next step was for the DCG to meet with the Chairs of each Committee to follow up on the action plans and ensure completion. **Resolved that:** a) the results of the Committee's self-assessment Effectiveness Review for 2019-20 be noted b) the action plan for improvement to be completed by March 2021 in preparation for the next annual self-assessment which will feed into the 2020-21 Annual Governance Statement be approved.	
AAC 20/11/023	**Job Planning Update** The Executive Medical Director (EMD) confirmed that this was being brought back to Committee as previously it had received a Limited assurance rating. This was due to come to the February meeting but as significant progress had been made it was sensible to provide an update at this time and a further one in 6 months' time. The EMD highlighted that the job planning component had 2 key work streams:	**SW**

	• **Job Planning Procedure** – Related to the development of the relevant procedure which was not a guideline but a procedure that needed to be followed. • **E-Job Planning System (Allocate)** – this was currently in wide spread use across the UK and had been modified for Welsh use. The EMD stated that they were in the process of refining this system for local requirements. Progress made included: • Identification of Champions • Training • Identification of Super Users • Number of engagement events • Shifting of data into the system The EMD reported that they were now at a point where they could go live with the Job Planning System and upload job plans to the centralized solution. A timeline was contained within the slides and provided the Committee with the key milestones. The EMD added that everything was to be centralized and all job plans uploaded by the end of the financial year. IM-TU commented that the EMD had a really difficult starting position but had got it right and achieved fantastic work. The HIA agreed that it was very positive and added that it needed to be scheduled into the Internal Audit plan for follow up in around January or February 2021 to provide assurance to the Committee. The EMD agreed to this and welcomed reassessment after March. The HIA and EMD agreed to have a meeting in place by April for inclusion in the 2021 Internal Audit plan. **Resolved that:** a) the presented action plan as follow up from the Limited assurance report be approved and supported.	**SW / IV**
AAC 20/11/024	**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 20/11/025	**Review of the Meeting** The CC thanked everyone for their attendance and contribution to the meeting.	
AAC 20/11/026	**Date and Time of Next Meeting** To note the date, time and venue of the next Committee meeting: **Tuesday 9th February 2021 at 9.00am**	

Action Log
Following Audit & Assurance Committee Meeting
17th November 2020

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
AAC 20/09/007	Internal Audit Progress and Tracking Reports	Report on pre-employment checks to be brought to the next meeting.	Ian Virgil	**17.11.20**	**Complete** November, item 9.1
AAC 20/09/008	Audit Wales (AW) Update	AW reports on clinical coding & national follow up study on elective waiting times to be brought to the next Committee meeting.	AW	**17.11.20**	**Complete** Clinical Coding & Planned Care on Agenda for November, items 7.4 & 7.5
AAC 19/12/015	Internal Audit Tracking Report	The Head of Internal Audit to provide sample of validation from Clinical Boards to test for accuracy in a future Internal Audit and Review	I Virgil	**17.11.20**	**Complete** November, item 7.1
AAC 20/03/008	Consultant Job Planning Follow-up: Limited Assurance Report	An update to be presented to the Committee in February 2021.	Stuart Walker	**17.11.20**	**Complete** November, item 9.4
AAC 20/05/005	Effectiveness of Clinical Audit Report	To clarify plans to progress post COVID-19 with AW	Nicola Foreman	**17.11.20**	**Complete** November, item 9.3
Actions in Progress					
AAC 20/09/008	Audit Wales (AW) Update	AW reports on TTP to be brought to the next Committee meeting.	AW	**06.04.21**	Update on TTP to be provided at April 2021 meeting.
AAC 20/04/005 AAC 20/11/023	Consultant Job Planning Follow-up: Limited Assurance Report	Follow up Internal Audit Report to be carried out at an appropriate time to be agreed with EMD & to be included in the 2021 Internal Audit plan.	Stuart Walker / Ian Virgil	TBC	March 2021
AAC 20/11/023	Job Planning Update	To provide a further update in 6 months' time.	Stuart Walker	06.04.21	Update to be brought to the April Meeting
AAC 19/12/012	Effectiveness of Clinical Audit Report	To consider arrangements to deliver effective programme of Clinical Audit	Stuart Walker	**09.02.21**	To be brought to February 2021 meeting.

AAC 20/11/021	Business of other Committees and Review of Inter-relationships	To share with the other Committees for information.	Nicola Foreman	TBC	In progress
Actions referred to Board / Committees					
AAC 20/11/010	Management of Clinical Coding Across Wales	To include in a future Board Development session.	Nicola Foreman	TBC	To be taken to a future Board Development session
AAC 20/11/010	Management of Clinical Coding Across Wales	IM-ICT to take to future DHIC meeting.	Eileen Brandreth / Audit Wales	11.02.21	On agenda for February meeting
AAC 20/11/011	10 Opportunities for Planned Care	To take report to a future Strategy and Delivery Committee to ensure that the 10 opportunities are considered as part of the Health Board's planning arrangements.	Nicola Foreman	12.01.21	To be taken to a future S&D Meeting
AAC 20/11/013	Welsh Community Care Information System	IM-ICT to take report to future DHIC meeting.	Eileen Brandreth / Audit Wales	11.02.21	On agenda for February meeting

Report Title:	**Internal Audit Progress Report**								
Meeting:	Audit & Assurance Committee						**Meeting Date:**	09/02/21	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**	**X**	**For Information**		
Lead Executive:	Director of Governance								
Report Author (Title):	**Head of Internal Audit**								

Background and current situation:

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

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

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

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

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

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

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

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

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

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

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

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

Recommendation:

The Audit & Assurance Committee is asked to:

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

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term	x	Integration	x	Collaboration	x	Involvement	
Equality and Health Impact Assessment Completed:	~~Yes~~ / ~~No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*								

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee February 2021

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cardiff and Vale University Health Board, no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. INTRODUCTION

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

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

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

2. ASSIGNMENTS WITH DELAYED DELIVERY

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

Audit	Current Position	Draft Rating	Reason
Integrated Health Pathways	Draft Report	Reasonable	Delay in agreeing report due to lead manager working on vaccination programme
UHW Surge Hospital – Lakeside Wing	Draft Report	Reasonable	Delay in agreeing report and obtaining responses from Management
Compliance with the Nurse Staffing Levels Act (Wales) 2016	Draft Report	Substantial	Delay in agreeing report and obtaining responses from Management
IM&T Control & Risk Assessment	Work in Progress		Delay in completion of fieldwork due to availability of HB staff and supply of information
CD&T CB – Ultrasound Governance	Planning		Delay in commencing fieldwork; initially due to availability of Internal Audit resource and then availability of HB Management during Covid
Claims re-imbursement	Work in Progress		Delay in commencing fieldwork due to introduction of new WRP process

Engagement Around Service Planning	Planning		Delay in commencing fieldwork due to availability of HB Management during Covid
Charitable Funds	Work in Progress		Delay in completion of fieldwork due to availability of HB staff and supply of information
Recruitment & Retention of Staff	Work in Progress		Delay in commencing fieldwork due to availability of HB Management during Covid

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

3. OUTCOMES FROM COMPLETED AUDIT REVIEWS

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

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

FINALISED AUDIT REPORTS (2020/21 Plan)	ASSURANCE RATING	
Specialist CB - Patient assessment and provision of equipment by ALAS	Substantial	
Asbestos Management	Reasonable	
MH CB – Outpatient Clinic Cancellations	Limited	

4. DELIVERY OF THE 2020/21 INTERNAL AUDIT PLAN

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

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

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

A first round of adjustments to the plan was formally approved by the Audit Committee in July with a second round then approved at the November meeting.

However, due to the ongoing impact of the pandemic a number of additional audits have been identified for removal from the plan. A separate 'Plan to Complete' paper has been produced that provides a detailed analysis of the current position regarding delivery of the plan in order to complete a programme of Internal Audit work that enables the provision of a full Head of Internal Audit Opinion for 2020/21. This paper is included separately within the Committee Agenda.

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

The additional adjustments for agreement by the February Audit Committee are summarised below:

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

- **Clinical Board QS&E Governance**

  Determined that Clinical Boards would be unable to engage in this audit due to the pressures of dealing with Covid;

- **Medicine CB Bank & Agency Nurses Scrutiny Process**

  The CB Director of Nursing identified that the service would not be able to engage in the audit due to the pressures of dealing with Covid;

- **Public Health**

  Considered inappropriate to carry out an audit in this area given the current situation; and

- **Management of Staff Sickness Absence**

  The Director of Workforce identified that it would be inappropriate to carry out this audit at the current time due to service pressures.

Audits with adjusted scope:

- **Commissioning**

  This will now be replaced by an audit of the processes for producing the Health Board's Annual Plan for 21/22. This was agreed with the Director of Planning.

The adjustments identified above, combined with those previously agreed, mean that there will be 31 audits remaining for delivery within the 20/21 plan. As detailed within the 'Plan to Complete' paper, this will still allow sufficient coverage for the provision of a full Head of Internal Audit annual opinion at the end of the year. This will however be dependent on the Health Board being in a position to engage with the remaining audits.

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

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

5. ASSURANCE ON RECOMMENDATION TRACKING

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

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

5.3. Appendix D provides detail of the entries from the tracker that have been validated since the last meeting of the Committee and the outcome of that validation. The validation completed during this period has focused on the 2018/19 recommendations detailed within the tracker that was presented to the November 20 Audit Committee. The overall outcome can be summarised as follows:

- The tracker included a total of 25 recommendations from 2018/19;
- A sample of 10 of the recommendations was selected for validation;
- We were able to obtain evidence to confirm that the stated progress for 8 of the 10 sampled recommendations was accurate; and

- We are still waiting for evidence to be supplied for the remaining 2 recommendations.

5.4. The outcome of the validation process means that the Audit Committee can take assurance that the progress information detailed within the tracker for the 2018/19 recommendations represents an accurate position.

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

6. DEVELOPMENT OF THE 2021/22 INTERNAL AUDIT PLAN

6.1. The process for developing the 2021/22 Internal Audit plan has commenced. Meetings are being held with Executive Directors, including the Chief Executive, and key Independent Members.

An initial draft plan will be submitted to a meeting of the Executive Management Team during March for comment. An updated draft will then be presented to the April Audit & Assurance Committee for formal approval.

Whilst a full plan for 21/22 will be produced, as required by the Internal Audit Charter and Public Sector Internal Audit Standards, it is acknowledged that the plan will need to be regularly updated as the year progresses. This will ensure that the audits undertaken effectively reflect the Health Board's changing priorities and emerging risks and provide appropriate assurance.

7. FINAL REPORT SUMMARIES

7.1. Specialist CB - Patient assessment and provision of equipment by ALAS

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

The BEST Patient Management System used by ALAS is a comprehensive integrated system which records and links all relevant patient and equipment information and maintains a full audit trail of who did what, when and why.

There's a reconciliation mechanism to ensure that all transactions are accurately recorded in Oracle and the transactions tested were appropriately approved.

ALAS places contracts with its main suppliers on fixed term cycles following a procurement process which is overseen by Shared Services Partnership Procurement. However, it has experienced problems due to supplier catalogues not being updated on Oracle.

7.2. Asbestos Management

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

The UHB has, in the last few years, migrated its asbestos data from an Access database to the MiCAD electronic property management system, providing a more robust and comprehensive asbestos register.

Management has identified and reported (to the monthly Capital & Estates Health & Safety forum and the Asbestos Management Group) some issues remaining to be resolved, in respect of the new system. These include:

- The migration of data, and historical survey issues, resulted in a high number of areas classed as 'non-compliant' within MiCAD, i.e. areas for which asbestos data was not available. Risk-prioritised survey work in the last year has seen these numbers significantly reduce, with further work planned to ensure full compliance where possible; and
- Usage of MiCAD by contractors and UHB staff is lower than expected, suggesting this key record is not always being reviewed prior to work commencing.

Being cognisant of the work that has been invested by the UHB and the observations made, general compliance was noted with the established control frameworks in each of the objective areas sampled.

However, the audit identified the following control weaknesses:

- training (Asbestos awareness and Category B) had lapsed for a significant proportion of staff during the period reviewed; and
- there was lack of compliance with the signing-in/authorisation sheet process at community sites.

In addition, certain enhancements have been recommended in respect of:

- reporting of the Asbestos risk register to the Asbestos Management Group;
- completion of the compliance auditing targets for the year;
- retention of waste consignment notes generated from asbestos jobs; and

retention of Risk Assessment/Method Statement (RAMS) for asbestos jobs undertaken.

7.3. MH CB – Outpatient Clinic Cancellations

RATING	INDICATOR	DEFINITION
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.

There is no monthly reporting and monitoring of Mental Health Outpatient Clinic Cancellations and there is a lack of knowledge regarding cancellations

reports available in the PARIS Patient Management System and so they are not used.

The date, clinician and reason for a cancellation must be recorded in pre-set cells in the PARIS Patient Management System. However the reason is simply a short statement from a drop-down menu of possible reasons and so does not indicate fully what factors and options were considered by the clinician before concluding that there was no alternative to cancelling the clinic.

The PARIS Patient Management System is not used consistently across Mental Health as Adult Mental Health and Mental Health Services for Older People use different modules to record Outpatient Clinic appointments. Furthermore, there are no written procedures to ensure consistency across the various Mental Health Outpatient Clinics.

Testing a sample of Outpatient Clinic Cancellations indicated that the delay until replacement clinic appointments generally appeared reasonable.

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.

CARDIFF AND VALE UHB INTERNAL AUDIT ASSIGNMENT STATUS SCHEDULE

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Annual Quality Statement	**16**	**Nursing**	**Q2**	**Final – Issued August 20**	**Substantial**	**Sept**
Surgery CB – Theatres Directorate Sickness Absence Management	**29**	**COO**	**Q2**	**Final – Issued September 20**	**Reasonable**	**Nov**
Regional Partnership Board	**07**	**Strategic Planning**	**Q2**	**Final – Issued October 20**	**Reasonable**	**Nov**
Governance During COVID-19 (Advisory Review)	**46**	**Corporate Governance / Finance**	**Q2**	**Final – Issued October 20**	**n/a**	**Nov**
Sustainability Reporting	**38**	**Finance**	**Q2**	**Final - Issued November 20**	**Reasonable**	**Nov**
Management of Serious Incidents	**18**	**Nursing**	Q2	**Final – Issued November 20**	**Reasonable**	**Nov**
Specialist CB – Patient Assessment & Provision of Equipment in ALAS	**28**	**COO**	Q2	**Final – Issued November 20**	**Substantial**	**Feb**
Asbestos Management	**40**	**Finance**	Q2	**Final – Issued November 20**	**Reasonable**	**Feb**
MH CB – Outpatient Clinic Cancellations	**31**	**COO**	**Q2**	**Final – Issued January 21**	**Limited**	**Feb**
Compliance with the Nurse Staffing Levels Act (Wales) 2016	17	Nursing	Q3	Draft – Issued December 20	Substantial	April
Integrated Health Pathways	20	Transformation & Informatics	Q2	Draft – Issued January 21	Reasonable	April

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
UHW Surge Hospital – Lakeside Wing	44	Strategic Planning	Q2	Draft – Issued January 21	Reasonable	April
IM&T Control & Risk Assessment	01	Transformation & Informatics	Q2	Work in Progress		April
CD&T CB – US Governance	33	COO	Q3	Planning		April
Claims Reimbursement	02	Nursing	Q3	Work in progress		April
Health and Care Standards	03	Nursing	Q3	Planning		April
Engagement Around Service Planning	06	Strategic Planning	Q3	Planning		April
Charitable Funds	14	Finance	Q3	Work in progress		April
Recruitment & Retention of Staff	35	Workforce	Q3	Work in progress		April
Annual Planning process 21/22	08	Strategic Planning	Q3	Replaces audit of Commissioning, as agreed with Director of Planning		April
UHB Core Financial Systems	13	Finance	Q3	Work in progress		April
Infrastructure / Network Management	23	Transformation & Informatics	Q3	Planning		April
Risk Management	02	Corporate Governance	Q4	Planning		April
Data Quality Performance Reporting	10	Transformation & Informatics	Q4			April

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Tentacle IT System Follow-up	26	Transformation & Informatics	Q4	Planning		April
Cyber Security System Follow-up	27	Transformation & Informatics	Q4			April
C&W CB – Rostering in Community Children's Nursing	34	COO	Q4			April
Consultant Job Planning Follow-up	37	COO	Q4			April
Shaping Future Wellbeing in the Community Scheme	43	Strategic Planning	Q4			April
Development of Integrated Audit Plans	45	Strategic Planning	Q1-4	Work in progress		April
Post Contract Audit of DHH Costs	47	Finance	Q4	Added to the plan following request from Director of Finance – Agreed by November AC.		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 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		

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Whistleblowing Policy	05	Corporate Governance		Director of Governance proposed deferral to the 21/22 plan. Work is currently ongoing to update the Health Board's Raising Concerns process which incorporates whistle blowing - Agreed by Nov AC		
Strategic Performance Reporting	09	Transformation & Informatics	Q3	Postponed to the 21/22 plan. Formal performance reporting requirements have been paused by Welsh Government - Agreed by November AC		
Directorate Level Financial Control	15	Finance		Deferral to the 21/22 plan agreed with the acting Director of Finance. Lower risk area and issues with accessing Directorate Managers during Covid – Agreed by the November AC		
ITIL Service Management	21	Transformation & Informatics		Director of Digital requested removal from the plan due to the current pressures on key IT staff - Agreed by November AC		
Departmental IT System	25	Transformation & Informatics		Director of Digital requested removal from the plan due to the current pressures on key IT staff - Agreed by November AC		
PCIC CB – GP Access	32	COO		Deferred to 21/22 as agreed with CB Management. GP Access monitoring paused due to Covid - Agreed by the November AC		
Fire Safety	39	Finance		Director CEF requested deferral to the 21/22 plan due to current pressures on key staff - Agreed by November AC		

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Major Capital Scheme – UHW New Academic Avenue	42	Strategic Planning		Removed from the plan as the scheme has not progressed - Agreed by November AC		
Major Capital Scheme – UHW II	41	Strategic Planning		Removed from the plan as the scheme has not progressed - Agreed by November AC		
Capital Systems Management	*44*	*Strategic Planning*		Director CEF proposed that this audit be removed from the plan and replaced with the audit of the UHW Surge Facility - agreed by November AC.		
Clinical Board QS&E Governance	19	Nursing		Determined that Clinical Boards would be unable to engage in this audit due to the pressures of dealing with Covid – To be agreed By February AC		
Medicine CB – Bank & Agency Nurses Scrutiny Process	30	COO		The CB Director of Nursing identified that the service would not be able to engage in the audit due to the pressures of dealing with Covid – To be agreed by February AC		
Public Health	12	Public Health		Considered inappropriate to carry out an audit in this area given the current situation – To be agreed by February AC		
Management of Staff Sickness Absence	36	Workforce		The Director of Workforce identified that it would be inappropriate to carry out this audit at the current time due to service pressures – To be agreed by February AC		

INTERNAL AUDIT REPORT RESPONSE TIMES								
Audit	**Rating**	**Status**	**Draft issued date**	**Responses & exec sign off required**	**Responses & Exec sign off received**	**Final issued**	**R/A/G**	
Annual Quality Statement	Substantial	Final	03/08/20	25/08/20	13/08/20	19/08/20	G	
Surgery CB – Theatres Dir Sickness Absence Management	Reasonable	Final	15/09/20	07/10/20	28/09/20	01/10/20	G	
Regional Partnership Board	Reasonable	Final	28/08/20	06/10/20	29/09/20	07/10/20	G	
Governance During Covid-19	n/a	Final	21/08/20	15/09/20	21/10/20	23/10/20	R	
Sustainability Reporting	Reasonable	Final	10/09/20	02/10/20	02/11/20	03/11/20	R	
Management of Serious Incidents	Reasonable	Final	23/10/20	16/11/20	02/11/20	02/11/20	G	
Asbestos Management	Reasonable	Final	03/11/20	25/11/20	10/11/20	11/11/20	G	
Specialist CB – Patient Assessment & Provision of Equipment in ALAS	Substantial	Final	03/11/20	25/11/20	20/11/20	24/11/20	G	
MH CB – Outpatient Clinic Cancellations	Limited	Final	17/12/20	12/01/21	04/01/21	13/01/21	G	
Nurse Staffing Levels	Substantial	Draft	17/12/20	12/01/21				
Integrated Health Pathways	Reasonable	Draft	11/01/21	01/02/21				
UHW Surge Hospital – Lakeside Wing	Reasonable	Draft	11/01/21	01/02/21				

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2020/21	G	April 2020	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 20/21	R	67% 12 from 18	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 12 from 12	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	A	78% 7 from 9	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 9 from 9	80%	v>20%	10%<v< 20%	v<10%

Information from Recommendation Tracker							Validation Process	
Audit Reference	**Audit Log Reference No**	**Final Report Issued on**	**Audit Title**	**Audit Rating**	**Rec. Rating**	**Rec. status**	**Basis of validation**	**Outcome**
C&V-1819-07	IA 09 1819	15/05/2019	Strategic Planning / IMTP	Substantial	Medium	No action	IMTP process paused during Covid - Confirmed by Dir of Planning	Recommendation confirmed as no action taken
C&V-1819-07	IA 12 1819	30/08/18	Dental CB – Theatre Sessions	Reasonable	High	Part Complete	Evidence received from Manager to confirm part completion	Recommendation confirmed as part complete
C&V-1819-02	IA 28 1819	15/02/19	CRI Safeguarding Works	Reasonable	Medium	No action	Confirmed as noted for any future projects	Recommendation confirmed as no action needed
C&V-1819-02	IA 28 1819	15/02/19	CRI Safeguarding Works	Reasonable	Low	No action	Confirmed as noted for any future projects	Recommendation confirmed as no action needed
SSU C&V-1819-03	IA 31 1819	15/05/19	Water Safety	Reasonable	Medium	Part Complete	Evidence not yet obtained	
SSU C&V-1819-03	IA 31 1819	15/05/19	Water Safety	Reasonable	Medium	Part Complete	Evidence not yet obtained	
C&V-1819-14	IA 32 1819	15/05/19	UHB Core Financial Systems	Reasonable	Medium	Part Complete	Evidence received from Manager to confirm part completion	Recommendation confirmed as part complete

Information from Recommendation Tracker							Validation Process	
Audit Reference	**Audit Log Reference No**	**Final Report Issued on**	**Audit Title**	**Audit Rating**	**Rec. Rating**	**Rec. status**	**Basis of validation**	**Outcome**
C&V-1819-14	IA 32 1819	15/05/19	UHB Core Financial Systems	Reasonable	Medium	Part Complete	Evidence received from Manager to confirm part completion	Recommendation confirmed as part complete
C&V-1819-14	IA 32 1819	15/05/19	UHB Core Financial Systems	Reasonable	Medium	Part Complete	Evidence received from Manager to confirm part completion	Recommendation confirmed as part complete
C&V-1819-31	IA 40 1819	12/02/19	Surgery CB – Medical Finance Governance	Limited	High	Part complete	Follow-up of Limited Assurance audit completed in October 19. This confirmed that the action was part complete	Recommendation confirmed as part complete

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Audit and Assurance Services

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

INTERNAL AUDIT PLAN TO COMPLETE 2020/2021

December 2020

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Introduction

Internal Audit Operational Plans for all NHS Wales organisations for 2020/21 were reviewed and in a number of cases re-issued, through the summer and autumn of 2020 to take into account the impact of Covid-19. In most organisations the revised plans include fewer audit reviews than previous years. However, they were produced following the established domain-based approach assuming that, if completed, they would support the provision of the Head of Internal Audit opinion in the usual way.

As time moves on and organisations continue to respond to the pandemic whilst seeking to re-commence or continue other services, we are coming to the view that it may not be possible to deliver these revised programmes in full.

The Head of Internal Audit for Cardiff and Vale University Health Board ('the Health Board') reported adjustments to the agreed Internal Audit plan to the June and November 2020 meetings of the Audit Committee. He also stated that the on-going delivery of the revised plan would be kept under review.

This paper sets out the results of that ongoing review and details the current position regarding delivery of the plan in order to complete a programme of Internal Audit work that enables the provision of a full Head of Internal Audit Opinion for 2020/21.

Forming the Annual Head of Internal Audit Opinion

The Head of Internal Audit draws upon the following in order to produce an annual opinion that can meaningfully inform the annual governance statement:

1. The evidence obtained from a sufficient number of individual audit and advisory reviews.
2. The results of internal audit reviews at other NHS Wales organisations that are relevant to the governance, risk management and control processes of the organisation, e.g. NHS Wales Shared Services Partnership ('NWSSP').
3. Cumulative knowledge of the organisation based on the results of internal audit work undertaken in previous years
4. Knowledge of governance and risk management arrangements obtained from ongoing observation of Board and committee meetings and meetings with Executive Directors, senior managers and independent members.
5. Knowledge obtained undertaking other ad hoc work, including requests for advice, attending working groups and investigations.

6. The results of work undertaken by regulators and inspectors, including Audit Wales and Health Inspectorate Wales and liaison with LCFS and PPV.
7. Knowledge obtained through general research and understanding of the organisation.

The Head of Internal Audit considers whether the above provides a sufficient basis to enable a professional conclusion to be drawn in respect of governance, risk management and control processes (the basis of the Head of Internal Audit opinion) and, in particular, whether the coverage of internal audit reviews is sufficient to be able to give an overall opinion.

While neither the Public Sector Internal Audit Standards (see Appendix B) nor guidance prescribe a minimum coverage of internal audit work required to support an annual opinion, it is implicit that the annual plan needs to cover a sufficient quantity of work for the Head of Internal Audit to be able to issue the opinion with confidence.

Our approach to date has combined a risk based focus, using the organisation's assurance framework and risk management arrangements where appropriate, combined with a 'domain based' approach for Health Boards to ensure we undertake work across all the key areas of activity and that there is rotational coverage.

However, due to the fact that we anticipate delivering fewer audits than in 2019/20 we have agreed with the Board Secretaries Group to remove the formal use of our domain approach to arrive at the Head of Internal Audit Annual Opinion at Health Boards in 2020/21.

In forming the annual opinion it is not necessarily the number of reviews that is important because the scopes of individual engagements can vary considerably depending upon the objectives and risks addressed. It is the quantity and quality of the cumulative evidence in respect of governance, risk management and control activities that is key.

Governance and Risk Management

Our audit approach provides coverage of governance and risk management arrangements in the majority of internal audit reviews. There is also broader evidence available to the Head of Internal Audit in respect of governance and risk management from other sources (2 to 7 above).

The revised plan also includes a specific review of risk management arrangements scheduled for quarter 4 which is still planned to be completed.

The Head of Internal Audit therefore anticipates that sufficient evidence will be available to reach a conclusion on the adequacy and effectiveness of governance and risk management processes.

Control Activities

The primary source of evidence of the adequacy and effectiveness of control processes is testing and reviewing activity undertaken in audit and advisory reviews. The key question is therefore whether there is sufficient coverage of control activities from the programme of audit and advisory reviews to enable the Head of Internal Audit to form a robust and meaningful conclusion on their adequacy and effectiveness.

Progress to Date

The current updated plan, as agreed at the November 2020 Audit and Assurance Committee includes 35 individual audit/advisory reviews (The Committee has already agreed a net reduction of 10 reviews from the original 20/21 plan that included 45 reviews).

The position at 18th December 2020 is as follows:

- 17 of the planned 35 reviews are either complete or sufficiently advanced that they will be completed;
- 14 reviews are still planned to be commenced and completed; and
- 4 reviews cannot now be completed as part of the 20/21 plan.

The reviews that can't be completed were identified following discussions with the relevant lead executives and / or consideration of the Health Board's current and future position in dealing with the pandemic. The key reasons in relation to each of the 4 reviews can be summarised as follows:

- Clinical Board QS&E Governance – Determined that Clinical Boards would be unable to engage in this audit due to the pressures of dealing with Covid;
- Medicine CB Bank & Agency Nurses Scrutiny Process – The CB Director of Nursing identified that the service would not be able to engage in the audit due to the pressures of dealing with Covid;
- Public Health – Considered inappropriate to carry out an audit in this area given the current situation; and
- Management of Staff Sickness Absence – The Director of Workforce identified that it would be inappropriate to carry out this audit at the current time due to service pressures;

Review Activity

In addition to considering the reviews completed or still planned to be completed from the updated plan, the review by the Head of Internal Audit has taken into account the following:

1. Engagement with senior managers and Executive Leads in order to ascertain which audits can be progressed. In a number of cases we have received requests for audits to be deferred either into quarter 4 or into next year due to operational pressures at the present time.

2. Re-assessment of the risk profile of the organisation and the environment it is operating in, with reference to the Board Assurance Framework, latest available Corporate Risk Register and discussions with Executives and Independent Members.
3. Anticipated continuing difficulties with undertaking audit work remotely and capacity within the Health Board during what is likely to be a very challenging winter.
4. Consideration of professional guidance on the production of the Head of Internal Audit Opinion where internal audit work is impacted by Covid-19 and the interpretation of Audit & Assurance Services of that guidance, in consultation with the Board Secretaries Group and Welsh Government as our standard setter.

Having considered the above, the Head of Internal Audit has determined that the audits that are still planned to be completed allow sufficient detail to provide an appropriate level of evidence in respect of control activities.

Appendix A details the full updated coverage for the 2020/21 year, including the audits completed or in progress and those audits still planned to be completed.

The traditional domain based presentation has been retained for reporting consistency and to allow comparability to the original plan. As stated previously the domain approach will not however be used to arrive at the Head of Internal Audit Opinion for 20/21.

The following modifications have also been included within Appendix A to show the breadth of coverage:

1. Where a review provides evidence in respect of more than one domain this has been shown in italics (for example, Surgery CB – Theatres Directorate Sickness Absence Management).
2. More direct assurance is being provided from individual reports for each organisation from the national systems audits of Purchase to Pay, Payroll and Primary Care Contractor Services Payments which is shown in the Financial Governance and Management domain.

As a sense check and whilst re-iterating the number of reviews in itself is not an accurate measure of sufficient coverage, the programme can be compared with 2019/20 as follows:

Final and draft reviews to date	**10**
Work in progress	7
Planned to be commenced	14
Reviews to be included in 2020/21 Opinion	**31**
Reviews included in 2019/20 Opinion	**39**

Conclusion

The Head of Internal Audit considers that this updated plan for the year provides sufficient coverage to enable the provision of a Head of Internal Audit Annual Opinion. This approach has been discussed and agreed with the Director of Audit & Assurance.

If it is not possible to complete this programme in full, alternative forms of Head of Internal Audit Annual Opinion may need to be considered, including potentially providing a limited scope opinion if the Head of Internal Audit considers that there is insufficient coverage to provide a full Opinion.

Planned output	Outline timing	Status	Assurance
Corporate Governance, Risk and Regulatory Compliance			
1. Governance Arrangements during Covid-19 Pandemic (Advisory review)	Q2	Final Report	Advisory
2. Risk Management	Q4	To be commenced	
3. Claims Reimbursement	Q3	Work in Progress	
4. Health and Care Standards	Q4	Work in Progress	
Strategic Planning, Performance Management and Reporting			
5. Engagement Around Service Planning	Q4	To be commenced	
6. Regional Partnership Board	Q2	Final Report	Reasonable
7. Q3/4 Delivery Framework / Annual Planning (Replaces Commissioning)	Q4	To be commenced	
8. Data Quality Performance Reporting	Q4	To be commenced	
Financial Governance and Management			
Public Health	Q3	Proposed to be removed from 20/21 plan	
9. UHB Core Financial Systems		To be commenced	
10. Charitable Funds		Work in progress	
Governance Arrangements during Covid-19 Pandemic (Advisory review)	*Q2*	*Final Report*	*Advisory*
NWSSP – Payroll	*Q3/4*	*Work in Progress*	
NWSSP – Accounts Payable	*Q3/4*	*Work in Progress*	

Planned output	Outline timing	Status	Assurance
NWSSP – PCS Contractor Payments	*Q3/4*	*Work in Progress*	
Clinical Governance, Quality and Safety			
11. Annual Quality Statement	Q1	Final Report	Substantial
12. Nurse Staffing Levels Act	Q3	Draft Report	Substantial
13. Management of Serious Incidents	Q2	Final Report	Reasonable
Clinical Board QSE Governance	Q3	Proposed to be removed from 20/21 plan	
14. Integrated Health Pathways	Q2/3	Work in Progress	
Information Governance and Security			
15. IM&T Control and Risk Assessment	Q3	Work in Progress	
16. Infrastructure / Network Management	Q2	To be commenced	
17. Tentacle IT System Follow-up	Q4	To be commenced	
18. Cyber Security System Follow-up	Q4	To be commenced	
Operational Service and Functional Management			
19. Specialist CB – Patient Assessment & Provision of Equipment in ALAS	Q3	Final Report	Substantial
20. Surgery CB – Theatres Directorate Sickness Absence Management	Q2	Final Report	Reasonable

Planned output	Outline timing	Status	Assurance
Medicine CB – Bank & Agency Nurses Scrutiny Process	Q3	Proposed to be removed from 20/21 plan	
21. MH CB – Outpatient Clinic Cancellations	Q3	Draft Report	Limited
22. CD&T CB – Ultra Sound Governance	Q3/4	To be commenced	
23. C&W CB – Rostering in Community Children's Nursing	Q4	To be commenced	
Workforce Management			
24. Recruitment & Retention of Staff	Q4	To be commenced	
Management of Staff Sickness Absence	Q4	Proposed to be removed from 20/21 plan	
25. Consultant Job Planning Follow-up	Q4	To be commenced	
Surgery CB – Theatres Directorate Sickness Absence Management	*Q2*	*Final Report*	*Reasonable*
C&W CB – Rostering in Community Children's Nursing	*Q4*	*To be commenced*	
Capital & Estates			
26. Environmental Sustainability Report	Q2	Final Report	Reasonable
27. Asbestos Management	Q2	Final Report	Reasonable
28. Shaping Future Wellbeing in the Community Scheme	Q4	To be commenced	

Planned output	Outline timing	Status	Assurance
29. Development of Integrated Audit Plans	Q1-4	Work in Progress	
30. UHW Surge Facility	Q3/4	Work in Progress	
31. Post Contract Audit of DHH Costs	Q4	To be commenced	

Extract from the Public Sector Internal Audit Standard Requirements

2450 Overall Opinions

When an overall opinion is issued, it must take into account the strategies, objectives and risks of the organisation and the expectations of senior management, the board and other stakeholders. The overall opinion must be supported by sufficient, reliable, relevant and useful information.

Public sector requirement

The chief audit executive must deliver an annual internal audit opinion and report that can be used by the organisation to inform its governance statement.

The annual internal audit opinion must conclude on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

Overall Opinion

The rating, conclusion and/or other description of results provided by the chief audit executive addressing, at a broad level, governance, risk management and/or control processes of the organisation. An overall opinion is the professional judgement of the chief audit executive based on the results of a number of individual engagements and other activities for a specific time interval.

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Archwilio Cymru
Audit Wales

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

Date issued: February 2021

Document reference: 1996A2020-21

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

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

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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). **This update should be read alongside the attached letter from the Auditor General for Wales which details our response to the current challenges and pressures faced by public bodies as they continue to deal with the ongoing pandemic.**

Accounts audit update

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

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2019-20 Funds Held on Trust Account	At the time of writing this update, Trustee Members were due to consider and approve the audited account and our audit report on 26 January 2021. Thereafter, the Audit General was scheduled to certify the account on 29 January. The Charity Commission's certification deadline being 31 January.
Audit of the 2020-21 Accountability Report and Financial Statements	Audit planning and testing has commenced.

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
Follow-up of Operating Theatres	February 2021
Doing it differently, doing it right? Governance in the NHS During the COVID-19 Crisis	February 2021
Annual Audit Report 2020	February 2021
2021 Audit Plan	February 2021

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Follow-up of previous IM&T recommendations Executive Lead – Director of Informatics	In 2014, we carried out work to assess progress in addressing previous IM&T related issues and recommendations. We concluded that the Health Board had made some progress, but further work was needed. At that time, we made some additional recommendations. This work will follow-up progress against these recommendations.	Draft report in clearance April 2021
Structured Assessment 2020 Supplementary Outputs	To support our annual structured assessment work, we are undertaking further work to pull together two all-Wales outputs.	All-Wales output on staff well-being being drafted April 2021*

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

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Executive Lead – Director of Public Health	for Test, Track and Protect, and of the Local COVID-19 Prevention and Response Plans for each part of Wales.	
Quality Governance Executive Lead – Director of Nursing and Patient Experience	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured assessment work across Wales which has pointed to various challenges with quality governance arrangements.	Re-scheduling / streamlining audit activities given the current challenges and pressures associated with the ongoing pandemic September 2021*
Structured Assessment 2021 (Phase 1) – Operational Planning Executive Lead – Director of Governance	Our annual structured assessment is one of the main ways in which the AGW discharges his statutory requirement to examine the arrangements NHS bodies have in place to secure efficiency, effectiveness and economy in the use of their resources. Our work in 2021 will be undertaken in two phases, as follows: • Phase 1 will examine the operational planning arrangements of each NHS body. • Phase 2 will look at the governance and financial management arrangements of each NHS body.	Re-scheduling / streamlining audit activities given the current challenges and pressures associated with the ongoing pandemic Phase 1 – July 2021* Phase 2 – September 2021*

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

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Review of Unscheduled Care Executive Lead – Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	Data analysis currently being completed. Module currently being developed focusing on Choose Well. Any further modules postponed to 2021 and replaced with work on Test, Track and Protect. TBC
Follow-up of radiology services Executive Lead – Chief Operating Officer	In 2016, we undertook a review of radiology services. The work examined the actions the health board was taking to address the growing demand for radiology services, and the extent to which those actions were providing sustainable and cost-effective solutions to the various challenges that existed at the time. We made a number of recommendations to the health board. This work will follow-up progress against these recommendations.	Scoping currently underway TBC

Good Practice events and products

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

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

Exhibit 5 – Good practice events and products

Event	Details
Mental health and wellbeing during COVID-19 (December 2020)	This webinar focussed on how public services have adapted the services they provide during the pandemic as well as their successes and challenges, focusing on: • Community based services working together to provide mental health support; • Supporting staff health and wellbeing; • How technology can be harnessed to overcome loneliness and social isolation; • What it's like to lead organisations through a pandemic; • Different approaches to providing mental health support.

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
NHS Wales Finances Data Tool	November 2020
Procurement and supply of PPE during the COVID-19 pandemic - Observations of the Auditor General as at December 2020	December 2020

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Reference: AC/245/caf
Date issued: 22 January 2021

Dear Colleague

As the public sector continues to grapple with the impact of Covid-19, I am writing to outline how I intend to approach our audit work with you over the next few months.

Firstly, however, I want to acknowledge the tremendous efforts that your organisations are continuing to make in the battle against Covid. Our on-going engagement with you throughout last year, albeit remotely, gave Audit Wales staff an insight into just how challenging this has been and also how public sector bodies have risen to that challenge. Above all, so many staff within public bodies and government departments have gone above and beyond their normal duties to keep services going and to try to keep the people of Wales safe. As Auditor General, and on behalf of Audit Wales staff, I'd like to record our continued thanks and admiration for this incredible effort and commitment.

Though roll-out of vaccine gives us all hope of some light at the end of the tunnel, I am conscious that current pressures are extreme and frontline services must be prioritised. The approach of Audit Wales remains, therefore, to take forward our work in ways which do not impede the public service response to the pandemic. We are continuing to work remotely, and I am sympathetic to the need, in some areas, to adjust the timing and focus of our work to take account of the pressures within individual public sector bodies. We will do this on a case by case basis which will mean some of our workstreams can continue to be progressed whilst others will need to be paused and either rescheduled or substituted for work which better suits the current environment. I will keep a degree of flexibility within my programmes of work to enable this. Unsurprisingly our own resources are also somewhat depleted at the moment as a result of sickness absence and staff having to adjust their daily lives around caring, home-schooling and other responsibilities, so that also has a bearing on our current activities and delivery.

My over-riding aim will be to deliver my statutory responsibilities, and to continue to comment on significant issues of public interest, in a pragmatic way which is sensitive to the pressures that services are under. To help us achieve that balance while managing the pressures on your own organisation, please continue to liaise closely with your Audit Wales engagement lead as you have done throughout the pandemic.

I hope that this is a helpful approach and update. I wish you all the very best for the challenges that lie ahead.

Yours sincerely

ADRIAN CROMPTON
Auditor General for Wales

Archwilio Cymru
Audit Wales

Doing it Differently, Doing it Right?

Governance in the NHS During the COVID-19 Crisis – Key Themes, Lessons, and Opportunities

January 2021

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

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg

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Summary

1 In times of crisis, the challenge for all public bodies is to adapt their governance systems, processes, and structures to ensure good governance is maintained. Indeed, it could be argued that maintaining good governance is more necessary than ever during a time of crisis to:

- sustain public confidence and trust;
- support agile and effective decision making;
- provide continued assurance to all relevant stakeholders; and
- facilitate post-crisis learning and recovery.

Governing during a crisis, therefore, is about doing it differently, but still doing it right.

2 As the COVID-19 crisis unfolded, it became increasingly clear there was no blueprint for governing during such unprecedented times. As a result, all NHS bodies in Wales were required to adapt their governance systems, structures, and processes and embrace new ways of working at an extraordinary pace.

3 Our structured assessment work this year provided a unique opportunity for us to see exactly how each NHS body adapted their governance systems, processes, and structures during the crisis to enable them to respond effectively to the numerous challenges and pressures posed by the pandemic.

4 We found that all NHS bodies operated effectively with a sense of urgency and a common purpose to adopt lean and agile ways of working and achieve rapid transformation whilst also maintaining a clear focus on core areas of business and governance.

5 This report provides an all-Wales summary of our structured assessment work with the aim of highlighting key themes, identifying future opportunities, and sharing learning in relation to the following areas of governance:

- putting citizens first;
- decision making and accountability; and
- gaining assurance.

> In times of crisis, the challenge for all public bodies is to adapt their governance systems, processes, and structures to ensure good governance is maintained. Indeed, it could be argued that maintaining good governance is more necessary than ever during a time of crisis.
>
> I have been assured that NHS bodies have largely maintained good governance throughout the crisis, with revised arrangements enabling them to govern in a lean, agile, and rigorous manner.
>
> The challenge now for each individual body is to fully evaluate their new ways of working, consider the opportunities outlined in this report, and maintain the sense of urgency and common purpose created during the crisis to establish and embed new approaches to governance in a post-pandemic world.

Adrian Crompton
Auditor General for Wales

1. Introduction

1.1 NHS bodies in Wales have faced unprecedented challenges and considerable pressures during the COVID-19 pandemic. Throughout this crisis, NHS bodies have had to balance several different, yet important, needs - the need to ensure sufficient capacity to care for people affected by the virus; the need to maintain essential services safely; the need to safeguard the health and wellbeing of their staff; and, the need to maintain good governance. In order to respond to these needs effectively, NHS bodies have been required to plan differently, operate differently, manage their resources differently, and govern differently.

1.2 Our structured assessment work[1] this year was designed and undertaken in the context of the ongoing pandemic. As a result, we were given a unique opportunity to see how NHS bodies have been adapting and responding to the numerous challenges and pressures posed by the COVID-19 crisis.

1.3 This report is the first of two publications which summarise the findings of our structured assessment work on an all-Wales basis with the aim of highlighting key themes, identifying future opportunities, and sharing learning both within the NHS and across the public sector in Wales more widely. This report focuses on how NHS bodies have governed during the COVID-19 crisis. Our second report will focus on how NHS bodies have supported the health and wellbeing of their staff during the pandemic, with a particular emphasis on the arrangements they have put in place to safeguard staff at higher risk from COVID-19.

1.4 In this report, we discuss the importance of maintaining good governance during a crisis and describe how NHS bodies in Wales operated differently during the pandemic in relation to the following areas of governance:

- putting citizens first;
- decision making and accountability; and
- gaining assurance.

This reports also considers the key lessons that can be drawn from the experiences of NHS bodies of governing during the COVID-19 crisis and concludes by highlighting potential opportunities for the future.

1 A structured assessment is undertaken in each NHS body to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2014, to be satisfied they have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources. Individual reports are produced for each NHS body, which are available on our website.

2. Maintaining good governance during a crisis

2.1 The systems, processes, and structures in place to maintain good governance are often placed under pressure when public bodies are reacting and responding to a crisis. This is understandable, as those systems, processes, and structures are largely designed to support and maintain good governance in normal times. In times of crisis, the challenge for public bodies is to adapt their systems, processes, and structures to ensure good governance is maintained and not weakened or overlooked in any way.

2.2 Indeed, it could be argued that maintaining good governance is more necessary than ever during a time of crisis for the following reasons:

- **Sustaining public confidence and trust** – public scrutiny is often greater during times of crisis. The public need to be assured that public bodies are responding appropriately in the public interest to the pressures and challenges they face during a crisis, and that any disruptions or changes to service provision or quality are managed, minimised, and communicated as much as possible. A failure to act in the public interest, to communicate effectively, and to maintain openness and transparency during a crisis could significantly weaken public confidence and trust in public bodies.
- **Ensuring the right decisions are made in the right way at the right time** – due to the uncertain, complex and dynamic nature of a crisis, leaders and managers need to be empowered to react and respond at pace. Agile and rapid decision making, therefore, are critical during a time of crisis. However, decision-making authority during a time of crisis needs to be clearly defined and communicated to ensure the right decisions are made by the right people in the right way at the right time. Furthermore, in the interests of openness, transparency, and accountability, decisions made during a time of crisis need to be documented accurately, accompanied by a clear rationale, and made available for inspection and scrutiny.

- **Providing continued assurance** – maintaining, and adapting where necessary, key internal controls is more necessary than ever during a time of crisis to assure stakeholders that all relevant risks are managed; that resources continue to be used efficiently and economically; and, that service quality and safety is maintained. The challenge, however, for those responsible for providing oversight and scrutiny of public bodies – both internally and externally – is not to overburden or distract leaders and managers whilst they are dealing with a crisis. Instead, the level of oversight and scrutiny should be proportionate and targeted to ensure the relevant stakeholders receive sufficient assurance over key matters during the crisis.
- **Supporting public bodies to build back better** – maintaining good governance during a crisis can support public bodies to transition effectively from the response phase of a crisis to the recovery phase by ensuring non-essential services, processes, and systems are reinstated and reintroduced in the right way at the right time. Good governance during a crisis can also support public bodies to 'build back better' by enabling them to capitalise on the opportunities created by a crisis for them to innovate, transform, and achieve greater resilience.

In short, therefore, governing during a crisis is about doing it differently, but still doing it right.

3. How health bodies governed differently during the pandemic

3.1 All NHS bodies quickly adapted their governance arrangements at the outset of the pandemic in line with their emergency plans and Welsh Government guidance.[2] The Welsh Government guidance, which was issued in May 2020, endorsed a series of principles developed by Board Secretaries which were designed to help focus consideration of governance matters during the response phase of the pandemic. The guidance also outlined key areas for the Quality and Safety Committees and Audit Committees of each NHS body to discharge during the period.

3.2 In this section, we briefly describe how NHS bodies governed differently during the pandemic, focusing in particular on their arrangements for putting citizens first, decision making and accountability, and gaining assurance.

Putting citizens first

3.3 All NHS bodies are expected to conduct their business in an open and transparent manner and actively encourage the engagement of their local populations, partners, and other stakeholders. This is achieved in a number of ways, including actively engaging partner organisations such as Community Health Councils, conducting board meetings in public, and making board and committee papers and minutes available for public inspection. However, NHS bodies have been unable to hold their meetings in public in the normal manner during the pandemic due to the need to observe social distancing guidelines and restrict public gatherings. As a result, they have been required to embrace new ways of working to maintain openness and transparency and to ensure effective engagement with all relevant stakeholders during the crisis.

3.4 We found that all NHS bodies moved swiftly to holding virtual board and committee meetings at the start of the pandemic. Although a small number of NHS bodies encountered some challenges rolling-out the necessary technology and software required to support virtual meetings, these were overcome relatively quickly. We found that all NHS bodies adapted well to virtual meetings, with participants observing suitable etiquette and using the relevant software features appropriately to ensure online meetings were conducted effectively.

2 Guidance Note: Discharging Board Committee Responsibilities during COVID19 response phase

3.5 In order to maintain openness and transparency during the pandemic, we found that NHS bodies have been using a range of different online video platforms to either live-stream or record all relevant meetings. Several NHS bodies also increased the frequency of their board meetings to provide greater public transparency on their response to the pandemic. In terms of facilitating public involvement in virtual meetings, we found that most NHS bodies have been able to support members of the public either to submit their questions in advance of a meeting or to ask their questions directly during the relevant meeting.

3.6 In addition to holding virtual meetings, we found that all NHS bodies continued to publish board and committee papers on their websites in advance of meetings. We also found that minutes of meetings were produced in a timely manner, with some NHS bodies publishing summary versions on their websites within a matter of days to enhance openness and transparency. In addition to publishing information on their websites, we found that all NHS bodies have also been making effective use of their official social media channels to provide information to the public and other stakeholders on a range of matters, including information relating to their revised governance arrangements.

3.7 We found that all NHS bodies established mechanisms to maintain regular communication with partners during the pandemic, such as Members of Parliament, Members of the Senedd, Local Authority Leaders and Chief Executives, Police Forces, Fire and Rescue Services, Community Health Councils, third sector organisations, and other health bodies within their regional footprint. In terms of Community Health Councils (CHCs), we saw examples of effective communication and joint working between some health bodies and their respective CHCs, such as:

- inviting CHC Chief Officers to participate in virtual board and committee meetings;
- sharing details of temporary services changes introduced during the pandemic with CHCs; and
- involving CHCs in quarterly operational planning arrangements, or consulting with them on draft operational plans prior to their submission to Welsh Government for approval.

Decision making and accountability

3.8 All NHS bodies are required to operate within a robust framework for decision making and accountability, which is largely codified in a series of governing documents such as Standing Orders, Schemes of Delegation, and Standing Financial Instructions. Collectively, these documents set out the arrangements within which the boards, committees, and the executive and operational structures of NHS bodies undertake their day-to-day activities, make decisions, and ensure accountability. However, during the COVID-19 crisis, all NHS bodies were required to revise their arrangements and structures in order to respond strategically, tactically, and operationally to the challenges and pressures posed by the pandemic.

3.9 We found that the majority of NHS bodies agreed temporary revisions to their Standing Orders to enable and facilitate new ways of working during the crisis; to ensure a focus on essential business and key COVID-19 related risks and matters; and, to minimise the administrative and reporting burden placed on leaders and managers during the pandemic. Whilst each body revised their Standing Orders to meet their own individual business needs and circumstances, we found some common temporary changes, including:

- standing down some board committees;
- redistributing essential committee business and postponing non-essential business;
- creating provision for streamlined agendas, including the use of a consent agenda[3] in some bodies;
- enabling focused reporting, including greater use of verbal reporting; and
- allowing Independent Members to submit questions and comments on papers in advance of board and committee meetings.

Revisions to Standing Orders were also made to enable the changes discussed previously relating to virtual meetings and public participation during the pandemic. We found that boards and committees adapted well to these new ways of working, with Independent Members continuing to provide effective scrutiny and challenge within the streamlined and virtual meeting environment.

3 A consent agenda is a technique for addressing and approving several matters in a single agenda item, such as reports, minutes, and other items that do not require discussion.

3.10 We found that all NHS bodies established formal command and control structures to enable rapid and agile decision making and ensure a coordinated response to the pandemic at a strategic, tactical, and operational level within their organisations. The command and control structures in most NHS bodies included Gold (Strategic) Groups, Silver (Tactical) Groups, and Bronze (Operational) Groups, underpinned by planning cells with responsibility for specific aspects of the response, such as securing and distributing personal protective equipment for example. All NHS bodies also had clear deputising arrangements in place to ensure resilience, responsiveness, and continuity as required.

3.11 We found that most command and control structures operated within existing frameworks for decision making. However, some NHS bodies needed to introduce temporary revisions to their Schemes of Delegation to ensure the relevant groups, managers and leaders were empowered to operate at pace during the pandemic. We found that most NHS bodies had clear arrangements in place for recording and documenting decisions, with some key decisions being published with the papers of board meetings to ensure openness and transparency.

3.12 All boards continued to meet during the pandemic, albeit virtually as noted earlier, thus allowing the corporate decision-making body of each organisation to maintain oversight of the response, hold the command structure to account, and make collective decisions on key matters during the crisis. Recognising the importance of reacting and responding at pace to the dynamic nature of the crisis, we found that each NHS body had suitable processes in place to enable Chair's actions on urgent matters. However, we found that Chair's actions were kept to a minimum and only used as a last resort in the majority of NHS bodies during the pandemic.

3.13 Some NHS bodies established temporary decision making and oversight groups involving Independent Members as part of their command and control structures. One body established a Cabinet, consisting of three Independent Members and three Executive Officers, to oversee the organisation's response and enable timely decision making and scrutiny. Another body established a Board Governance Group, which operated as a Chair's Action Group, to provide scrutiny and governance over the decision-making process as well as to provide assurance to the board that this was taking place. The membership of the Board Governance Group was restricted to the Chair, Chief Executive Officer, and two Independent Members.

Gaining assurance

3.14 All NHS bodies are required to establish and maintain a robust risk and assurance framework to ensure their boards and committees receive sufficient, timely, and reliable information that enables them to exercise good oversight of the management of risks, the quality and performance of services, and the efficient and effective use of resources. NHS bodies gain assurance from a range of internal and external sources, and report on the effectiveness of their arrangements to the public and other stakeholders via Annual Governance Statements and Annual Quality Statements. However, during the COVID-19 crisis, all NHS bodies were required to revise their arrangements to ensure the flows of assurance to their boards and committees were timely, proportionate, and covered the relevant key issues during the pandemic.

3.15 We found that all NHS bodies adapted their risk management arrangements and considered their risk appetite during the pandemic. However, only some bodies decided to increase their risk appetite during the crisis. We found that some NHS bodies established stand-alone risk registers to capture, manage, and mitigate the key risks relating to COVID-19, whereas others adapted existing risk registers to incorporate COVID-19 related risks. We found that all NHS bodies had suitable processes in place to monitor and manage strategic, tactical, and operational COVID-19 risks through their command and control structures. However, we found there were variable approaches to the oversight of significant COVID-19 risks at board and committee level, with some NHS bodies not fully utilising their committees to review and scrutinise all relevant risks during the pandemic.

3.16 We found that the Quality and Safety Committee of each NHS body continued to meet during the pandemic, with some increasing the frequency of meetings to provide timely oversight and scrutiny. The majority of committees adjusted their work programmes in line with Welsh Government guidance to enable them to maintain a handle on core quality, safety, and experience issues, as well as to provide an increased focus on the impact of COVID-19 on the quality and safety of services. We saw evidence of good information flows to boards and committees to provide assurance and enable effective oversight and scrutiny on the relevant quality and safety matters during the pandemic. However, we found there was scope to strengthen these arrangements in a very small number of NHS bodies.

3.17 In addition to providing information and assurance to Independent Members via board and committee papers, we found that all NHS bodies used a range of different approaches and mechanisms to keep their Independent Members informed and engaged during the crisis, including:

- sharing daily situational reports which provided status updates across a range of COVID-19 related indicators;
- providing written and face-to-face briefings, either on a daily or weekly basis;
- using board development sessions to highlight and discuss topics relating to the pandemic;
- providing access to the papers of command and control group meetings, mostly Gold Command Groups and Silver Command Groups;
- enabling committee chairs to meet with the relevant executive leads on a regular basis; and
- establishing virtual groups for Independent Members on online and mobile communication platforms to enable them to communicate and share information with each other on an ongoing basis.

We also found that some NHS bodies created opportunities to build knowledge, understanding and resilience across its cadre of Independent Members during the pandemic by, for example, inviting them to observe committees they do not normally sit on.

4. Key lessons and opportunities for the future

4.1 As the COVID-19 crisis unfolded, it became increasingly clear there was no blueprint for governing during such unprecedented times. As a result, NHS bodies were required to redefine their governance systems, structures, and processes and embrace new ways of working at an extraordinary pace to meet their own business needs and circumstances. Indeed, the crisis demonstrated that NHS bodies are capable of operating effectively with a sense of urgency and a common purpose to adopt lean and agile ways of working and achieve rapid transformation whilst also maintaining a focus on core areas of business.

4.2 As they slowly move towards the full recovery phase and enter a post-pandemic world, NHS bodies should seek to reflect on their experiences of governing during the crisis by evaluating fully their revised arrangements in order to:

- consider what worked well and what did not work so well;
- identify what they would do differently during another crisis; and
- establishing which new ways of working introduced during the pandemic should be retained going forward to enhance their governance arrangements for the future.

We suggest this evaluation is undertaken as part of a wider formal programme of learning within each NHS body which enables them to reflect on all aspects of their response to the pandemic in a systematic and meaningful way. Indeed, we believe the sense of urgency and common purpose created by the crisis presents a unique opportunity for each NHS body to continue encouraging, embracing, and embedding innovation, transformation and learning in all aspects of their work going forward in order to enable them to truly become learning organisations.

4.3 In terms of governance specifically, we have identified several potential opportunities for the future:

- **Virtual meetings** – virtual meetings have proven to be an efficient and effective way of working and have also enabled boards and committees to maintain and, in some respects, enhance openness and transparency. Even when restrictions on public gatherings are lifted and social distancing rules are relaxed, we believe there is scope for NHS bodies to consider sustaining virtual meetings in some form particularly given their benefits and the level of investment that occurred during the pandemic to support and facilitate virtual working.
- **Effective and efficient meetings** – all NHS bodies adopted leaner and agile ways of working during the crisis which generated less bureaucracy and enabled more effective and efficient board and committee meetings to take place. For example, using more focused and organised agendas (such as consent agendas), keeping meetings as paper light as possible, and inviting Independent Members to submit questions in advance of meetings. The use of online video platforms also forced NHS bodies to think differently about the way they organised and structured their meetings to ensure they were run as effectively and efficiently as possible in a virtual environment.
  We believe there is scope for NHS bodies to consider retaining and refining some of these new ways of working to ensure meetings continue to be as effective and efficient as possible in a post-pandemic world.
- **Agile decision making** – one of the key features of governance during the crisis in each NHS body was the introduction of structures and processes that facilitated rapid and agile decision making. For example, clinicians were empowered to make swifter decisions about patient care within revised clinical and ethical parameters, and leaders, managers, and groups were given greater autonomy to make spending decisions. Whilst all of this was necessitated by the need to react and respond at pace to the crisis, we believe there is scope for NHS bodies to consider retaining and refining agile approaches to decision making to enable and facilitate innovation, transformation and learning on an ongoing basis in a post-pandemic world. However, to enable this, each NHS body would need to review and realign their individual risk appetites and be assured they have robust internal controls in place to minimise fraud and ensure high standards of probity.

- **Reshaping strategy** – NHS bodies have been operating within shorter planning cycles during the crisis to enable them to respond appropriately to the various operational challenges and risks posed by the pandemic. As NHS bodies slowly move towards the full recovery phase, there is both a need and an opportunity for them to review and reshape their vision and priorities to ensure they're appropriate for a post-pandemic world. Indeed, the crisis has enabled some NHS bodies to deliver their priorities in certain areas sooner than expected, such as rolling-out digital health and care. Furthermore, the crisis has also highlighted the need to ensure a greater focus in other areas, such as addressing health inequalities. Reshaping their strategies for a post-pandemic work will also enable NHS bodies to reframe their Board Assurance Frameworks and refocus their risk management arrangements.
- **Focused, targeted, and integrated assurance** – adopting more efficient and leaner ways of working has enabled NHS bodies to provide focused, targeted, and in some cases, integrated assurance to their boards and committees. This has been particularly true in the context of quality assurance, with many bodies combining operational, financial, and workforce issues with core quality, safety, and experience issues. In reshaping their vision and priorities, we feel there is scope for NHS bodies to also consider redesigning their governance structures and build upon existing arrangements to provide more integrated assurance to their boards and committees in future. However, in doing so, NHS bodies should ensure sufficient attention is given to each area of assurance embedded within an integrated framework.
- **Enhanced communication** – the crisis has undoubtedly facilitated greater communication between NHS bodies and their partners, as well as enhanced communication with and between Independent Members. The use of online video platforms and official social media channels has also enabled NHS bodies to ensure visibility, provide information, and maintain ongoing engagement with their local populations and communities. We feel there is scope for NHS bodies to maintain, and enhance where possible, new forms and ways of communication introduced during the pandemic to sustain collaboration, partnership working, and public engagement in the post-pandemic world.

4.4 In conclusion, NHS bodies have adapted well to the many challenges and pressures posed by the pandemic. We have been assured that NHS bodies have largely maintained good governance throughout the crisis, with revised arrangements enabling them to govern in a lean, agile, and rigorous manner. The challenge now for each individual body is to fully evaluate their new ways of working, consider the opportunities outlined in this report, and maintain that sense of urgency and common purpose created during the crisis to establish and embed new approaches to governance in a post-pandemic world.

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Follow-up of Operating Theatres – Cardiff and Vale University Health Board

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Summary report

Introduction

1 Operating theatre services are an essential part of patient care. Efficient management of theatres results in cost effectiveness, supports the achievement of waiting-time targets and contributes to high-quality patient care.

2 Between 2011-2013, Audit Wales reviewed operating theatres across Wales. In Cardiff and Vale University Health Board (the Health Board) we concluded that 'while there were a number of initiatives underway to improve theatre utilisation, action needed to be accelerated within the context of a whole system plan for operating theatres'.

3 In 2015, Audit Wales undertook a progress review to determine whether the previous recommendations had been implemented. This work concluded that 'the health board had improved theatre utilisation through a strong focus on processes and performance management but there was not the same focus on improving service quality and addressing problems with staff engagement'. More specifically, we found that:

- the theatre improvement project was driving change through a clear focus on improving processes and performance management to improve efficiency;
- theatre utilisation and productivity had improved but the Health Board had not clearly demonstrated that its investment had led to cashable financial savings;
- problems with staff engagement and workforce capacity meant there were risks to maintaining momentum; and
- the focus on utilisation had not been matched by a strong enough focus on quality, although staff had positive views about surgical safety.

4 We made several recommendations, which focused on the need to:

- ensure that momentum is maintained to deliver the benefits of the theatre improvement project, and that staff are engaged with its aims and successes;
- ensure sufficient time and resources are given for people management and that standards are put in place for professional management and leadership; and
- ensure that quality and safety improvement initiatives are developed and led by staff.

5 As part of the Auditor General's 2019 plan for the Health Board, we have undertaken a further review to examine the progress made in addressing the recommendations set out in the 2015 review of operating theatres.

6 In undertaking this work, we have:

- reviewed data and documentation;
- asked the Health Board to self-assess its progress so far;

- interviewed staff to discuss progress, current issues and future challenges; and
- undertaken a walkthrough of theatres at the University Hospital of Wales (UHW) site.

7 We summarise our findings in the following section. **Appendix 1** provides specific commentary on progress against each of our previous recommendations. The commentary reflects fieldwork that was undertaken prior to the COVID-19 pandemic[1], however, where possible we have looked to update our findings on actions that have taken place since our fieldwork was undertaken.

Our findings

8 **Exhibit 1** summarises the status of our 2015 recommendations.

Exhibit 1: Progress status of our 2015 recommendations

Total number of recommendations	Implemented	In progress	Overdue	Superseded
6	1	5	–	–

Exhibit source: Audit Wales

9 Our follow-up work has found that the Health Board has made an effort to address the issues highlighted in the previous review, but further work is needed to implement the recommendations fully.

10 Since our previous work, the Health Board has rolled out Day of Surgery Admission (DOSA) to more specialities, largely helped by the introduction of a designated DOSA lounge in 2018. This has had a positive impact on the patient experience but the ability to roll this out further is constrained by physical space.

11 Physical space is also impacting on the roll out of a standardised approach to the pre-operative assessment processes. While there are now more specialties supported by the central pre-operative assessment service, temporary accommodation and the lack of space are impacting on the ability to expand the service further and a number of specialties are still undertaking their own assessments. The impact of COVID-19 has led to some further standardisation to the process linked to the need for patients to self-isolate and be tested prior to

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

surgery. However, capacity in the system is enabling this to happen consistently and there is concern that this will not be maintained once activity levels start increasing.

12 Since our previous review, the Theatre Improvement Project has been disbanded but there remains a commitment to driving theatre improvement. Staff engagement and morale more generally however remain a challenge. The directorate has taken steps to address this by introducing a range of new initiatives to allow staff voices to be heard and to improve communication across the directorate. However, staff opinions on these are mixed.

13 Despite efforts to provide more dedicated time and support for people management, operational pressures prior to COVID-19 were having a negative impact on workforce and organisational development. Clinical leaders identified that they were not able to devote enough time to managerial and leadership duties, and staff did not feel positive about their access to skills training or opportunities for promotion.

14 Management training has however been offered to all relevant staff members to create a more consistent approach to leadership across the directorate and qualifications have been completed by most. The impact of this training has not been monitored and there is no process in place to identify when more training is needed for staff. The directorate is in the process of writing a training package for clinical leaders to address this.

15 Improvements have been made in applying lessons learned from incidents with the introduction of the E Datix system for reporting incidents and clearer dissemination to staff of action plans following investigations into incidents. There continue however to be issues with the completeness and timeliness of WHO checklists, and more generally, the standard of estates and equipment needs to be addressed to reduce safety risk within theatres.

Recommendations

16 In undertaking this work, we have made no new recommendations. The Health Board however needs to continue to make progress in addressing our previous recommendations. The outstanding recommendations are set out in **Exhibit 2**.

Exhibit 2: outstanding recommendations

Outstanding recommendations	
R1	Ensure that momentum is maintained to deliver the benefits of the theatre improvement project which relate to process improvement, such as Day of Surgery Admission and pre-operative assessment: • prioritise the expansion of the pre-operative assessment service across specialties where doing so will achieve maximum benefit in improving quality and safety of care.
R2	Ensure that staff are engaged with the aims and success of the theatre improvement project. Where possible and beneficial, build change management capacity and leadership from within the service to ensure that service changes are properly embedded, and that operational leaders are involved in the design of their services.
R3	Ensure sufficient time and resources are given for people management, including appraisals, sickness absence management, development and delivery of training.
R4	Create standards for professional management and leadership and ensure that team leaders meet that standard.
R5	Ensure that quality and safety improvement initiatives are developed and led by service staff. These could focus on areas such as reducing surgical site infection, cleanliness, improving WHO checklist processes, applying lessons from incidents and improving patient experience.

Appendix 1

Health board progress against our 2015 recommendations

Assessment of progress

Exhibit 3: assessment of progress

Recommendation	Status	Summary of progress
R1 Ensure that momentum is maintained to deliver the benefits of the theatre improvement project which relate to process improvement, such as Day of Surgery Admission and pre-operative assessment:		
• Roll-out the Day of Surgery Admission pilot to all specialties where this will have the greatest impact on patient experience and hospital bed utilisation. Create the physical environment including efficient access to medical records to enable this service to support this service.	Implemented	Our previous review showed that the project team delivered a reasonably successful pilot using DOSA for urology patients which had a positive impact on urology bed occupancy. The Health Board's own survey also indicated that the majority of patients preferred to be admitted on the day of surgery. However, rolling out the DOSA model to other specialities was constrained by the lack of dedicated and ring-fenced admission wards at the time. After the introduction of the designated DOSA lounge in 2018, DOSA was further rolled out to include General Surgery, ENT, Colorectal and Maxillo-facial services. The benefits of DOSA include reducing hospital length of stay, the risk of hospital acquired infection, the risk of cancellation and increasing the cost saving of not staying the night before. DOSA is positive but the Health Board has not been able to roll it out

Recommendation	Status	Summary of progress
		further due to lack of physical space. There has also been an issue with patients blocking recovery because there are no beds available for them post-surgery. The Theatre Manager at UHW is putting a business case together for a seating area for patients to use post-surgery to get them out of recovery before being discharged. The recovery area in main theatres still has the same capacity and staffing as it did when there were 12 theatres pooling in, there are now 15. DOSA changed slightly during the pandemic in that patients came in and went straight to their allocated bed on a green ward rather than waiting in the DOSA lounge. However, they will be going back to using the DOSA lounge this autumn and the process that was used before. There will be enough space for social distancing in the lounge as the number of patients listed per day will be less than pre-pandemic, the same applies to recovery. The directorate however will need to keep sight of this once throughput and productivity increase post-pandemic. It is the responsibility of the admitting directorate to ensure that patients' notes are brought to the DOSA lounge 48 hours prior to the patients' To Come In (TCI) date and staff said there had not been significant issues with this.
• Prioritise the expansion of the pre-operative assessment service across specialties where doing so will achieve maximum benefit in improving quality and safety of care	In progress	Our previous review found that there was inconsistency of pre-operative approaches across specialities and we recommended that funding and clinical engagement would need to be secured to move further towards a fully centralised model. The pre-operative assessment service now includes more specialities but there are still some specialities undertaking their own pre-assessment by specialist nurses. The Health Board is working towards all patients being pre-assessed in a standardised way, but the lack of physical space has been a barrier to further expansion of the service. The current service is based on temporary accommodation. There are also

Recommendation	Status	Summary of progress
		issues around pre-assessment details being logged on paper and cancellations as a result of pre-assessment being incorrectly recorded on TheatreMan. The impact of COVID-19 shows improvements have been made in the pre-assessment process in that every patient is pre-assessed and they cannot go to a green ward until they have been assessed. All patients are required to self-isolate for the two weeks prior to their surgery and will have a COVID-19 test 72 hours before the day of surgery. However, improvements are largely due to less patients being listed and there being more capacity to pre-assess them. There is concern about what will happen to the pre-assessment process when numbers return to pre-pandemic levels. Funding and clinical engagement are needed to fully embed an improved pre-assessment process. A business case was drafted to expand pre-operative assessment, but this was put on hold when the pandemic hit. The plan is to get it included in the funding round next April. There is an opportunity to apply the learning from COVID-19 and the standardised pre-operative process across all specialities. During the fieldwork in Autumn 2019, the directorate expressed a wish to move towards an electronic pre-assessment system to provide more clarity and improve data quality issues but said there had been a lack of support from IT on this. Since then, progress has been made. The IT department are in the process of developing a draft electronic pre-assessment programme which it is hoped will be in use by the end of this year. However, funding and clinical engagement are crucial for full roll out to be possible.
R2 Ensure that staff are engaged with the aims and success of the theatre improvement project. Where possible and beneficial, build change management capacity and	In progress	Our previous review identified a lack of staff engagement in initiatives to improve theatres and that low staff morale was also inhibiting theatre improvement progress. After this review, there was a change at management level with a new general manager and the introduction of the theatre manager role at University Hospital

Recommendation	Status	Summary of progress
leadership from within the service to ensure that service changes are properly embedded, and that operational leaders are involved in the design of their services.		Llandough (UHL) and UHW to provide clarity and consistency for the accountability of the functioning of each operating theatre suite. The Theatre Improvement Project was disbanded a few years ago but there is still a commitment to driving theatre improvement. There has been an effort to empower clinical leaders to take more of a leadership role. Training has been offered for this and they are also encouraged to hold frequent team meetings within which staff can raise issues and concerns. There have also been some initiatives to improve staff morale and engagement. For example, staff forums, drop-in sessions and staff newsletters. However, staff opinion of these is mixed, with some feeling that they were UHW focussed. At the time of our fieldwork, morale amongst staff was low due to lists being cancelled or over running, lack of appropriate equipment and lack of career progression from band 5 to 6. Staff were also frustrated with IT issues. For example, ESR and Roster PRO are not lined up, meaning that leave requests can be requested electronically but are approved on paper resulting in confusion and inaccuracies. The Health Board has identified that morale is an issue and are working on a new workforce plan for theatres to address issues such as recruitment, retention and career progression. A Staff Engagement Plan was developed in 2018 but progress has not been evaluated. A staff survey was conducted in February 2020 and the results and proposed actions were circulated to staff in a letter. The Lead Nurse and General Manager are also trying to ensure staff can voice concerns by arranging sessions for staff to come and talk to them. The management are aware that lists will be large following the pandemic and they will need to develop new models. Management should ensure staff are engaged and involved in service changes relating to this.

Recommendation	Status	Summary of progress
R3 Ensure sufficient time and resources are given for people management, including appraisals, sickness absence management, development and delivery of training.	In progress	Several efforts have been made to provide dedicated time and support for workforce and organisational development responsibilities. For example; HR have offered support and training around sickness management, absence policies and handling difficult conversations. Establishments have been developed so that Clinical Leaders have 50% of their time assigned to managerial and leadership duties but it was clear from staff during fieldwork that in practice they had 10-20% of their time for these duties, or were carrying them out during their own time. Our previous review found that staff felt the audit day programme was not as effective as it could be, and they were often not released because operational service pressures meant that they were needed in surgery for emergency lists. Although this is rare, more could be done to ensure the same teams do not miss multiple audit days. There was also concern amongst some staff that communication about training was poor with a perception that it was UHW focussed. On the whole, training is provided at UHW because there are more facilities there. However, more could be done to offer training and support for personal development to all, particularly because the most recent staff survey in February 2020 highlighted that 50% of staff do not feel positive about their access to skills training and 60% disagreed they could see opportunities for promotion. PADR compliance has been less than 50% over the last year due to pressures on staff time to complete them, and an unreliable IT system. The directorate is aware of this and has escalated it to the relevant department. A Values Based Appraisal process, which supports staff to translate the organisation's values into everyday actions, decisions and behaviours, has been rolled out across the Health Board. The directorate is committed to this and has pledged to work with staff and managers to ensure sufficient time for this to be completed regularly. The impact of COVID-19 means that staff do have more time now for administrative based tasks because fewer patients are being listed, but it is not clear what will

Recommendation	Status	Summary of progress
		happen when numbers go back to pre-pandemic levels. It has been difficult to plan for audit and training days because they do not have the rooms and space to conduct them with sufficient social distancing. All audits and training sessions have been put on hold during the pandemic.
R4 Create standards for professional management and leadership and ensure that team leaders meet that standard.	In progress	All band 7 and 8 staff have undertaken a management programme at a minimum of level 3 and approximately 75% of band 6 staff have undertaken a level 2 qualification but it is not clear how they are monitoring the impact of this training or identifying whether more needs to be done. There is also nothing concrete about what is expected of clinical leaders beyond the job description. However, the directorate is in the process of writing a training package for clinical leaders which would include things such as: various HR policies, Values Based Appraisal training, managing incidents and concerns, and health and safety. Clinical Leaders that are already in post will also be updated on these various subjects once the Clinical Leaders meetings, which have been postponed during the pandemic, are resumed.
R5 Ensure that quality and safety improvement initiatives are developed and led by service staff. These could focus on areas such as reducing surgical site infection, cleanliness, improving WHO checklist processes, applying lessons from incidents and improving patient experience.	In progress	Our previous review found that end-of-session debriefings were not regularly completed, and we identified this as an area for significant improvement. During this review, all staff were aware of the importance of the WHO Checklist, but they indicated there were still issues with timeliness of completeness of end-of-session briefings, particularly within trauma theatres. Routine audits were postponed during the start of the pandemic, but they have restarted now. The directorate are going to look at the root cause of why there are some issues with end-of-session briefings.

Recommendation	Status	Summary of progress
		The staff survey as part of our original review showed that more than 50% of staff disagreed that information obtained through incident reports was used to make patient care safer in operating theatres. Since then the organisation has introduced the E Datix system for the reporting of incidents. This system has improved the management of incidents within the operating theatre environment. A Root Cause Analysis is a common tool used within the directorate when investigating serious incidents. The action plans from these are developed by the clinical team and disseminated through the directorate to share learning and reduce the risk of similar incidents reoccurring. The directorate also has regular Quality and Safety meetings which are attended by a range of staff across a number of roles and ensure that messages are disseminated to all staff. Assurance and exception reports are also fed into the wider surgery clinical board Health and Safety meetings. A programme of audits is also in place to review quality and safety indicators. When observing main theatres at UHW, we noticed issues around the standard of the estates and equipment, and the lack of suitable places to store equipment which posed a health and safety risk. However, we know management are aware of these risks and are doing everything they can to escalate issues to Health and Safety meetings and inform the clinical board. We highlighted in the last review that whilst the Health Board had undertaken patient experience reviews of the pre-operative process, it had not done for the time spent during surgery or immediately after recovery. The directorate are aware of this and the Lead Nurse will be meeting with a patient experience contact to discuss how they can start introducing intra operation surveys.

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

Report Title:	**Declarations of Interest, Gifts, Hospitality & Sponsorship**									
Meeting:	**Audit & Assurance Committee**						**Meeting Date:**	**9th February 2021**		
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**	**X**		
Lead Executive:	**Director of Corporate Governance**									
Report Author (Title):	**Head of Risk and Regulation**									

Background and current situation:

As previously agreed by the Audit & Assurance Committee an update on Declarations of Interest, Gifts, Hospitality and Sponsorship would be provided to each Audit Committee for information. This report provides an up to date for the Financial Year 2020/21.

As the Health Board has begun to return to business as usual the Risk and Regulation Team have been able to re-commence its Standards of Behaviour communication plan.

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

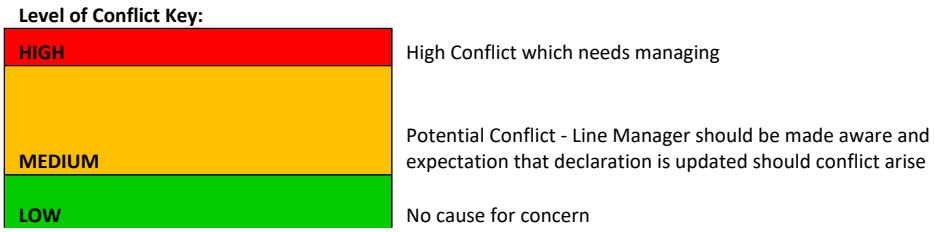
The Risk and Regulation team continue to work with colleagues from Betsi Cadwaladr University Health Board to put in place Declarations of Interest software from April 2021. The use of this software will modernise how the Risk and Regulation Team record and report on Declarations of Interest, Gifts, Hospitality and Sponsorship with the intention that a more comprehensive register of interests is collated and maintained year on year.

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

Following September's meeting, when 8 Declarations had been submitted, a further 705 Declarations have been received and included on the Health Board's Declarations of Interest register from 1 April 2020. These have been RAG rated as follows:

- One Hundred and forty four (144) Declarations of Interest declared (up from 26 in November 2020); three of which present as a potential conflict with the others presenting as no cause for concern. Those entries presenting as potential conflicts are categorised as follows:
  - One declaration that would only arise in procurement scenarios and would be picked up by the Health Board's internal procurement systems in the event that a potential conflict could be perceived; and
  - Two declarations that concern external appointments and interests. The declarants for these interests have been asked to complete appropriate Secondary Employment and Interest forms so that they can be formally considered and managed by an appropriate line manager.

- Five Hundred and sixty nine (569) Declarations of Interest with 'No Interest' declared (up from 72 in November 2020) which present no cause for concern
- Eleven (11) Declarations of Gifts (up from 3 in November 2020) have been made. which present no cause for concern albeit 6 of those declarations await further approval and sign off from an appropriate line manager.



To date 713 Declarations have been received for the year 2020/21 (up from 109 in November 2020). Whilst it is accepted that this number will need to improve, assurance should be taken from the significant increase in returns since November's Committee meeting and the predicted increases expected over the coming months following the implementation of the Risk and Regulation Team's Communications Plan.

Following a further email targeting colleagues employed at Band 8A and above in January it is predicted that the number of declarations received will increase significantly again in April.

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

The management of the Standards of Behaviour Policy by the Corporate Governance Team should provide the Audit and Assurance Committee with assurance that adequate systems are in place for the ongoing monitoring of conflicts of interest and the declaration of gifts and hospitality.

Further assurance should be taken from the Corporate Governance Team's ongoing work with the Health Board's Countefraud Department for the investigation of specific cases and also following recent developments that will allow Declarations to be lodged and recorded through soon to be acquired specialist software which will allow a more efficient and all encompassing approach to be taken to the recording of declarations.

Recommendation:

The Audit & Assurance Committee is asked to:

- **NOTE** the ongoing work being undertaken within Standards of Behaviour.
- **NOTE** the update in relation to the Declarations of Interest, Gifts, Hospitality & Sponsorship Register.

Shaping our Future Wellbeing Strategic Objectives

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

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

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

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

Appendix 1 – Communications Plan

September 2020 Reminder issued in CEO connects. ESR advert published advertising the ability to submit DoI returns via ESR and reminding all staff members Band 8A and above of the requirement for them to submit a return.	CEO Connects communication circulated on 30/09/2020
October 2020 Global Email circulated and posters distributed across Health Board sites. Circulation of posters to main sites and outlying areas to ensure that those areas without access to emails are aware of the requirement to submit returns.	Email circulated 08/10/2020
November 2020 Email reminder to all Band 8A employees and above to submit their Declaration of Interest. Governance Team Social Media page to be established to capture additional declarations and target staff members without regular access to work emails.	Update on 8A responses to be shared at April's Audit and Assurance Committee
December 2020 Global email and CEO connects updated to be circulated specifically reminding staff of our Gifts and Hospitality policies.	Gifts and Hospitality Poster shared online and via CEO connects (Poster attached)
January 2021 A Global Declaration of Interest global email and CEO Connects update will be circulated. The content and tone of this will be dependent on the present position of the returns we have.	A further email circulated to target responses from colleagues employed at Band 8A and above was circulated.
February 2021 Covid Restrictions Dependent – A Declaration of Gifts and Hospitality update will be shared linked to the 6 nations.	
March 2021 Final DoI request of 2020/21 to be circulated for year end. Updated DOI's to be requested from all Executives and IM's for end of year reports.	
April 2021 New annual plan to be agreed.	

COVID-19 AND GIFTS FROM PATIENTS

If a patient would like to give you a gift this Christmas, you must consider how you can receive it safely, minimising the risk of transmission of COVID-19.

Remember to maintain a safe two-metre distance, wear a face covering, wash your hands and keep social interaction to a minimum.

Your responsibilities for receiving gifts

- Accept and enjoy gifts worth up to £20
- Decline any gifts worth more than £20
- Decline any cash, tokens, gift cards or vouchers
  Cash donations can be made to the Cardiff & Vale Health Charity
- Contact Corporate Governance for guidance on whether you can accept any offers of hospitality

Don't forget that online donations can be made to the Cardiff & Vale Health Charity

High Conflict which needs Managing
Potential Conflict - Line Manager should be aware and expectation that declrations is updated should conflict arise
No cause for concern

Level of Conflict	First Name	Surname	Position held in UHB	Directorate / Speciality	Band	Clinical Board / Corporate Dept	Date Form Returned	Interests to Declare (Yes/No)	Third Party Declaration eg Spouse/Partner (Yes/No)	UHB Address:	UHB Tel No:	Confirmed read & understood Standards of Behaviour Framework Policy	a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies
Low	Anna	Burgess	Pharmacist Team Leader	Pharmacy	8b	CD&T	29/09/2020	Yes	No	UHW	029 2184 4975	Yes	N/A
Low	Adam Joshua	Cann	Trainee Clinical Psychologist	Clinical Psychology		CD&T	29/09/2020	Yes			7545090589	Yes	N/A
Low	Ian	Williams	Paediatric Clinical Nurse Specialist	Children's Centre, St David's Hospital		Children & Women	08/10/2020	Yes	No	St David's Hospital	2920536789	Not Ticked	N/A
Low	Lynda	Jenkins	Nursing Informatics Lead	Corporate Nursing		Corporate Nursing	09/10/2020	Yes	No	UHL		Yes	N/A
Low	Alex	Speakman	PN Pharmacist	Pharmacy		CD&T	09/10/2020	Yes	No	UHW	02920 748109	Yes	N/A
Low	Claire	Main	Interim General Manager of Criticare Care and Major Trauma	Critical Care and Major Trauma		Specialist Services	09/10/2020	Yes	No	UHW	ext 45069	Yes	N/A
Low	Tanya	Burton	Myeloma Clinical Nurse Specialist	Haematology		Specialist Services	12/10/2020	Yes	No	UHW	7989168352	Yes	N/A
Low	Julie	Highfield	Consultant Clinical Psychologist /Associate Director	Critical Care		Specialist Services	12/10/2020	Yes	Yes	UHW	45114	Yes	N/A
Low	Kim	Atkinson	Strategic Lead Occupational Therapist	Therapies / Occupational Therapy		CD&T	12/10/2020	Yes	No	UHL	Ext 24893	Yes	N/A
Low	Michael	Pruski	Healthcare Scienctist (Evaluation)	Medical Physics and Clinical Engin	6	CD&T	12/10/2020	Yes	No	Medicentre	02921 848676	Yes	N/A
Low	Natalie	Robertson	Principal Physiotherapist in Mental Health	Physiotherapy		CD&T	13/10/2020	Yes	Yes	UHL	02921 824652	Yes	N/A
Low	Laura	Gwyther	CART Clinical Nurse Specialist	Haematology		Specialist Services	13/10/2020	Yes	No	UHW	Ext 48494	Yes	N/A
Low	Jessica	Hodges	Physiotherapist	Frailty	5		13/10/2020	Yes	No	UHW		Yes	N/A
Low	Laura	Price	Assistant Psychologist	Neuroscience		Specialist Services	13/10/2020	Yes		Rookwood Hospital	02920 313713	Yes	N/A
Low	Richard	Whitson	Consultant Vascular Surgeon	General Surgery		Surgery	14/10/2020	Yes	No	UHW	Ext 43356	Not Ticked	N/A
Low	Jill	Lubienski	Family Therapist	SHED	8a	Mental Health	14/10/2020	Yes	No	Global Link	2921 832200	Yes	N/A
Low	Debbie	Roberts	Health Visitor	Flying Start	7	Children & Women	15/10/2020	Yes	No	Eastmoors Road	029 2035 1375		N/A
Low	Nicola-Xan	Hutchinson	Consultant in Acute Respiratory Medicine	Medicine/Respiratory		Medicine	15/10/2020	Yes	No	UHL	2920716847	Yes	N/A
Low	Andy	Lodwick	Lead Clinician Psychological Therapy Hub	Psychology		Mental Health	19/10/2020	Yes	Yes	UHL	2183 22249	Yes	N/A
Low	Ieuan	Davies	Consultant Paediatric Gastroenterologist	Child Health		Children & Women	26/10/2020	Yes	Yes	UHW	029 2074 8789	Not Ticked	N/A
Low	Jonathon	Gray	Interim Director of Transformation and Informatics	Executive	Executive	Executive	04.02.20	Yes	Yes	UHW		Not Ticked	Previous role as CEO of SWAHSN - a Limited by guarantee Wife owns private company delivering training resilience training Brother-in-law Director of Ernst Young
Low	Ceris	Devereux	Public Health Dietitian	Nutrition and Dietetics		Community Dietetics	10.09.20	Yes		UHW	2920907698	Yes	N/A
Low	Kate	Littler	Principal Clincal Psychologist	Haematology		CD&T	11.03.2020	Yes	No	UHW	45558	Yes	N/A
Low	Mary	Hart	Consultant Radiologist	Radiology, Medical Physics, Clinical Engineering		CD&T	12.11.20	Yes	No	UHW	2920743538	Yes	Director Hart-Jones Consultancy LTD
Medium	Scott	Gable	Cellular Pathology Service Manager / lead Biomedical Scientist	Cellular Pathology and Mortuary Service, Laboratory Medicine	8b	CD&T	12.11.20	Yes	No	UHW		Yes	Director - Labxcell Ltd
Low	Paul	Davis	Consultant Paediatrician	Child Health	Consultant	Children & Women	12.11.20	Yes	No	St David's Hospital	2920536825	Yes	N/A
Low	Kenneth	May	Consultant Cellular Pathology	Cellular Pathology and Mortuary Service, Laboratory Medicine	Consultant	CD&T	12.11.20	Yes	No	UHW	48040	Yes	STTC Limited
Low	Declan	Coleman	Clinical Scientist	Medical Physics	8b	CD&T	12.11.20	Yes	No	UHW	42015	Yes	N/A
Low	Anna	Kuczynska	Clinical Board Director	PCIC	8+	PCIC	12.11.20	Yes	No	Woodland House		Yes	N/A
Low	Justyna	Witczak	Consultant Physician	Medicine	Consultant	Medicine	12.11.20	Yes	No	UHW	42341	Yes	N/A
Low	Rhys	Hewett	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	12.11.20	Yes	No	UHW	44687	Yes	N/A
Medium	Jared	Torkington	Consultant	General Surgery	Consultant	Surgery	12.11.20	Yes	Yes	UHW	44158	Yes	Director - Moondance Cancer Initiative Wife is a director of Cardiff Medical Ev... company that organises meeetings an...
Low	Andrew	Wood	Consultant	Radiology	Consultant	CD&T	12.11.20	Yes	Yes	UHW	3955	Yes	N/A
Low	Stefan	Schwarz	Consultant Radiologist	CD&T	Consultant	CD&T	16.11.20	Yes	No	UHW	43042	Yes	N/A
Low	Robert	Kidd	Consultant Psychologist	Mental Health	Consultant	Mental Health	16.11.20	Yes	Yes	UHL		Yes	N/A
Low	Ulrich	Von Oppell	Consultant Cardiac Surgeon	Cardiac Services	Consultant	Specialist Services	16.11.20	Yes	No	UHW	45078	Yes	Director - U & C Von Uppell Ltd
Low	Matthew	Boyd-Anderson	Physiotherapy Technical Instructor	Therapies		CD&T	19.05.2020	Yes	No	UHW		Yes	N/A
Low	Robert	Bauld	Principle Clinical Engineer / Design & Manufacture Team Leader / Health and Safety Coordinator	Artificial Limb and Appliance Service		Specialist Services	22.09.20	Yes	No	Treforest	01443 661799	Yes	N/A
Medium	Stuart	Walker	Executive Medical Director	Executive	VSM	Executive	30.09.20	Yes	Yes	UHW	2921836001	Yes	Sister - Gilead employee, Father ILC C... healthcare companies we may have re...
Low	Andrew	Vidgen	Consultant Psychologist	Mental Health	8c	Mental Health	15.04.20	Yes	No	Whitchurch Hospital	2921832610	Yes	N/A
Low	Thomas	Pembroke	Consultant Gastroenterologist	Gastroenterology	Consultant	Medicine	12.11.20	Yes	No	UHW	45608		N/A
Low	Richard	Hughes	Consultant Anaesthetist	Peri-Operative Care	Consultant	Surgery	12.11.20	Yes	No	UHW	44139	Yes	Director of R H Health Ltd (to manage ... anaesthetic activities undertaken outsi... contract)
Low	Matthew	Morgan	Consultant in ICU	Critical Care	Consultant	Specialist Services	12.11.20	Yes	Yes	UHW	7760220095		Matt PG Morgan Ltd, Director - Author/... Business for a book publishing about I... Spouse - Matt PG Morgan Ltd, Director... Author/Writing Business
Low	Simon	White	Consultant Orthopaedic Surgeon	Trauma and Orthopaedics	Consultant	Surgery	12.11.20	Yes	No	UHW	48044	Yes	Director, Simon P White Ltd
Low	Ryan	Trickett	Consultant Head Surgeon	T&O	Consultant	Surgery	12.11.20	Yes	Yes	UHL	25234		Director: Vale Hand Surgery (Private P... Dragon Locums Spouse - Director: Vale Hand Surgery ... GP Partner
Low	Daniel	Morris	Consultant Ophthalmologist	Opthalmology	Consultant	Surgery	13.11.20	Yes	Yes	UHW	42083	Yes	Dan Morris Ltd Spouse: Director
Low	Jamie	Hayes	Pharmacist	AWTTC	8d	CD&T	13.11.20	Yes	Yes	UHL	26869	Yes	Director of JMH Collaborations
Low	Catherine	Donan	Director of Health and Social Services Integration	Health and Social Services	9	Health and Social Services	12.11.20	Yes	No	Strategic Planning	07983 613875	Yes	No
Low	Natalie	Elliot	National AHP lead for Dementia	Mental Health	8D	Mental Health	13.11.20	Yes	Yes	Academic Centre UHL	7811020008	Yes	No
Low	Joon	Wong	Specialty Doctor in Paediatric Cardiology	Child Health	8+	Children & Women	13.11.20	Yes	No	Childrens Hospital for wales	02920 744743	Yes	No
Low	Sarah	Hale	Consultant Opthalmologist	Ophthalmmology	Consultant	Surgery	8.04.20	Yes	No	UHW	02920 748249	Yes	N/A
Low	Peter	O'Callaghan	Medical Consultant	Cardiothoracic	Consultant	Specialist Services	13.11.20	Yes	No	UHW		Not Ticked	Dr Peter O'Callaghan Ltd
Low	Claire	Ganderton	Senior Pharmacist	AWTTC	8b	CD&T	13.11.20	Yes	Yes	UHL	2921 826900	Yes	Director Spouse / Partner - Director
Low	Libby	Erin	Consultant Clinical Psychologist	Child Psychology	8c	Children & Women	13.11.20	Yes	No	Global Link		Yes	N/A
Low	Abraham David	Theron	Consultant Anaesthetist, CD Perioperative Care	Anaesthetics	Consultant	Surgery	13.11.20	Yes	No	UHW	43256	Not Ticked	N/A
Low	Philip	Smith	Consultant Neurologist	Neuroscience	Consultant	Specialist Services	13.11.20	Yes	No	UHW	0292074 2834	Yes	N/A
Low	Christopher	Hingston	Consultant Critical Care	Critical Care	Consultant	Specialist Services	13.11.20	Yes	Yes	UHW		Yes	N/A
Low	Richard	Cousins	Consultant in Immunology	Immunology	Consultant	Specialist Services	13.11.20	Yes	No	UHW	02920 748338	Not Ticked	N/A
Low	Ruth	Walker	Executive Nurse Director	Executive	VSM	Executive	13.11.20	Yes	No	Woodland House	36006	Not Ticked	N/A
Low	Andrew	Goringe	Consultant in Haematology	Haematology Laboratory	Consultant	CD&T	13.11.20	Yes	No	UHW	42033	Yes	N/A
Awaiting updated form	Gareth	Thomas	Consultant in Gastroenterology	Gastroenterology	Consultant	Medicine		Yes	No	UHW		Yes	N/A
Low	George	Eralil	Consultant Neurosurgeon	Neuroscience	Consultant	Specialist Services	13.11.20	Yes	No	UHW	46851	Yes	Director of my own PLC
Low	Kenneth	Lim	Consultant Obs & Gynae	Obs & Gynae	Consultant	Children & Women	13.11.20	Yes	No	UHW	41249	Yes	N/A
Low	Katie	Pink	Respiratory Consultant	Medicine	Consultant	Medicine	13.11.20	Yes	No	UHL	25088	Yes	N/A
Low	Joanne	May	Locum Consultant Paediatric Rheumatologist	Child Health	Consultant	Children & Women	13.11.20	Yes	No	UHW	43400	Not Ticked	N/A
Low	Lena	Thia	Consultant in Paediatric Respiratory Medicine	Child Health	Consultant	Children & Women	13.11.20	Yes	No	UHW	43530	Yes	N/A
Low	Aleksander	Marin	Consultant Radiologist	Radiology	Consultant	CD&T	14.11.20	Yes	No	UHL	25563	Yes	N/A
Low	Timothy	Sheppard	Locum Consultant O&G	Obs & Gynae	Consultant	Children & Women	16.11.20	Yes	No	UHW		Not Ticked	N/A
Low	Peter	Groves	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	15.11.20	Yes	Yes	UHW	43533 / 42354	Yes	Director of Groves Cardiology Services (Wife - Dr Andra Helen Groves) Direct... Shareholder in Groves Caridology Serv...
Low	Angela	Miser	Associate Specialist, Paediatric Haematology / Oncology	Acute Child Health	Consultant	Children & Women	15.11.20	Yes	Yes	UHW	48805	Yes	N/A
Low	Stuart Ashley	Roberts	Consultant Radiologist	Radiology	Consultant	CD&T	15.11.20	Yes	No	UHW	45207	Not Ticked	N/A
Low	Sarah	Hunt	Consultant Anaesthetist	Anaesthetics and Critical Care	Consultant	Specialist Services	15.11.20	Yes	No	UHW		Yes	Vale Anesthetics Ltd
Low	Jessica	Quirke	Consultant Clinical Neuropsychologist	Neuroscience	8c	Specialist Services	16.11.20	Yes	No	Rookwood Hospital	02920 313748	Yes	N/A
Low	Mark	Stacey	Consultant Anaesthetist	Anaesthetics	Consultant	Surgery	16.11.20	Yes	No	UHL	2920716860	Yes	N/A
Low	Mathew	Hoskins	Locum Consultant Psychiatrist	Adult Psychiatry	Consultant	Mental Health	16.11.20	Yes	No	Barry Hospital	1446 454300	Yes	N/A
Low	Roger	Maggs	Laboratory Manager	Dental	8c	Surgery	16.11.20	Yes	No	UHW	42411	Yes	N/A
Low	Christopher	Lewis	Interim Executive Director of Finance	Finance	VSM	Executive	13.11.20	Yes	Yes	Woodland House	41507	Yes	N/A
Low	Peter	Lindsay	Locum Consultant	Obs & Gynae	Consultant	Children & Women	13.11.20	Yes	No	UHL	21841268	Yes	N/A
Low	Nicholas	Drage	Consultant in Dental and Maxillofacial Radiology	Dental	Consultant	Surgery	12.10.20	Yes	No	UHW		Not Ticked	N/A
Low	Paul	Hodgson	Consultant Trauma and Orthopaedic Surgeon	Trauma and Orthopaedics	Consultant	Surgery	16.11.20	Yes	No	UHL	2071 5677	Yes	N/A
Low	Ramsey	Sabit	Consultant Physician in General and Respiratory Medicine	Medicine	Consultant	Medicine	16.11.20	Yes	No	UHL		Yes	Director of Ramsey Sabit Ltd. This is ... earnings from private practice Spouse is a fellow share holder and di... "Ramsey Sabit ltd"
Low	Kathryn	Allen	Community Pharmacy Advisor	Pharmacy	8a	PCIC	16.11.20	Yes	No	Woodland House	36156	Yes	Davies Homes Ltd
Low	Rhiannon Meleri	Morgan	Consultant in Cellular Pathology	Cellular Pathology	Consultant	CD&T	16.11.20	Yes	No	UHW	41988	Yes	N/A
Low	Dennis Llewellyn	Cochlin	Locum Consultant Radiologist	Radiology	Consultant	CD&T	16.11.20	Yes	No	UHW	43572	Yes	N/A

First Name	Surname	Start - End Date	Financial / Other Benefits	b) Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the UHB	Start - End Date	Financial / Other Benefits	c) A personal or departmental interest in any part of the pharmaceutical/healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Start - End Date	Financial / Other Benefits	d) Sponsorship or funding from a known NHS supplier or associated company/subsidiary	Start - End Date	Financial / Other Benefits	e) A position of authority in a charity or voluntary body in the field of health and social care	Start - End Date	Financial / Other Benefits	f) Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Start - End Date	Financial / Other Benefits	g) Employment/self employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	Start - End Date	Financial / Other Benefits	h) I undertake to notify the UHB of any changes which may occur within four weeks from the date of the change, in writing to the Corporate Risk and Governance Office. Please return completed forms to cav.declarations@wales.nhs.uk	i) I confirm that the information accurately reflects my interests and those of my family and understand that relevant information will be included in the Register which is available for public inspection	Signed	Date	Document Saved in Corporate Governance *NB: For Office Use Only*	Escalation/Other details:	Level of Conflict Key:
Anna	Burgess	N/A	N/A	N/A	N/A	N/A	The Neonatal and Paediatric Pharmacists Group (NPPG) have corporate partners (pharmaceutical companies) who pay the organisation for benefits such as access to professionals for advisory meetings. I attend these as an NPPG executive committee member.	2018 - Ongoing	Sponsorship to NPPG	Annual attendance at Neonatal and Paediatric Pharmacists Group (NPPG) Conference - this is an event sponsored by multiple pharmaceutical companies.	Nov 12 Ongoing	Delegate fees are reduced thanks to the sponsorship received	Member of the Neonatal and Paediatric Pharmacists Group (NPPG) executive committee and their Information Officer.	Nov 11 - ongoing	SLA in place with WMIC to fund this position which is done as a team role. Personal expenses paid for attending meeting	N/A	N/A	N/A	Presented healthcare professional educational sessions on excipients in medicines for children at events sponsored by Desitin Pharma Ltd and Proveca Ltd.	July 20 - Nov 20	Honoraria received		Yes	Anna Burgess	29.09.20	Yes		
Adam Joshua	Cann	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Self employment as CBT therapist working with Efficacy Ltd	16/06/20 - ongoing	Yes	Yes	Yes	Adam Joshua Cann	15/10/2020	Yes		
Ian	Williams	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Tutoring with the Open University - Nursing	01/10/2020	Salary	Yes	Yes	Ian Williams	01/10/2020	Yes		
Lynda	Jenkins	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake hospital inspections in other health boards/ private health care in Wales on invitation from health inspectorate Wales. These are infrequent.			N/A	N/A	N	Yes	Yes	Lynda Jenkins	08/10/2020	Yes		

High Conflict which needs Managing
Potential Conflict - Line Manager should be aware and expectation that declrations is updated should conflict arise
No cause for concern

Low	Elijah	Ablorsu	Consultant Transplant and General Surgeon	Nephrology and Transplant	Consultant	Specialist Services	16.11.20	Yes	Yes	UHW	46647	Yes	Medlap Ltd, E&G Senior Care Ltd Spouse: Medlap Ltd, E&G Senior Care Ltd	MedLap 20/01/2012; E&G SC ltd: 22/1/2016 MedLap 20/01/2012; E&G SC ltd: 22/1/2016		E&G Senior Care Ltd E&G Senior Care Ltd			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	PP - Spire Cardiff		Yes	Yes	Yes	Elijah Ablorsu	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Pippa	Mundy	Consultant Clinical Psychologist	Child Health	Consultant	Children & Women	16.11.20	Yes		Global Link	07976 702638	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Orbis Education & Care	2014	Payment for clinical services	Independent practice as psychologist	2014	Payment for clinical services	Yes	Yes	Pippa Mundy	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Thomas	Hockey	Consultant Histopathologist	Cellular Pathology	Consultant	CD&T	16.11.20	Yes	Yes	UHW	41986	Not Ticked	Director Director / Secretary	Dividend Dividend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Thomas Hockey	16.11.20	Yes	Secondary Work Form sent 26.11.20
Low	Rona	Aldridge	Clinical Psychologist / Clinical Lead of the Integrated Autism Service	Psychology and Psychological Therapies / Autism	8b	Mental Health	12.11.20	Yes	No	Avon House	2921824240	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I do some private work in my capacity as a psychologist - autism assessments, sometimes interventions and court reports. I do not assess anyone for autism in CAV UHB in a private capacity.	2012 - current	Financial	Yes	Yes	Rona Eldridge	12.11.20	Yes	Secondary Work Form sent 30.11.20
Low	Peter	Welsh	Senior Hospital General Manager Llandough/Barry	Executives / Corporate	VSM	Executive	17.11.20	Yes	Yes	UHL	20715698	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Magistrate - Cardiff Bench	1989 - ongoing	N/A	N/A	N/A	N/A	Wife - Optician for Roberts Opticians Whitchurch Road, Cardiff Son has own web design business	1985 - ongoing 2014 - ongoing		Yes	Yes	Peter Welsh	17.11.20	Yes	
Low	Naushad Ali	Junglee	Consultant in Acute Medicine and Nephrology	Acute Medicine	Consultant	Medicine	17.11.20	Yes	No	UHL	46645	Yes	NAJ Clinical Services PLC. A PLC set up by me for the purposes of private medical practice	2018 - current	private practice earnings	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Nephrologist at Spire Hospital Cardiff	2017 - current	Private Practice earnings are paid	Yes	Yes	Naushad Ali Junglee	17.11.20	Yes	Secondary Work Form sent 30.11.20
Low	Menna	Jones	Clinical Lead	Mental Health	8c	Mental Health	16.11.20	Yes	No	Global Link	02921 832200	Yes	Director of Vegan International Ltd	24.12.19 - ongoing	none	Self employed as complementary therapist	2018 - ongoing	sessional payments		N/A	N/A	N/A	N/A	N/A	Director of British Eating Disorders Society	10.01.18 - ongoing	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Menna Jones	16.11.20	Yes	Secondary Work Form sent 30.11.20
Low	Sarah	Bailey	Senior Specialist Speech & Language Therapist	Neuropsychiatry Service	7	Mental Health	17.11.20	Yes	No	Hafan y Coed	24853	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I occasionally provide independent speech and language therapy assessment for case managers in brain injury litigation. The patients seen are always outside of the geographical and clinical remit of my cardiff and vale caseload.	current		Yes	Yes	Sarah Louise Bailey	17.11.20	Yes	Secondary Work Form sent 30.11.20
Low	Patrick	Fielding	Consultant Radiologist	Radiology	Consultant	CD&T	17.11.20	Yes	No	UHW	46959	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	received travelling expenses and a lecturing fee for a GE molecular imaging smyposium	Aug-18	Lecturing fee and travel	N/A	N/A	N/A	N/A	N/A	N/A	I undertake a small amount of private practice during my work at the UHB both in NM and via PETIC . I do not consider that these constitute a conflict of	Sept 2010 - ongoing	fee per patient basis	Yes	Yes	Patrick Fielding	17.11.20	Yes	Secondary Work Form sent 30.11.20
Low	Robert	Bleehen	Medical Consultant	Consultant Radiologist	Consultant	CD&T	17.11.20	Yes	Yes	UHL	26583	Yes	Cardiff Medical Consultant Ltd (Director) Partner: Cardiff Medical Consultant Ltd (Director)			Cardiff Medical Consulting Ltd Partner: North Cardiff Medical Centre (Partner) and Cardiff Medical Consultant Ltd			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff Medical Consultant Ltd (Director) Partner: Cardiff Medical Consultant Ltd (Director)			Yes	Yes	Robert Bleehen	17.11.20	Yes	Secondary Work Form sent 30.11.20
Low	Carwyn	Bridges	Physiotherapist	Specialty Medicine	7	Medicine	16.11.20	Yes	No	UHL	2071 6841	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Limited Consultancy Chiesi Ltd	June 20 - Oct 20	Honrarium	Yes	Yes	Carwyn Bridges	17.11.20	Yes	Secondary Work Form sent 30.11.20
Low	Robyn	Davies	Head of Innovation	Improvement and Implementation	8c	Corporate	16.11.20	Yes	No	Woodland House	7810636358	Not Ticked	Chairman - Culturvate Ltd	1.09.17	None	Chairman - Culturvate Ltd (existing UHB customer)	1.09.17	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Visiting Professor - University of South Wles; Hon Innovation Fellow - Cardiff University	1.07.20 - 1.07.23 16.11.20 - 1.01.25	None	N/A	N/A	N/A	Yes	Yes	Robyn Davies	17.11.20	Yes	
Low	Ann Marie	Procter	Consultant in Medical Genetics & Clinical Board Director	AWMGS	Consultant	Mental Health	17.11.20	Yes	No	UHL	24995	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of Kaleidoscope Addictions Charity	2018	Voluntary	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ann Procter	17.11.20	Yes	Secondary Work Form sent 01.12.20
Low	David Mark	Howells	Consultant Psychiatrist	Mental Health for Older People	Consultant	Mental Health	18.11.20	Yes	No	UHL	02921 711711	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of Resec (Research in Specialist and Elderly Care - Charity / Study Group)	2014 - current	None	N/A	N/A	N/A	Health Inspectorate Wales - Second Opinion Appointed Doctor (CAVUHB) Cwm Taf UHB, ABUHB Section 12 Dr Work	May 2019 - Current Oct 2017 - Current	Fees Fees	Yes	Yes	Dr David Howells	18.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Alexander	Kennedy	Consultant Anaesthetist	Perioperative Care / Anaesthetics	Consultant	Surgery	12.11.20	Yes	No		7413908743	Yes	Director South East Wales Hang Gliding and Paragliding Club Ltd	16.03.17 - ongoing	No benefits	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Alexander Kennedy	12.11.20	Yes	
Low	Tristan	Groves	Lead Cardiology and Anticoagulation Pharmacist	Adult Cardiology	8a	Specialist Services	18.11.20	Yes	No	UHW	20746826	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Receiving Honoraria for providing educational sessions from Pharmaceutical companies related to anticoagulation. Honoraria received from BMS/Pfizer alliance and Bayer. Sponsored attendance of educational meetings also supplied by the above companies	2016 - current	Honoraria and meeting travel expenses	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Tristan Groves	18.11.20	Yes	Sponsorship Form sent 1.12.20
Low	Zaheer	Yousef	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	18.11.20	Yes	No	UHW	42972	Yes	ZY Consultant Ltd - Director	31.07.19 - ongoing	Shareholder: ad hoc dividend payments (nil to date)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chairman: Heart Research Wales and Medical Director Pace4Life	2015 - ongoing	N/A	N/A	N/A	N/A	In receipt of honoraria, lecture fees and research funding from Astra Zeneca, Pfizer, Servier, Beoringer Ingelheim, Bristol Meyers Squibb, Lilly, Novartis, Abbott, Medtronic . Undertake private practice at Spire Hospital and Nuffield Healthcare and provide sports cardiology screening services to elite athletes (e.g. Cardiff City football club, Swansea Football club, Football Association of Wales, Welsh Rugby Union, Glamorgan cricket)	2005 - ongoing		Yes	Yes	Zaheer Yousef	18.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Alana	Adams	Principal Pharmacist	Pharmacy	8c	CD&T	18.11.20	Yes	No	UHW	43880	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	Attended two meetings as a Specialist Pharmacist in a consultancy role for Pharmaceutical Industry and Marketing company.	07.09.20 - 10.09.20	Honorarium received	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Participated in a podcast for Cardiff University	13.11.20 - 13.11.20	Payment received	Yes	Yes	Alana Adams	18.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Vakeaparamabil	Biju	Consultant	Elderly Care Medicine	Consultant	Medicine	12.11.20	Yes	No	UHW		Not Ticked	Medic Training Limited - private work from publication of articles, attending ad - board	1.03.17 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Vakeaparamabil Biju	12.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Charles	Janczewski	UHB Chair	Executives / Corporate	VSM	Executive	12.11.20	Yes	No	Woodland House		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Swansea University - Chair of Governance Board for Health & Wellbeing Academy	May 2018 - ongoing	Unpaid	N/A	N/A	N/A	Yes	Yes	Charles Jancewski	12.11.20	Yes	
Low	David	Tuthill	Consultant Paediatrician	Child Health	Consultant	Children & Women	12.11.20	Yes		UHW	46725	Not Ticked	Director Cardiff Paediatrics Partner: Director Cardiff Paediatrics	ongoing ongoing		N/A	N/A	N/A	I do occasional lectures for pharmaceutical and infant feed companies			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	David Tuthill	12.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Annette	McLean	Dietetic Lead Mental Health	Dietetics	8a	CD&T	12.11.20	Yes		UHL	2071 5281	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ad hoc private dietetic work: Orbis education, plus dietetic consultation/training ad hoc on request, eg: cardiff uni/somek/knights-absorb.	2005 - ongoing		Yes	Yes	Annette McLean	12.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Andrew	Beamish	ST8 General Surgery	General Surgery	ST8	Surgery	19.11.20	Yes	No	UHW		Yes	Director and Trustee of Limited Company "ASiT Events"	2014 - ongoing	Nil (Voluntary)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Director and Trustee ofAssociation of Surgeons in Training - Currently applying for its Limited	2014 - ongoing	Nil (voluntary)	N/A	N/A	N/A	N/A	N/A	N/A	Yes	yes	Andrew Beamish	19.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Richard	Hain	Consultant and Clinical Lead, Paediatric Palliative Care	Child Health (Community)	Consultant	Children & Women	19.11.20	Yes		UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CVUHB Office space within Ty Hafan Children's Hospice	2018		Office space, coffee			Yes	Yes	Richard Hain	19.11.20	Yes	
Low	Aled	Roberts	Clinical Board Director	Medical Consultant	Consultant	Medicine	19.11.20	Yes	Yes	UHW	42344	Yes	Co-Director SAGE Roberts PLC Co-Director SAGE Roberts PLC	2018 - ongoing 2018 - ongoing	dividend only (not taken this financial year) "	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Aled Roberts	19.11.20	Yes	
Low	Mary	Lawrence	Associate Specialist in Psychiatry	Mental Health	Consultant	Mental Health	20.11.20	Yes	No	Hamadryad CMHT	2046 3488	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Occasional private work in the form of reports for solicitors, DVLA, CPS, CICB, Child Services, Benefits Appeals, Immigration Applications, Occupational Health, Police etc. plus Mental Health Act Assessments. These are conducted in my own time (if undertaken during my normal working hours time slipping utilised with equivalent amount of NHS work undertaken in my own time)	Ongoing		Yes	Yes	Mary Lawrence	20.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Frauke	Pelz	Associate Specialist in Clinical Genetics	All Wales Medical Genomics Service	Associate Specialist	All Wales Medical Genomics Service	20.11.20	Yes	Yes	UHW	48921	Not Ticked	Director of limited company	Since May 2016 - ongoing	Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I hold a very small private psychotherapy practice, limited to very few monthly hours, well outside my job planned hours in NHS post			Yes	Yes	Frauke Pelz	20.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Mari	Lea-Davies	Lead Pharmacist - Respiratory	Pharmacy	8a	CD&T	20.11.20	Yes	No	UHL	2071 5261	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff University MSc in clinical pharmacy. Provide 2 hour teaching session every 12 or 24 months. Annual leave taken, therefore undertaken during my	March 11 - present	Hourly rate for delivering presentation	Yes	Yes	Mari Lea-Davies	20.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Joy	Whitlock	Head of Quality and Safety Improvement	Patient Safety and Quality Improver	8b	Corporate Nursing	23.11.20	Yes	No	Woodland House	36311	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Sole trader of Joy Whitlock Coaching and Business Development www.joywhitlock.co.uk . Since I work part time for the UHB there will not be conflict with NHS duties. I'm declaring this, however, in the name of transparency.	2016 - ongoing	Hourly fee as work arises. Mostly pro bono	Yes	Yes	Joy Whitlock	23.11.20	Yes	Secondary Work Form sent 01.12.20
Low	Gary	Howell	Macmillan AHP Cancer Lead	Therapies	8a	CD&T	13.11.20	Yes	No	UHW	44294	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private dietetic practice	2008 - ongoing	Salary	Yes	Yes	Gary Howell	13.11.20	Yes	Secondary Work Form sent 03.12.20
Low	Julie	Loxton	Clinical Lead Nurse	Vale Locality Office / Daytime Servi	7	PCIC	24.11.20	Yes	No	Barry Hospital	7989223435	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	There is a call handler who is now related via Marriage to my son, they have now separated, she is band 2, I have nothing to do with managing her she is managed by Tracey Stafford my deputy. My cousin also works for the C&V UHB band 2 admin	2016 - ongoing	none	Yes	Yes	Julie Loxton	13.11.20	Yes	
Low	Sheelagh	Rogers	Dental Consultant	Orthodontics		Surgery	24.11.20	Yes	No	UHW	42448	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Specialist Practitioner; Cathedral Orthodontics; Cathedral Road; Cardiff	N/A	N/A	Yes	Yes	Sheelagh Rogers	24.11.20	Yes	Secondary Work Form sent 3.12.20
Low	Michael	Stechman	Consultant Surgeon	General Surgery	Consultant	Surgery	13.11.20	Yes	Yes	UHW		Yes	Director of KVMS Medical, Private Medical Practice Company Director of KVMS Medical, Private Medical Practice Company	June 2019 - present June 2019 - present	Dividends Dividends	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of the British Association of Endocrine and Thyroid Surgeons	October 2018 - Present	Nil	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Michael Stechman	23.11.20	Yes	
Low	Gail	Clayton	Lead Clinical Nurse Specialist in MS	Neurosciences	8a	Specialist Services	25.11.20	Yes	No	UHW	45018	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of UKMSSNA Committee		Sponsorship for overnight	N/A	N/A	N/A	Yes	Yes	Gail Clayton	26.11.20	Yes	Sponsorship Form sent 3.12.20
Low	Dev	Detta	Consultant in Metabolic Medicine	Haematology/ Immunology / Metabolic Medicine	Consultant	Specialist Services	26.11.20	Yes	No	UHL	26844	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Honoria received for expert advice and speaker fees from Amgen, Sanofi, Ackea, Amryt, Kyowa Kirin, Novartis	2011 - ongoing	Financial	N/A	N/A	N/A	Trustee, HEART UK	2018	None	N/A	N/A	N/A	Private Practice- Metabolic Clinic Ltd	2011	Financial	Yes	Yes	Dev Datta	26.11.20	Yes	Secondary Work Form sent 3.12.20
Low	Amy	Jones	Consultant Geriatrician	Clinical Gerontology	Consultant	Medicine	24.11.20	Yes	No	UHL	25653	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	On the committee for the British Geriatrics Society cardiovascular special interest group	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Amy Jones	26.11.20	Yes	
Low	Somashekara	Shivashankar	Consultant Psychiatrist	Adult Mental Health	Consultant	Mental Health	26.11.20	Yes	No	CRI	20335555	Yes	Director of a Limited company but have no actual or perceived conflict with the Health Board Spouse is also a Director of a Limited company but have no actual or perceived conflict with the Health Board	01/04/2019 April 2019		Part ownership of a limited company but have no actual or perceived conflict with the Health Board Spouse is also a part owner of a Limited company but have no actual or perceived conflict with the Health Board	01/04/2019 April 2019			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Ad hoc work as SOAD for HIW but have no actual or perceived conflict with the Health Board	Jan-19		Ad hoc work as SOAD for HIW but have no actual or perceived conflict with the Health Board	Jan-19		Yes	Yes	Somashekara Shivashankar	26.11.20	Yes	
Low	Ceri Hopcyn	Jones	Consultant Haematologist (BMT & CAR T)	Consultant Haematologist	Haematology	Specialist Services	1.02.20	Yes	No	UHW	41976	Yes	I received sponsorship to attend various conferences including European Haematology Asssociation General meeting (EHA) 2019 and American Society of Hematolgy (ASH) 2019 from Abbvie, and EHA 2020, British Society of Haematology Annual General Meeting 2020 and ASH 2020 from Kite Gilead and Novartis	May 2019 - ongoing	Travel and registration costs only	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Ceri H Jones	1.12.20	Yes	Sponsorship Form sent 3.12.20
Low	David Hywel	Thomas	Consultant Histopathologist	Histopathology	Consultant	CD&T	01.12.20	Yes	No	UHW	45316	Yes	Co-director of company to provide autopsy service for HM Coroner My wife is a co-director of the company	March 20 - ongoing March 20 - ongoing	payment from HM Coroner per autopsy salary from company	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	David Thomas	1.12.20	Yes	Secondary Work Form sent 3.12.20
Low	Matthew	Thomas	Consultant Restorative Dentistry	Dental	Consultant	Surgery	26.11.20	Yes	No	UHW	42519	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	West Coast Dental Care - Self employed private practice	ongoing		Yes	Yes	Matthew Thomas	26.11.20`	Yes	Secondary Work form sent 4.12.20
Low	Mark	Jones	Team Lead for the Young Onset Dementia Service	MHSOP	7	Mental Health	30.11.20	Yes	Yes		1446 454200	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Chair of Trustees for Re-Live (Registered Charity Number: 1162546) Spouse is a Board Member with the charity 'Wish Upon a Star'.(Registered Charity Number 1168140).	01/07/2015 01/07/2015	None None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mark Jones	30.11.20	Yes	
Low	Sarah	Spencer	Deputy Head of Midwifery	Obs & Gynae	8b	Children & Women	4.12.20	Yes	No	UHW		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Huntleigh Healthcare	2014 - ongoing	£1,000	N/A	N/A	N/A	N/A	N/A	N/A	Huntleigh Healthcare	2014 - ongoing	£1,000	Huntleigh Healthcare	2-14 - ongoing	£1,000	Yes	Yes	Sarah Spencer	4.12.20	Yes	Secondary form sent 2.12.20
Low	Megumi	Baba	Consultant Paediatric Palliative Care	Child Health	Consultant	Children & Women	4.12.20	Yes	No	UHW	2920532200	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I have an honorary cotract with Ty Hafan Children's Hospice as their consultant	21.06.16 - ongoing	CAVUHB invoices part of my salary (4 sessions per week)	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Megumi Baba	4.12.20	Yes	
Low	Paul	Bracegirdle	Senior Projects & Deputy Directorate Manager	Dental/Ophthalmology	8a	Surgery	6.12.20	Yes	No	UHW	44846	Yes	Active Director at Tre-Oda Court Management Ltd, Companies House Reference Number 08945509	5.10.17	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Paul Bracegirdle	6.12.20	Yes	
Low	Fiona	Jenkins	Executive Director of Therapies and Health Science	Executive	Executive	Executive	26.11.20	Yes	No	UHW		Yes	Interim Executive Director Therapies and Health Science, Cwm Taf Morganngw UHB	Nov 20 - tbc	Shared role with C&V UHB	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Fiona Jenkins	26.11.20	Yes	
Low	Balarao	Oruganti	Consultant in Psychiatry	Psychiatry	Consultant	Mental Health	18.11.20	Yes	No	UHL	47747	Not Ticked	Director of limited company but cannot see any conflict as not doing or seeking any business with UHB Spouse - Director of a limited company but cannot see any conflict as not seeking or doing any business with UHB			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Works for HIW and Judicial Appointment Committee for MHRT on ad hoc basis			Yes	Yes	Balarao Oruganti	18.11.20	Yes	Secondary form sent 21.12.20
Low	Carly	Jackson	Clinical Psychologist	Child Health	8a	Children and Women	14.12.20	Yes	No	St David's Hospital	2920536733	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clinical Psychologist with Sport Wales (employeed by Sport Wales) and Clinical Psychologist for Mindful Mindset (Self-Employed)	Sports Wales (1.09.19) both ongoing	Sports Wales Salary	Yes	Yes	Carly Jackson	14.12.20	Yes	Secondary form sent 5.1.20
Low	Peter	Sharp	Consultant Cardiologist	Cardiology	Consultant	Specialist Services	14.12.20	Yes	No	UHW	2921847089	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Consultant: Medtronic, Philips, Recor Medical, Penumbra	1.07.20 - ongoing	Speaker's and/or consultancy compensation for time	Research funding, Boston Scientific	1.10.20 - 2025	Executive committee recompense for time running study	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Andrew Sharp	14.12.20	Yes	Secondary form sent 5.1.20
Low	Karen	Visser	Professional UHB Lead for Speech & Language	Community Child Health	8c	Children and Women	17.11.20	Yes	No	Riverside Health Centre	029 2183 6585	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trustee of Community Music Wales	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Karen Visser	17.11.20	Yes	Secondary form sent 5.1.20
Low	Peter	Mullaney	Consultant Radiologist	Radiology	Consultant	CD&T	11.12.20	Yes	No	UHW	43956	Yes	Yes	2019		Yes	2019	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Peter Mullaney	11.12.20	Yes	Secondary form sent 5.1.20
Low	Mary Annette	Thomas	Director Weqas	Weqas	8d	CD&T	17.12.20	Yes	No	Llanishen	48332	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Becton Dickinson - European Advisory Board member for Point of Care. Provided Advice and attended meetings. Invited Speaker at Siemens Healthineers meeting in Bangkok in 2019 and Brussels Oct 2018. Invited speaker at Nova Biomedical User Group meetings in Manchester and London November 2018.	Aug 18 - current	Received travel expenses to attend meeting in London 2018, Aberdeen in 2020	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Mary Thomas	17.12.20	Yes	Secondary form sent 6.1.20
Low	William Jonathan	Kell	Consultant Haematologist	Haematology	Consultant	Specialist Services	22.12.20	Yes	No	UHW	42654	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Occasional requests from Pharmaceutical companies to give education (non-promotional) talks, or to sit on paid advisory boards	2002 - ongoing	Less than £2k	Treasure of UK MDS forum	2010 - ongoing	none	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Jonathan Kell	22.12.20	Yes	Secondary form sent 6.1.20
Low	Sumit	Goyal	Consultant Surgeon	Surgery	Consultant	Surgery	23.12.20	Yes	No	UHW			Director of limited company Dr Goyal Ltd Spouse - secretary of company	Oct 2014 - ongoing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Member of Breast Centre Charity	2009 - ongoing		N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Sumit Goyal	23.12.20	Yes	Secondary form sent 6.1.20
Low	Sian	Moynihan	Consultant Paediatrician	Child Health	Consultant	Children and Women	4.02.21	Yes	No	St David's Hospital	2920536789	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	I am welfare Officer (Safegarding Officer) which is voluntary and unpaid for the Maindy Youth Cycling club- Im on the committee supporting decision making for the club that involves child welfare. It is recognised by British Cycling Authority and Welsh Cycling Authority and done necessary Safeguarding training. I do not believe there is any conflict of interest as this is done in outside work hours.		None	N/A	N/A	N/A	Yes	Yes	Sian Moynihan	4.01.21	Yes	
Low	Adam	Jones	Consultant Dental Surgeon	Dental	Consultant	Surgery	8.01.21	Yes	No	UHW	44365	Not Ticked	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Merck Sharp & Dohme Ltd. funded travel / hotel and course expenses for training on 'PD-L1 testing (22C3) Professional Expert Course Head and Neck - Advanced Training'.	13.01.21 - 14.01.21	Course, travel and hotel expenses	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Adam Jones	8.01.21	Yes	Secondary form sent 11.01.21
Low	Darren	Robinson	Registered Nurse	Addictions	7	Mental Health	8.01.21	Yes	No	UHW	2920744901	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Trusteeship with Recovery Cymru	Jan-11	None	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Darren Robinson	8.01.21	Yes	
Low	David	Hanna	Consultant Paediatrician	Emergency Medicine	Consultant	Medicine	11.01.21	Yes	Yes	UHW	48008	Yes	N/A	N/A	N/A	My wife, Dr Alison Whyte is a partner in Clark Avenue Surgery, a GP Practice in Cwmbran, within the Aneurin Bevan UHB area. This practice does not currently do business or is it seeking to do business with Cardiff and Vale UHB.	2019		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	David Hanna	11.01.21	Yes	
Low	Louise	Ingleton	Avanced Paediatric Clinical Nurse Specialist	Community Child Health Deurodevelopmental	8a	Children and Women	13.01.21	Yes	No	St David's Hospital		Yes	N/A	N/A	N/A	N/A	N/A	N/A	Member of UK Nurse Advisory Board-ADHD sponsored by Takeda Pharmaceuticals	March 20 - ongoing	honoria	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Louise Ingleton	13.01.21	Yes	Secondary form sent 13.01.21
Low	Mirander	Barber	Consultant Clinical Psychologist	MHSOP	8+	Mental Health	13.01.21	Yes	No	UHL	20715782	Yes	I am the Director of a Ltd company which has not traded for 18 months	2015 - current	none	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Miranda Barber	13.01.21	Yes	
Low	Helen	Griffiths	Occupational Therapist	Community Resource Team	7	PCIC	14.10.20	Yes	No	Whitchurch Hospital	32501	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Work as occupational therapist for Stroke case management on ad hoc basis	Sept 2016 - ongoing	zero hour contract	Yes	Yes	Helen Griffiths	14.10.20	Yes	Secondary form sent 20.01.21

Report Title:	**Legislative and Regulatory Tracker Report**								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	9th February 2021	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Head of Risk and Regulation								

Background and current situation:

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

Good progress has been made on the development of the Legislative and Regulatory Tracker but there is still some work to be done to ensure that the tracker is fit for purpose in providing assurance to the Audit Committee and the Board.

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

Since September's meeting the Risk and Regulation Team have been able to devote additional time to the preparation and management of the Regulatory and Legislative Compliance Tracker. The additional support has allowed greater communication to be made with executive leads and accountable individuals and whilst this has not resulted in any significant changes to the Tracker for this meeting, it is predicted that noticeable improvements to the content of the Tracker and management of recommendations contained therein will be reported in the new financial year.

This in turn will provide further assurance to the Audit and Assurance Committee and the Board and ensure that any outstanding actions from the Internal Audit on this piece of work are implemented.

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

The tracker now provides the following details:

- All Regulatory Bodies which inspect Cardiff and Vale UHB are listed and include the bodies detailed at Appendix 1;
- The Regulatory Standard which is being inspected is listed
- The Lead Executive in each case is detailed
- The Assurance Committee where any inspection reports will be presented along with any action plans as a result of inspection is detailed
- The accountable individual is detailed and where there is a gap this will be the lead Executive

- Where we have been informed what the inspection cycle is we have detailed it where we have not been informed or simply don't know we have put 'ad hoc'.
- The last inspection date is detailed and also detailed is where Cardiff and Vale have not been inspected in the last 10 years.
- Where we know the inspection date it is detailed. Where we know the inspection cycle and the last time it was inspected we have put in a predicted date so we don't completely lose sight of it. Where the cycle time is ad hoc we have stated that no inspection has been notified and when we are notified via the central inbox, which has been set up, this will be added to the tracker. Hence we have called this column 'expected date of inspection'. Where there is an * it means an inspection was expected but never took place.
- Where we know the outcome of the inspection we have included it. Where there were no issues picked up we have put this column to 'action complete' this links to the final column which is a binary complete or not complete. The reason for this is that it will link to the dials in due course.

The tracker will continue to be updated throughout the organisation and reported to the Audit Committee on a bi-monthly basis as well as being reported to Management Executive and HSMB meetings.

A further 3 entries have been noted on the register since November's committee meeting, including inspections that had taken place prior to the committee but had not previously been reported. The additional inspections are as follows:

1) An inspection was undertaken by the British Standards Institute on the 1st July 2019.

   Outcome – A further Audit took place on the 26/01/2021 during which it was confirmed that required actions had been undertaken.

2) A scheduled inspection by Health Inspectorate Wales of the Paediatric Surgical Ward which was due to take place following November's Committee Meeting has been placed on hold.

3) An un-announced inspection of the Birchgrove Dental Practice was undertaken by Health Inspectorate Wales on the 2nd October 2020.

   Outcome – The Health Board's improvement plan provided sufficient assurance that issues raised would be resolved.

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

1. The British Standards Institute are scheduled to undertake an inspection of Clinical Engineering within the CEDAR Evaluation Centre on the 01/03/2021.
2. Fire and Rescue Services are scheduled to undertake inspections of Ward A6 and the Artificial Limb Centre (Rookwood Hospital) on the 18/02/2021 and 09/02/2021 respectively.

3. The Human Tissue Authority is scheduled to undertake inspections of the South Wales BMT Programme and Stem Cell Processing Unit during February 2021.
4. The Medicines and Healthcare products Regulatory Agency are scheduled to inspect Pharmacy SMPU on 18/02/2021.
5. UKAS are scheduled to undertake inspections at Celular Pathology (Mortuary) on the 02/03/2021
6. UKAS are scheduled to undertake inspections at Haematology and Phlebotomy between the 20th and 22nd April 2021.

Recommendation:

For Members of the Audit Committee to:

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

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

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

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

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

Appendix 1 – Regulatory Bodies

- All Wales Quality Pharmacist;
- British Standard's Institute;
- Cardiff and Vale of Glamorgan Food Hygiene Ratings;
- Community Health Council;
- Fire and Rescue Services;
- Health Education and Improvement Wales;
- Health Inspectorate Wales;
- Health and Safety Executive;
- Human Tissue Authority;
- Information Commissioners Office;
- Joint Education Accreditation Committee
- Medicines and Health Products Regulatory Agency;
- Natural Resources Wales;
- Office for Nuclear Regulation;
- Quality in Primary Immunodeficiency Services;
- United Kingdom Accreditation Service;
- Welsh Water;
- West Midlands Quality Review Service.

Clinical Board	Directorate	Regulatory body/inspector	Service area	Regulation/Standards	Lead Executive	Assurance Committee	Accountable individual	Inspection Cycle Time	Last Inspection Date	Next Inspection Date	Recommendation Narrative / Inspection outcome	Inspection Closure Due by	Management Response	Please Confirm if completed (c), partially completed (pc), no action taken (na)
ALL WALES QUALITY ASSURANCE PHARMACIST														
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy SMPU	Quality Assurance of Aseptic Preparation Services	Stuart Walker	QSE Committee	Darrel Baker	183	27/01/2020	27/07/2020	166 actions	31/12/2020		pc
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy UHL	Quality Assurance of Aseptic Preparation Services	Stuart Walker	QSE Committee	Darrel Baker	365	06/08/2020	06/08/2021	91 actions	tbc	We have received the report but we are currently working on an action plan so we don't have a set closure date for the plan currently. Action plan is to be finalised by beginning of November, so will have the date for this then.	pc
CD&T	Pharmacy			Falsifying Medicines Directive	Stuart Walker	QSE Committee	Darrell Baker	n/a	n/a	n/a	no inspection data as yet			na
BRITISH STANDARDS INSTITUTE														
CD&T	MPCE	BSI	Clinical Engineering, CEDAR	ISO9001:2015	Fiona Jenkins	QSE Committee	Edward Chapman/Kathy Ikin/Rhys Morris	180	01/06/2020	01/03/2021	CE: 2 Non-conformities 1. No clear professional leadership in place 2. lack of space to operate efficiently and safely.	01/06/2020	Directrate Management Team seeking resolution of these issues	c
Planning	Planning	British Standards Institute	Capital, Estates & Facilities	ISO - 14001 Environmental management system and accreditation	Abigail Harris	Health and Safety	Jon McGarrigle	185 (Twice Yearly)	01/07/2019	01/01/2021	Minor non conformances which will be addressed by next audit	31/01/2021	BSI External Audit completed on 26/1/21a	c
CARDIFF AND VALE OF GLAMORGAN FOOD HYGIENE RATINGS														
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Teddy Bear Nursery	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Kelly Lovell, Ruth Hutchinson		22/05/2020		Food rating 4		Due to COVID-19 an intelligence gathering exercise was undertaken. No matters of public health concern was identified.	
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Barry Hospital Kitchens	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Lesley James, Linda Watts, John Smith	Annual	10/03/2020	10/03/2020	Food rating 5		All recommendations actioned with the exception of the taps in St Barrucs unit 1 and 2 which are in progress. Inspection overdue. Update - Schedule B Requirement. New Style taps being trialled.	
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Teddy Bear Nursery	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Kelly Lovell, Ruth Hutchinson		20/02/2020		Food rating 5			
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Ward Based Catering, Brecknock House	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Keith Prosser		02/12/2019	Planned for 02/12/20 but due to Covid-19 awaiting confirmation from EHO	Food rating 4	02/12/2020	Currently awaiting confirmation from Food Safety & Port Health (Cardiff), Shared Regulatory Services, of when inspections will re-commence	
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Bwyd Blasus	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Ranjith Akkaladevi		28/11/2019		Food rating 4			
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Aroma Express, Brecknock House	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Stepfanie Burgess		28/11/2019		Food rating 3			
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Rookwood Hospital	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Andrew Wood		25/11/2019	Planned for 02/12/20 but due to Covid-19 awaiting confirmation from EHO	Food rating 5	25/11/2020	Currently awaiting confirmation from Food Safety & Port Health (Cardiff), Shared Regulatory Services, of when inspections will re-commence	
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Teddy Bear Nursery	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety			04/09/2019		Food rating 4			
COMMUNITY HEALTH COUNCIL														
Estates		Community Health Council	Disabled Car Park		Abigail Harris	Audit and Assurance	Geoff Walsh		21 and 25 November		10 recommendations			na
Mental Health	St Barrucs Ward,	Community Health Council			Abigail Harris	Audit and Assurance			3.02.20		1. Explore opportunities for volunteer groups to visit regularly & spend more time with patients there. Possibly befriending groups to visit.		The Young Onset Dementia team have started to improve their links with Ty Hapus charity and the Alzheimer's Society. Due to the Covid 19 pandemic the Health Board are limiting visiting to control the risk of infection spread. We are exploring opportunities to enhance our	c
Mental Health	Daffodil Unit, UHL	Community Health Council			Abigail Harris	Audit and Assurance			3.02.20					c
Surgery	Ward B6, Trauma Unit, UHW	Community Health Council			Abigail Harris	Audit and Assurance			25.02.20		1. Consider improving the non-HCSW staffing levels (incentives for retention of staff) across the Ward's multidisciplinary teams, including a deputy to assist the Nurse Manager, and the possible impact of the MTC on this area regarding polytrauma patients.		Ward B6 has changed its function since the Covid pandemic and is currently a Medical ward. The ward team will shortly be moving to University Hospital Llandough (UHL) to care for Trauma patients in the UHL footprint. 2 full time deputy sisters have been appointed to support the Ward Sister since Feb 2020. With planned move to UHL staffing levels will be improved. The Trauma and Orthopaedic Directorate works hard to retain staff, practice development nurse will be working clinical shifts alongside staff on the ward to offer support and guidance not only to newly registered but those wishing to progress. The impact of MTC is less likely to impact B6 with move to UHL	c
Surgery	Ward B6, Trauma Unit, UHW	Community Health Council			Abigail Harris	Audit and Assurance			25.02.20		2. Liaise with Estates to repair the bathroom/toilet problems and upgrade the interim reception desk.		The refurbishment of the ward including the bathroom/toilets was due to be undertaken in 2019/20 but it was agreed to prioritise C7 with B6 being programmed for 20/21. Unfortunately, due to the Covid situation the refurbishment programme has been put on hold for this financial year but it is hoped that this can be re-commenced in 21/22 and B6 would be the priority. In the interim Estate will visit the area to determine if any interim works can be undertaken to improve the facility.	c
Surgery	Ward B6, Trauma Unit, UHW	Community Health Council			Abigail Harris	Audit and Assurance			25.02.20		3. Place a 'Putting Things Right' Information Notices in the Day Room.		Sister Hodges has obtained a Putting Things Right poster and place in the day room. Subsequently with the planned move to UHL, she will ensure that this is included in patient areas in UHL also.	c

Medicine	Ward C7, UHW	Community Health Council			Abigail Harris	Audit and Assurance			26.02.20		1. Update the notice boards on the Ward	To be completed by Friday 31st July 2020	The visit undertaken by the CHC representatives occurred following the reopening of C7 North on 22nd January, 2020 to make C7 a full 38 bedded ward. Following the interim ward manager arrival in post on the 5th January a maintenance request was placed to have notice boards hung which was completed in the month of January. Following this, action content was prepared ready to display.	c
Medicine	Ward C7, UHW	Community Health Council			Abigail Harris	Audit and Assurance			26.02.20		2. Install a suggestion box so patients, relatives, carers and visitors can leave comments or suggestions.	To be completed by Friday 31st July 2020	Discussed by the ward manager and team as an additional source of feedback to the '2 minutes of your time' and National feedback surveys that the ward participates in.	c
Medicine	Ward C7, UHW	Community Health Council			Abigail Harris	Audit and Assurance			26.02.20		3. Place hand washing notices at all sink areas	To be completed by Friday 31st July 2020	Additional, hand washing notices ordered following CHC visit, which arrived the day of the ward move to A5.	c
FIRE AND RESCUE SERVICES														
Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Lansdowne Ward, St David's Hospital	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	21/01/2020	20/01/2021	Failed to comply with requirements of safety order. Schedule of works required included: 1 x management 1 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.		**pc**
Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Sam Davies Ward, Barry Hospital	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	27/01/2020	26/01/2021	Failed to comply with requirements of safety order. Schedule of works required included: 2 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.		**pc**
Medicine	Capital and Asset Management	Fire and Rescue Services	Ward A6	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety		365	19/02/2020	18/02/2021	Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises. Aritcle 17: Maintenance - Fire resisting doors are not adequately maintained	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.		**pc**
Specialist Services	Capital and Asset Management	Fire and Rescue Services	Rookwood Hospital, Artificial Limb Centre	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety		365	10/02/2020	09/02/2021	Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.		**pc**
Mental Health	Capital and Asset Management	Fire and Rescue Services	Vale Mental Health Services, Barry Hospital	Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety		365	27/01/2020	26/01/2021	Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.		**pc**
HEALTH EDUCATION AND IMPROVEMENT WALES														
HEALTH INSPECTORATE WALES														
Children's & Women	Acute Child Health	HIW	Paediatric Surgical Ward		Ruth Walker	QSE	**Director of Nursing for C&W**				Quality Checks put on hold by HIW.			
PCIC	GP Practice	HIW	Radyr Medical centre	HIW	Ruth Walker	QSE	**Director of Nursing, PCIC**				Quaity Check undertaken on the 24/11/20. Awaiting update			**PC**
PCIC	GP Practice	HIW	Porthceri Surgery, Barry.	HIW	Ruth Walker	QSE	**Director of Nursing, PCIC**				Planed for 1/12/20 HIW informed that this branch of the Vale Group Practice Surgery is no longer a GP surgery as USC hub.			
Specialist	Haematology	HIW	Teenage Cancer Trust	HIW	Ruth Walker	QSE	**Director of Nursing, Specialist**				Contact, self assesssment and evidene forwarded. Virtual Inspection Interview 6/1/21 CNCELLED DUE TO COVID - AWAITNG NEW DATE			
Medicine	Medicine	HIW	MEAU, UHL	HIW	Ruth Walker	QSE	**Director of Nursing, Medicine**				Quality check to take place in MEAU , UHL on 08.12.20. via video call. Action plan and completed actions and Factual Accuracy submitted 7/1/20 and accepted			**PC**
PCIC	Dental	HIW	Birchgrove Dental Practice	HIW	Ruth Walker	QSE	**Director of Nursing, PCIC**				Unannounced inspection (non-compliance) took place on 02.10.20 following a whistleblowing report on COVID IPC/Social distancing measures in the Practice. Practice to respond to actions by 13.10.20. Letter received from HIW 15.10.20 confirming improvement plan provides sufficient assurance. 16.11.20 - Final Report received from HIW.			**C**

Children & Women		HIW	Youth	HIW	Ruth Walker	QSE	**Director of Nursing, C&W**				In this thematic review of services across Wales HIW made 37 recommendation for WG, UHBs and indepdent service users to consider and act on. Template was returned to HIW by 09.10.20.		**Was reported to QSE in Sept 2019. Action plan / position submitted Awating conformation from HIW**	**PC**
Medicine	Medicine	HIW	E4, UHL	HIW	Ruth Walker	QSE	**Director of Nursing, Medicine**		23rd September 2020		Tier 1 remote inspection took place on 7th October 2020. Contact details to be confirmed by 23.09.20. **21/9/20 Nominated contact details confirmed** **30/9/20 evidence sent** **7/10/20 virtual interview** **16/10/20 Letter from HIW - improvement plan response required 28.10.20 - Improvement Plan**		**Reported to Dec 2020 QSE Committee. Action plan submitted with actions completed. Awating conformation from HIW**	**PC**
Specialist	Neurooscience	HIW	T4	HIW	Ruth Walker	QSE	**Director of Nursing Specialist Services**		30th September 2020		Tier 1 remote inspection took place on the 30th of September 2020. Documented evidence submitted by the 25th of September. **21/9/20 Nominated contact details confirmed.** 25/9/20 Evidence sent 30/9/20 Virtual Interview 12/10/20 Letter from HIW - response required by 21/10/20 Improvemnt plan submitted - awaiting confirmation from HIW 26.10.20 - Letter from HIW accepting comments. Findings report now finalised. Improvement plan accepted and will be published 28.10.20. Evidence submitted 4/1/2021		**Reported to Dec 2020 QSE Committee. Action plan submitted with actions completed. Awating conformation from HIW**	**PC**
Medicine	Clinical Gerontology	HIW	Morgannwg Ward, Barry Hospital	HIW	Ruth Walker	QSE	Director of Nursing		22nd September 2020		Tier 1 remote inspection requested by HIW to take place 22nd September 2020. Documentary evidence to be submitted by 16th September 2020. **Self assessment and documentary evidence uploaded to HIW 16/09/20. 01/10/20 Factual Accuracy comments requested by 12/10/20** 19.10.20 - Letter from HIW confirming the Quality Check Report has now been finalised and published.		**Reported to Dec 2020 QSE Committee**	**c**
Children & Women	Maternity	HIW	Maternity Services	HIW	Ruth Walker	QSE	Head of Midwifery				HIW are undertaking a national review of maternity services across Wales (Phase 2). **Letter recevied 13/1/21 from HIW Phase 2 on hold.**	Details of community maternity sites sent to HIW 17.07.20 and self assessement sent 24.07.20.		**PC**
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.	**Was reported at September 2020 QSE**	**C**
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.	Reported at August 2020 QSE (Delayed to September)	**C**

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**	R reported at August 2020 QSE (delayed to September)	**PC**
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.**			**N/A**
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	reported at April 2020 QSE Committee	**C**
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. Revised improvement plan sent 25th February	Reported at February 2020 QSE Committee	**C**
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 - The practice are in the process of taking the actions required. 13.11.19 - Response sent.			**C**
PCIC	Dental	HIW (Non-compliance notice)	Newport Road Dental Clinic	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		02/10/2019		The practice was found to be committed to a positive patient experience and rated excellent by patients. Areas of improvement were recommended in compliance with current regulations, standards and best practice guidelines. • Immediate improvement plan initiated re emergency drugs and resuscitation equipment • The practice must provide evidence to HIW that the dental nurse has undertaken the required number of hours (five) of verifiable training in disinfection and decontamination. • Feminine hygiene bins must be made available within the appropriate toilets and feminine hygiene waste must be disposed of appropriately. • Patient records must be fully maintained in keeping with current guidance and professional standards for record keeping (including those recommended within this report). **HIW satisfied with Immediate Improvemtn plan Immediate actions have been undetaken and practice confirmed.**			**C**
Specialist	Rehabilitation	HIW (Unannounced)	Rookwood Hospital	HIW	Ruth Walker	QSE	Director of Nursing, Specialist		02/10/2019		14.11.19 - Letter received from HIW for response with action plan by 29.11.19. Action plan submitted 29/11/2019. Response sent 29.11.19. Will be reported in February 2020 QSE Committee.	Final report to be published 3/01/20. To be reported in February 2020 QSE committee		**C**
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	**C|**
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.			**C**

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. **All action completed by publicatipn of reprot on the 20/11/19**		Final report published 20/11/2019	**C**
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. Awaitng update **All action complete**		Final report published 14/11/2019	**C**
PCIC	GP Practice	HIW (GP Announced visit)	Waterfront Medical Centre	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		Inspection due on March 23rd 2020					**NA**
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	**C**
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 Awaiting update from PCIC. **HIW accepted compliance responce. DPA continue to monitor**		Final report published 24/10/2019	**C**
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. **Action was undertaken immediately**		Final report published 11/10/2019	**C**

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	**C**
PCIC	Dental	HIW (Announced visit)	Llanederyn Dental Practice	Private Dentistry Regulations/All Healthcare Standards	Ruth Walker	QSE	Director of Nursing, PCIC		23/05/2019		HIW found some evidence that they were not fully compliant with Private Dentistry Regulations and all Health and Care Standards. The practice has been recently bought by its current owners and through discussions with them it was clear that they are keen to develop and improve the practice. There were a number of policies and procedures in place, but they were not dated, not version controlled, did not contain a review date and in the majority of instances did not include a staff signature demonstrating that the policies and procedures had been read and understood. HIW recomended that the practice need to ensure that all staff are appropriately trained with evidence of this training held on file. HIW recommended a number of improvements should be made including the review of policies and procedures which should be communicated to staff; training to be given to all staff as required and evidence maintained of this training on a training matrix; introduction of a programme of clinical and quality audits; provision of more		Final report published 26/08/2019	**C**
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	**C**
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	**C**
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,			**C**

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. **HIW accepted improvmetn plan. DPA continue to monitor**		Final report published 27/06/2019	**C**
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	**C**
Mental Health		HIW (Unannounced)	Hafan Y Coed	HIW	Ruth Walker	QSE	Director of Nursing, Mental Health		19-21/03/2019		HIW found the Health Board did not always meet all standards required within the Health and Care Standards (2015), the Mental Health Act (1983), Mental Health (Wales) Measure (2010) and the Mental Capacity Act (2005). HIW recommended that the service could improve upon: Areas of Mental Health Act documentation require improvement Garden areas on all wards are in need of maintenance and the responsibility for this, needs to be confirmed Inconsistency of information displayed for patients and relatives across the wards Page 7 of 34 HIW report template version 2 Areas of good practice employed on some wards are not shared with others to maintain consistency Some patients are sleeping out1 from their designated ward due to additional demand and		Final report published 8/7/2019	**C**
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	**C**
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	**C**
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 strong 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 Reoirted in April 2019 QSE	**PC**
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	**N/A**

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	**C**
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.			**C**
HEALTH AND SAFETY EXECUTIVE														
CD&T	Medical Physics	HSE	Medical Physics	Control of Artificial Optical Radiation at Work Regulations 2010	Martin Driscoll	Health and Safety	Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years	No future inspection date set	last inspections pre 2004, no inspeciton data currently available			**na**
CD&T	Medical Physics	HSE	Medical Physics	The Control of Electromagnetic Fields at Work Regulations 2016	Martin Driscoll	Health and Safety	Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years	No future inspection date set	last inspections pre 2004, no inspeciton data currently available			**na**
HUMAN TISSUE AUTHORITY														
Specialist Services	N&T	HTA	South Wales Transplant and NORS programme	Human Tissue Act	Fiona Jenkins	QSE Committee	Rafael Chavez	730	01/10/2019 - self assessment compliance update	01/10/2021	Number of areas of good practice noted from inspection in 2016/17. Self assessment compliance update provided in September 2019 which demonstrated evidence and compliance with the updated questions	n/a		**c**
CD&T	Haematology	HTA	South Wales BMT Programme	Human Tissue Act	Fiona Jenkins	QSE Committee	Xiujie Zhao	730	22-23/01/2019	expected Jan/Feb 21			WBS Audit January - no major deficiencies, some minor actions to complete	**c**
CD&T	Haematology	HTA	Stem Cell processing Unit (HTA)	Human Tissue Act	Fiona Jenkins	QSE Committee	Alun Roderick/Sarah Phillips	730	22/01/2019	expected Jan/Feb 22			WBS Audit January - no major deficiencies, some minor actions to complete	**c**
CD&T	Cellular Pathology	HTA	Mortuary (Cell Path - HTA)	Human Tissue Act	Fiona Jenkins	QSE Committee	Adam Christian/Scott Gable	730	22/11/2018	no date set			Compliance is dependent upon ongoing commitment to rebuild/refurbish the facility	**c**
INFORMATION COMMISSIONERS OFFICE														
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that the IGET covers all necessary topics during meetings the organisation should introduce a set of formal ToRs		Following a review, IGET has been replaced by a new IG Group. The ToR are enclosed.	c
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that policies remain fit for purpose and that staff have appropriate direction and information to avoid the risk of data protection breaches, the organisation should ensure that they are subject to timely routine review.		All D&HI policies to be reviewed and updated if necessary	pc
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that staff are fully aware of the responsibilities regarding IG, the organisation should consider means by which assurance can be given that staff have read appropriate policies and therefore are aware of organisational requirements and their responsibilites		IG Manager to investigate the feasibility of implementing a process that provides this assurance	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that staff receive the appropriate level of IG training for their role, regular training needs analysis should be undertaken in order to inform the IG training programme		There currently is a national piece of work looking at the different training requirements across NHS staff in Wales. This is being considered at the Information Governance Management Advisory Group (IGMAG)	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				In order to ensure that specialised roles with IG responsibility have received appropriate training to carry out their role effectively, a training needs analysis for these roles should be undertaken. To ensure that training requirements for staff with specialised DP roles are recognised and formalised, these should be included in all job descriptions of roles with IG responsibilities. This should ensure that staff can carry out their roles effectively		For the following staff, a TNA shall be undertaken separate to the piece of work referenced in A4: Caldicott Guardian, SIRO, Data Protection Officer, Information Asset Owners, Information Asset Administrators	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should provide detailed information about how compliance with data protection policies and procedures is to be monitored to give assurance regarding observance.		The IG Policy will be reviewed and consideration given to potential data protection compliance monitoring.	na

IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that management have a complete picture of performance and compliance, and provide assurance that the organisation is complying with the relevant legislation, the reporting of KPIs relating to records management should be reinstated		The reporting of such measures, as outlined, may be more appropriately, and may already be, reported at a Medical Records Group. If this isn't the case, the IG Manager will work with the Medical Records management to ensure that these KPIs are reported.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that all areas have carried out comprehensive data mapping exercises to ensure that the there is a clear understanding and documentation of information processing.in line with the requirements of the organisation's IG policy and national legislation.		All IAR are currently being centrally collated. A review will be conducted to ensure that IAO are correctly capturing lawful basis etc...	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that it has a complete ROPA which includes all the information required by the legislation, so they are aware of all information held and the flows of information within the organisation, and have assurance that the record is an accurate and complete account of that processing.		Ensure that a ROPA is undertaken in line with Art 30 of the GDPR.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that there is an internal record which documents all processing activities in line with the legislation. This will provide assurance that all information processed is recorded as required by the appropriate legislation.		Ensure that a ROPA is undertaken in line with Art 30 of the GDPR.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should review the purposes of processing activities to ensure that they identify and document a lawful basis for general processing and an additional condition for processing criminal offence data, and therefore obtain assurance that they meet their obligations under the current legislation. The organisation should ensure that it documents the reasons for determining the lawful bases for each processing activity. Otherwise they risk failing to correctly identify the lawfull basis for processing and not meeting their obligations under the relevant legislation. The organisation should ensure that there are clear procedures in place to ensure that the t lawful basis is identified before starting any new processing of personal data or special category data. This will provide assurance that the organisation is relying on the correct lawful bases as required by the legislation.		Review Privacy Notice and IG Policy to ensure lawful basis for processing criminal data is clearly documented. 5.2.5.1 of the IG Policy (Data Protection Impact Assessment) states that 'All new projects or major new flows of information must consider information governance practices from the outset' and 'In order to identify information risks, a DPIA must be completed'. This is the point at which the lawful basis will be determined by theIG dept. The UHB's Privacy Notice does not document the lawful basis for each processing activity. We would be unable to document within the scope of the Privacy Notice the lawful basis for each of the UHB's numerous processing activities.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should document its lawful bases for processing special category data is correct based on the requirements of Article 9 of the GDPR and Schedule 1 of the DPA 2018 to provide assurance that it has appropriately considered how a determination was reached.		Ensure that our lawful basis for processing special category data is reviewed and documented	c
	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that there is an APD in place to define which schedule 1 conditions are relied on, so that the organisation is in compliance with the legislation. In order to ensure compliance with the legislation, the organisation should further: Create an APD which considers what procedures are in place to ensure compliance with the Article 5 principles of GDPR. Ensure the APD considers how special category data will be treated for retention and erasure purposes Ensure the APD defines a responsible individual for the processing activity		APD to be implemented	c
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				In order to be sure that it is keeping to data protection legislation by providing accurate processing information, the organisation should ensure that only current and accurate privacy information containing all the information as required under Articles 13 & 14 of the GDPR is available on its website. To ensure that it is upholding the requirement for data subjects to be properly informed of ho their information is being processed, the organisation should ensure there is a clear link to the general privacy notice from the front page of its website.		UHB website to be reviewed and any old documentation removed. Access to privacy notice considered.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that there is a process in place to provide privacy information to individuals if personal data obtained from a source other than the individual it relates to. This should be recorded on privacy information to make sure that the organisation is fulfilling its obligations in regard to the data which it processes.		In the context of referrals into the UHB and out of the UHB, the patient is likely to already be aware of this dataflow. This represents an exemption under Article 14 (5)(a) of the GDPR. In all other cases, we believe that manually informing individuals of this information would represent a 'disproportionate effort' given that we are unable to determine what a referring organisation has made their patients aware of and the volume of referrals received by the UHB -- therefore being exempt under Art 14(5)(b).	na

IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should consider additional means in which privacy information can be promoted or made available to individuals, to ensure that it does not rely on passive communication which risks individuals not being made aware of how their data is processed. This would help ensure that the a organisation is not in breach of legislation.		Will raise at the national Information Governance Group to investigate how other UHBs/Trusts are achieving this requirement.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that privacy information is available to all areas of the population the organisation must consider means of providing information to those who may not understand the standard notice. This would help ensure that the a organisation is not in breach of legislation, and all data subjects can understand the provided privacy information.		To consider alternative versions are available to ensure all data subjects can understand their rights and how their data is processed. The UHB was of the view that the current privacy notice satisfied this requirement but this will be reviewed.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				In order to ensure that the privacy information is effective, the organisation should consider means to evaluate how effective it is by means of user testing or evaluation of complaints. This would provide the organisation with assurance that they were effectively providing privacy information as required by the legislation. A log of historical Privacy Notices should be maintained to allow a review of what privacy information was provided to data subjects on what date. This would provide the organisation with assurance that it has carried out effective reviews of privacy information.		A log of privacy notices should be kept and maintained. The IG dept will work with the Concerns to ensure that a mechanism is introduced to ensure any concerns received about the Privacy Notice are fed back to the IG dept and used to inform future publications of the Privacy Notice.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that all staff receive regular training and refresher training on fair processing policies and privacy information.		Will speak to NWIS regarding national e-learning module to understand whether training on fair processing can be incorporated. The IG dept will also add guidance to its internal webpage for staff engagin with patients.	pc
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that it has documented what information needs to be given to the ICO in the event of a reportable data breach. This will provide assurance that breaches are being reported in accordance with the legislation.		Procedure detailing breach reporting procedure and what detail needs to be provided should be created	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that the organisation notifies individuals appropriately where there their personal data has been breached, the organisation should ensure that there is a documented procedure to ensure that the following is included in all breach reporting: the DPO details, a description of the likely consequences of the breach and a description of the measures taken to deal with the breach (including mitigating any possible adverse effects). This will help the organisation keep to the legislation when informing individuals about a data breach.		Procedure detailing breach reporting procedure and what detail needs to be provided should be created	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				Retained data should be reviewed on regular basis to identify any opportunities for minimisation or pseudonymisation of data to provide assurance for the organisation that they process the least information possible in line with the legislation.		This should be achieved by regular review of IAR. Linked to A23.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that the IAO function is effective, the organisation should formalise the appropriate level of access which IAOs have to the SIRO and DPO, and ensure that designated IAO responsibility is included in job descriptions. This will provide assurance to the organisation that the IAOs are able to effectively carry out their role in the risk management process as required in legislation. When IAO responsibility has been included in job descriptions, the organisation should ensure that all staff are aware of this and what the responsibility entails. This will provide further assurance to the organisation that the IAOs will effectively carry out their role in the risk management process as required in legislation.		The IG dept suggests that the role of IAO is assigned to a designated level of management across the organisation (e.g. Directorate Manager/General Manager) and that this role is incorporated into Job descriptions.	na
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that all staff with specific information risk roles receive regular training to provide assurance that they are able to carry out their roles effectively with regard to information risk.		TNA to be performed. National piece of work currently being undertaken.	na

IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that staff with specific risk management roles are fulfilling those roles effectively, the organisation should formalise means by which IAOs are routinely consulted on project and change management processes s and attend or are able to feed into IG meetings. This will provide assurance that they are carrying out their roles in relation to risk management effectively and thereby reduce the risk of a breach of legislation through information risk not being handled properly.		This is being considered by the IG group which will feed into Digital Management Board	na
JOINT EDUCATION ACCREDIATION COMMITTEE														
Specialist Services	Haematology	JACIE	South Wales BMT Programme	6th edition of JACIE standards	Stuart Walker	QSE Committee	Keith Wilson	1460	4-5/02/2019	01/02/2023	Minor deficiencies noted	01/10/2019	**One of the JACIE recommendations is a new fit for purpose facility and the plans for academic avenue were shared with the inspection team. If a new facility isn't progressed then the programme will not be re-accredited - the service have submitted the required improvement plan - awaiting re-accreditiaon status**	pc
MEDICAL GENETICS														
	Medical Genetics	SGS/UKAS		ISO 15189:2012	Fiona Jenkins	QSE Committee	Peter Thompson		2 and 5/11/19		Action Mandatory x 14 Require Evidence to UKAS x 14 Action Recommended x 5	05/12/2019	**Medical Genetics no longers sits in SpS CB. The service has transferred to the instiute of Medical Genetics**	
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			Descalated from MHRA Inspection Action Group March 2020	**c**
CD&T	Radiology, Medical Physics and Clinical Engineering	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			Descalated from MHRA Inspection Action Group 1st July 2020 Compliance is dependent upon ongoing commitment to rebuild of the facility	**c**
CD&T	Pharmacy	MHRA	Pharmacy SMPU	Good manufacturing practice (GMP) and good distribution practice (GDP)	Stuart Walker	QSE Committee	Darrel Baker	365	18/02/2020	18/02/2021	1 major 10 others	31/03/2021	Outstanding Estates issues to resolve to meet requirements of the regulator	**pc**
CD&T	Pharmacy	MHRA	Pharmacy UHL	Good manufacturing practice (GMP) and good distribution practice (GDP)	Stuart Walker	QSE Committee	Darrel Baker	365	23/07/2019	23/07/2020	3 majors 2 others	31/03/2020	Descalated from MHRA Inspection Action Group 1st July 2020	**pc**
CD&T	Medical Physics	MHRA	Medical Physics	Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices 2015.	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	ad hoc	02/01/2011	no inspection notified	No inspection to date in this area	n/a		na
CD&T	Medical Physics	MHRA	Medical Physics	Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use 2015.	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	ad hoc	03/01/2011	no inspeciton notified	no inspection to date in this area	n/a		na
CD&T	Medical Physics/ Clinical Engineering	MHRA	Medical Physics	Managing Medical Devices 2015	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	ad hoc	05/01/2011	no inspeciton notified	no inspection to date in this area	n/a		na
NATURAL RESOURCES WALES														
CD&T	Radiology	NRW	Radiology UHL	Environmental Permitting (England and Wales) Regulations 2016 Permit HB3393NA (Sealed Source Cat 5)	Fiona Jenkins	QSE Committee	Andrew Gordon/ Lesley Harris	1461	12/02/2020	no date set	none	compliant n/a		**c**
CD&T	Radiology	NRW	Radiology UHL and Theatres (unable to seperate visit and report)	Environmental Permitting (England and Wales) Regulations 2016 Permit HB3393NC (Open Sources)	Fiona Jenkins	QSE Committee	Andrew Gordon/ Lesley Harris	730	12/02/2020	no date set	Radiology - 3 actions - completed 0 non compliance	13/03/2020		**c**
CD&T	Radiology	NRW	Radiology UHW, Medical Physics, Radiopharmacy, Pathology & InVitro Lab (unable to seperate visit and report)	Environmental Permitting (England and Wales) Regulations 2016 Permit ZB3793ND (Open Sources) Previously CD9399	Fiona Jenkins	QSE Committee	Andrew Gordon/ Lesley Harris	730	30/04/2019	no date set	Radiology - 1 action, completed 1 recommendation, completed	01/05/2019		**c**
CD&T	Radiology	NRW	Radiology UHW, Medical Physics, Radiopharmacy, Pathology & InVitro Lab (unable to seperate visit and report)	Environmental Permitting (England and Wales) Regulations 2016 Permit CD9437 (Sealed Sources CAT 5)	Fiona Jenkins	QSE Committee	Andrew Gordon/ Lesley Harris	1461	30/04/2019	no date set	Radiology - None	Compliant n/a		**c**
OFFICE FOR NUCLEAR REGULATION														

CD&T	Radiology, Medical Physics and Clinical Engineering	ONR	Radiopharmacy	Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 (CDG), the Ionising Radiations Regulations 2017 (IRR17) and the Radiation (Emergency Preparedness and Public Information) Regulations 2019 (REPPIR19)	Fiona Jenkins	QSE Committee	Marc Sutton/Kathy Ikin	730	17/11/2020		Green rating 1 non-compliance 4 recommendations	15/01/2021		c
CD&T	Medical Physics	Office for Nuclear regulation	Medical Physics	The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	185 (Twice Yearly)	17/03/2017	17/11/2020	4 non conformances, 3 recommendaitons	01/05/2017	Inspection scheduled 17th November 2020 Gap analysis/readiness assessment completed	c
QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES														
Specialist Services	Immunology	Quality in Primary Immunodeficiency Services (QPIDS)	Immunology	Quality in Primary Immunodeficiency Services Standards	Stuart Walker	QSE Committee	Stephen Jolles/Richard Cousins	365	01/10/2019	**01/10/2024**	**Accreditation granted**		**Service has now been re-accreditated**	c
RESEARCH AND DEVELOPMENT														
	Haematology	Research and Development			Stuart Walker	QSE Committee								
UKAS														
CD&T	Cellular Pathology	UKAS	Cellular Patholgy/ (Mortuary - UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Adam Christian Scott Gable Sally Jones	365	25/03/2020- 02/04/2020 Reassessment 3/11/2020 interim inspection	02/03/2021				c
CD&T	Lab Med/Haematology	UKAS	Haematology/ Blood Transfusion laboratory	ISO 15189	Fiona Jenkins	QSE Committee	Andy Goringe Alun Roderick Vicky Cummings Rachel Borrell	365	31/03/20 - 7/04/20	20/04/21 - 22/04/21				c
CD&T	Lab Med/Haematology	UKAS	Phlebotomy (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Alun Roderick Vicky Cummings	365	31/03/20 - 7/04/20	20/04/21 - 22/04/21				c
CD&T	Biochemistry	UKAS	Biochemistry (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Carol Evans/Nigel Roberts	365	08/12/2020 to 11/12/2020		15 findings			c
CD&T	Biochemistry	UKAS	Specimen Reception (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Carol Evans/Nigel Roberts	365	08/12/2020 to 11/12/2019		Included in findings of Biochemistry UKAS			c
CD&T	Haematology	SGS/UKAS	Haematology/Blood Transfusion (UKAS)	ISO 15189:2012	Fiona Jenkins	QSE Committee	Alun Roderick	n/a	06/11/2019	n/a	Accreditation extra visit: Action Mandatory x 2 Require Evidence to UKAS x 1 Action Recommended x 1	06/12/2019	Blood transfusion sits in CD&T CB not SpS CB	
Institute of Medical Genetics	Medical Genetics	SGS/UKAS		ISO 15189:2012	Fiona Jenkins	QSE Committee	Peter Thompson		2 and 5/11/19		Action Mandatory x 14 Require Evidence to UKAS x 14 Action Recommended x 5	05/12/2019	Medical Genetics no longers sits in SpS CB. The service has transferred to the instiute of Medical Genetics	
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			
Specialist Services	ALAS	SGS/UKAS	ALAS (CAV)	ISO 9001:2015	Fiona Jenkins	QSE Committee	Paul Rogers	185 (Twice Yearly)	03-04/12/2020	03/06/2021	No corrective actions.	N/A	Happy with progress from previous audit, especially considering the circumstances over the last 8 months	c
Specialist Services	ALAS	SGS/UKAS	ALAS (CAV)	ISO 9001:2015	Fiona Jenkins	QSE Committee	Paul Rogers	185 (Twice Yearly)	15-17/01/2020	01/01/2021	2 x Major Corrective Actiions, 1 X Minor Corrective Action, Several Opportunities for Improvement	06/09/2019	Happy with progress from previous audit. The 2 opportunities for improvement are in progress and we will be able to demonstrate this at the next audit. RAG rating amber as will not receive confirmation of closure until next audit in Dec 2020.	pc
Surgical Services	Perioperative	SGS/UKAS	SSSU	ISO 13485:2016	Fiona Jenkins	QSE Committee	Clare Jacobs	365	01/01/2019	01/09/2019	3 minors	01/01/2020		
Surgical Services	Perioperative	SGS/UKAS	HSDU	ISO 13485:2017	Fiona Jenkins	QSE Committee	Mark Campbell	365	07/08/2019	01/08/2020	2 minors	07/08/2020		
WELSH WATER														
Estates		Welsh Water			Abigail Harris	Health and Safety								
WSAC														
Specialist Services	Audiology	WSAC	audiology - adults	audiology quality standards	Fiona Jenkins	QSE Committee	Lorraine Lewis	1095	01/06/2019	01/06/2022	compliant with 8 of 9 standards and meeting 85% target	12/07/1905		
Specialist Services	Audiology	WSAC	Newborn hearing screeing wales	audiology quality standards	Fiona Jenkins	QSE Committee	Jackie Harding	730	01/06/2018	01/06/2020	80% target met in all standards and 85% overall target met	01/01/2019		
Specialist Services	Audiology	WSAC	audiology - paediatrics	audiology quality standards	Fiona Jenkins	QSE Committee	Jackie Harding/Rhian Hughes	730	01/06/2018	01/06/2020	80% target met in all standards and 85% overall target met	12/07/1905		
WEST MIDLANDS QRS														
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	**Business case approved and funding relrease letter has been received.**	c

Report Title:	**Internal Audit Recommendation Tracker Report**								
Meeting:	Audit Committee						**Meeting Date:**	9th February 2021	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

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

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

The tracker shows progress made against recommendations from 17/18, 18/19 and 19/20. Following the Committee Meeting in November 2020 the tracker now also records recommendations which have been made during 2020/21.

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

As can be seen from the attached summary tables the overall number of outstanding recommendations has reduced from 111 individual recommendations to 110 during the period November 2020 to February 2021. Whilst the reduction is modest, this is reflective of the fact that a further 19 recommendations were added for the current financial year which counterbalanced the 20 that were recorded as completed in November.

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 (November 2020). Each Executive Lead has been sent the recommendations made by Internal Audit which fall into their remits of work.

The table below shows the number of internal audits which have been undertaken over the last three years and for the financial year 2020/21 (to date) and their overall assurance ratings.

	Substantial Assurance	Reasonable Assurance	Limited Assurance	Rating N/A	Total
Internal Audits 17/18	7	25	5	-	37
Internal Audits 18/19	10	26	7	-	43
Internal Audits 19/20	10	25	2	2	39
Internal Audits 20/21 (to date)	1	4	-	1	6

Attached at Appendix 1 are summary tables which provide an update on the November 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 regular follow ups with the Executive Leads.

Recommendation:

The Audit Committee Members are asked to:

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

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

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

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

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

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	No. of Recs Made	Rec No.	Rec. Rating	Recommendation Narrative	Management Response	Operational Lead for Recommendation	Agreed Implementation Date	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update
IA 1718	01/02/2018	WLI Payments Follow-Up	Chief Operating Officer	Reasonable	2	R1/2	M	The UHB has produced a WLI Payments Policy /Procedure and this has been disseminated to Directorates, but has yet to be finalised and approved by the organisation. Additionally, there are no local Directorate procedures in place for the management of WLI payments as they will work to the UHB Payments Policy/Procedure (Finding 1 – Partially Actioned).	Not Provided	Not Provided	01/06/2018	pc	WLI Policy drafted but review to ensure it aligns with the latest Welsh Consultant Contract delayed due to resources divrted to suport COVID. Aim is to complete review in February 2020.
IA 1718	01/02/2018	Residences	Director of Planning	Reasonable		R6/10	L	The UHB should document future plans for the provision and utilisation of residences.	The UHB 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.	D Winstone		na	All rental arrears are addressed with tennats and payments are agreed.
IA 1718	01/04/2018	Wellbeing of Future Generations Act	Director of Public Health	Reasonable		R4/5	M	The Health Board must ensure that its obligations in respect of the Act are appropriately communicated to all staff within the Health Board. We recommend that the Health Board develop a communications plan, which could be included within an Action Plan, to ensure that there is a cohesive approach to disseminating its obligations under the Act.	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 Communications	01/06/2018	c	The Director of Comms has confirmed 4.8.20 that the current comms plan is the formal plan, and will be subject tA communications plan has been regularly circulated for updates and feedback from the steering group. The activities and promotion of the benefits of the WFGA have been promoted but due to the ongoing global pandemic the steering group has not met. The work remains ongoing to support and promote the WFGA wherever possible.o at least annual updates. This will be circulated to all WFG Steering Group members
IA 1718	01/04/2018	University Hospital of Wales Neo Natal Development	Director of Planning	Reasonable		R6/7	L	The Capital Procedures Manual should be revised to include the requirement for a Project Director's Acceptance Certificate signed by the Chief Executive and Project Director.	Agreed	Director of Capital, Estates and Facilities	31/05/2018	pc	A review of the capital management procedure is due to be undertaken by internal audit in this financial year and the management will be updated to incorporate this and any other changes identified
IA 1718	01/04/2018	University Hospital of Wales Neo Natal Development	Director of Planning	Reasonable		R7/7	M	Requests for 'Single Tender Action' should be approved and reported to the Audit Committee in accordance with Standing Financial Instructions and the current UHB Scheme of Delegation. The Estates Department's Capital Projects Manual pro-forma, Single Tender Action Request form should be brought into line with the requirements of the Scheme of Delegation. Approval signatures for all Single Tender Actions should be obtained in accordance with the requirements of SFIs.	Agreed	Director of Capital, Estates and Facilities	31/05/2018	pc	Ongoing
IA 1718	01/05/2018	Business Continuity Planning Follow-Up	Director of Planning	Reasonable	1	R1/1	H	The significant, high priority, issue that remains from the original review can be summarised as follows: The EPRR team have begun to accumulate BCPs from across the Health Board, but at the time of fieldwork these plans do not cover all areas of the Health Board. Where plans have been supplied, these are not in the prescribed format set out by the templates within the BC guidance. Our review of the 3 sampled Clinical Boards identified that none had any documented BCPs in place. The audit has noted that whilst plans are not formally documented, that does not mean that there are not processes in place to manage business continuity in the event of some types of incidents. (Finding 2 – Not Actioned)	Not Provided	Not Provided	Not provided	pc	This action will be included for all future reports as appropriate so is partially completed.
IA 1718	01/05/2018	Mortality Reviews	Executive Medical Director	Reasonable		R2/3	M	The Health Board must ensure that level 1 mortality reviews are completed for all inpatient deaths.	A review of the current paper trail will be undertaken and improved as necessary. Clinical Boards will be reminded of the need to complete the level one reviews at the time of death certification as acquiring the notes afterwards is often difficult due to the current process of managing case notes of deceased patients in medical records. A meeting will take place with the CD for Internal Medicine to review their processes as they have the most deaths in the UHB. The Medical Director will note the findings of the Internal Audit in the June HSMB Meeting to ensure the Clinical Boards are reminded of their responsibility to complete level one reviews.	Quality & Safety manager/ Medical Director	01/06/2018	pc	Approx 80% of inpatient deaths undergo level 1 review New process in development, superseeding this issue The MD is currently working with the AMD for patient safety and governance, and the patient safety team, to develop a new process for learning from death reviews. This will be aligned with the introduction of the National Medical Examiner process which is curently in development in Wales. The new delivery process has the same aspirations as outlined in this audit . The Medical Examiner was due to made statuatory by April 2021. This has been delayed becuase of COVID-19. The Medical Examiner is due to start on a pilot basis from the 18th Jan 2021 at the UHL site.
IA 1718	01/05/2018	Mortality Reviews	Executive Medical Director	Reasonable		R3/3	M	The Universal Mortality Review form question pertaining to the need to trigger a Level 2 review should be revised and re-written to improve clarity and remove ambiguity as to its application.	The wording on the form and subsequent IT development was so that any 'yes' answer would trigger a level 2 review. The double negative was a calculated risk. Given this feedback we will review and revise it.	Quality and Safety Improvement Manager	01/07/2018	pc	Approx 80% of inpatient deaths undergo level 1 review New process in development, superceding this issue The MD is currently working wit the AMD for quality and safety, and the quality and safety team, to develop a new process for learning from new death reviews. This will be aligned with the introduction of the new Medical Examiner process which is curently in development in Wales. That new process has the same aspirations as outlined in this audit with a new delivery process. At the UHB level, a Mortality review group has been set up with representation from all the CB's. The review group is piloting different Stage 2 forms in clinical areas. Once the lay out of the stage 2 forms are agreed it will be rolled out across the HB.
IA 1718	01/06/2018	RTT Performance Reporting	Director of Transformation and Informatics	Reasonable	4	R1/4	M	The Health Board should ensure there is a formalised policy that encompasses the operational procedures for data collection, monitoring and reporting of RTT.	We accept that there is a need to review the appropriateness of our RTT policy, ensuring it is live and covers our developing processes for managing patients as well as any rule and definitional changes. At the present time WG are reviewing RTT measures and we have received requirements from WG that have material impact and conflict with existing guidance, primarily around ophthalmology measures, but there are also changes to diagnostics, sleep, cancer and cardiac. Whilst we will review and approve a local policy, the use of our limited resources will be directed primarily to influencing the development of the new waiting time rules and the requisite local implementation policy, procedures and training and awareness exercise.	Assistant Director of Informatics	01/09/2018	pc	performance reporting is being reviewed with input from the COO's office

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IA 1718	01/06/2018	RTT Performance Reporting	Director of Transformation and Informatics	Reasonable		R2/4	M	The Health Board should consider validating data of patients that are 'in target' due to the potential that these patients may have incorrectly applied suspensions and thus overall understating the amount of breaches.	We accept the point made in the context that data quality audits should extend to reported cancer waiting times – periodic audit of RTT pathways does already occur. Validation of all cancer pathways open and closed does occur at the weekly tracking meetings, and teams are reminded of the requirement to ensure that all management actions are accurately captured on the PMS system. A periodic audit, which will not be monthly, of data quality for cancer patients will be put in place as part of the new member of the cancer services team.	Head of Cancer Services	01/11/2018	pc	
IA 1718	01/06/2018	RTT Performance Reporting	Director of Transformation and Informatics	Reasonable		R3/4	M	The Performance Report should include a note next to the SCP compliance figures to ensure the Board understands that these figures are not necessarily accurate and are not a true reflection of performance as data collection systems are currently not fit for purpose and data sets have not been defined.	Accepted	Assistant Director of Informatics	01/05/2018	pc	the overall performance report is being reviewed for Qtr 4 2020/21
IA 1718	01/06/2018	RTT Performance Reporting	Director of Transformation and Informatics	Reasonable		R4/4	L	The Performance Report should include data on the related Cancer patient volumes in addition to percentage compliance as this will be a useful metric to aid the Board's understanding of scope (eg. Total number of USC/Non-USC and corresponding number of patients 'in target' and 'breached').	The reporting of volumes occurs infrequently. There is a balance to be had in the detail presented within the board report. The board have asked that they receive less granular information on the operational performance of the board and more detail on the strategic and tactical performance of the board. As such we will partially accept the recommendation and provide an infrequent update on volumes, unless of course it is a material factor in explaining performance.	Assistant Director of Informatics	01/06/2019	pc	the overall performance report is being reviewed for Qtr 4 2020/21
IA 1718	01/08/2018	Costing Review	Director of Finance	Reasonable	6	R1/6	H	Management will look to increase the level of clinical engagement throughout the costing process.	The agenda around costing, benchmarking and value has developed both nationally and within Cardiff and Vale, including clinical engagement and leadership across a number of value and improvement projects. The PCG/Assista patient level costing system and the PCB benchmarking platform now provide the UHB with an effective dashboard and detailed source information for analysing costing data at a component level. Utilisation may be complex, requiring statistical, financial and service knowledge, but an experienced team can support requests and projects as required. Data and analysis outputs are used by the organisation to inform the I&I agenda, CRPs and the IMTP more generally. Ad-hoc engagement over costing methodologies and service changes will continue to take place as part of the normal costing process.		01/04/2018	c	There is an increased and positive level of engagement with regard to benchmarking / costing data and the value agenda more broadly. Supported by the I&I team and clinical boards, a number of clinically led projects will make use of the available information and financial support, as part of the UHB's strategic objectives. Many projects have currently been paused due to the COVID-19 response, but the strategic direction is clear and projects will be prioritised and supported to recommence and complete as soon as possible.
IA 1819	12/02/2019	Performance Reporting Data Quality - Non RTT	Director of Public Health	Substantial		R2/3	L	The Performance Report working spreadsheet should be linked to data sources and SOPs in order to aid collation and ensure the on-going robustness of the process.	As identified above – not all the data is available to achieve this. The UHB is actively contributing, via membership of WG & NHS Wales committees to changing and improving data flows and making the required data available.	Assistant Director - Information and Performance		pc	work in progress to ensure accurate reporting is in place for Q4 2020/21
IA 1819	15/05/2019	Strategic Planning/IMTP	Director of Planning	Substantial	1	R1/1	M	Management should ensure that the plans for Clinical Boards are produced on a timely basis to enable the Clinical Boards to report on their projects in a consistent manner and allow them to monitor them appropriately.	A revised monitoring process for reporting clinical board progress on IMTPs will be in place for 2019/20. This will utilise the Shaping Our Future Wellbeing- Annual Plan (X-Matrix) methodology to provide clarity on performance and accountability arrangements. Progress against key IMTP priorities as captured in the annual plan document will be reported to Management Executives on a monthly basis as agreed at Management Executives on 09/05/19.	Corporate Strategic Planning Lead	01/07/2019	na	
IA 1819	30/08/2018	Dental CB – Theatre Sessions	Chief Operating Officer	Reasonable	3	R1/2	H	The Dental administration staff should ensure that Patient Dental files contain copies of all necessary documentation relating to the procedures undertaken.	Urgent meeting to be arranged with Clinical Lead and Peri-Operative Care Manager to define a process to manage documentation	Eira Yassien	01/09/2018	c	Now complete
IA 1819	15/02/2019	Kronos Time Recording System - Estates	Director of Planning	Reasonable	6	R1/6	H	Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system.	Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system.	Business Manager	01/06/2019	pc	Interface requires testing to complete pilot
IA 1819	15/02/2019	Kronos Time Recording System - Estates	Director of Planning	Reasonable		R4/6	M	Where overtime has been worked this should be reflected in the start and finish times recorded in Kronos, and should be authorised on the timesheets. Management should investigate the feasibility of including a 'reason for overtime' or Notes field on timesheets with the system providers so that in future all overtime can be claimed and authorised on individual timesheets	The issue will be considered as part of the system review although all overtime is authorised and recorded therefore the risk is low. Kronos has been updated to include overtime reasons.	Senior Manager (Performance and Compliance)	01/06/2019	na	
IA 1819	15/02/2019	Kronos Time Recording System - Estates	Director of Planning	Reasonable		R5/6	M	Staff should be instructed to clock in no more than 27 minutes before the start of their shift. Where staff do clock in more than 27 minutes before the start of their shift, supervisors should amend the timesheet start time to the scheduled start time if the additional time is not to be paid as overtime. Supervisors should	Staff clock in on arrival on site but are not paid from this point, unless authorisation is given for overtime. Staff will be advised not to clock in as suggested and this will be monitored but the risk associated with this practice is considered low.	Head of Patient Safety	01/03/2019	na	system rules setup to overide early clocking in. If staff clocks in early and work overtime supervisers amend early clocking in.
IA 1819	15/02/2019	CRI Safeguarding Works	Director of Planning	Reasonable	5	R1/5	M	Progression at risk should be fully documented, approved and recorded at the risk register (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Capital Estates and Facilities	22/05/2020	na	Included on the project risk register
IA 1819	15/02/2019	CRI Safeguarding Works	Director of Planning	Reasonable		R4/5	L	4) Project benefits should be clearly identified and documented in the business case, including: • Baseline value; • Method of measurement; • Target improvement; • Timing of when the benefit would be achieved; and • Lead responsibility for the benefit (D). (This recommendation being for implementation at future projects). Post project evaluations should be delivered in accordance with agreed Business Case requirements, or a revised approach should be appropriately approved (O).	Agreed. **ALL FUTURE PROJECTS**	Head of Outcomes Based Commissioning	01/05/2019	na	
IA 1819	15/02/2019	CRI Safeguarding Works	Director of Planning	Reasonable		R5/5	L	5) The required approach to post project evaluation and benefits assessment should be agreed with the Welsh Government, in relation to the CRI afeguarding project and wider investment at the CRI site (O).	Agreed.	Head of Outcomes Based Commissioning	01/04/2020	na	

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IA 1819	11/04/2019	Commissioning	Director of Transformation and Informatics	Reasonable	3	R1/3	H	Strategic Commissioning Group Terms of Reference document should be revised and updated to state the quorate attendance level and its current membership. Additionally, its membership should include representation from the Clinical Boards to ensure a broad contribution and as such an improved strategic approach in full alignment with the Group's Terms of Reference.	The Strategic Commissioning Groups Terms of Reference, including membership was reviewed at a facilitated workshop on 20th Feb 2019. The first draft of a refreshed Terms of reference is scheduled for discussion at the May 2019 meeting of the Strategic Commissioning and Finance Group. Clinical Board representation will be fully considered.	Eleri Probert	01/04/2019	na	
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R2/7	M	The current position in respect of the backlog of remedial jobs, should be routinely reported to the Water Safety Group (O).	Agreed	Director of Capital, Estates & Facilities	30/06/2019	pc	Ongoing discussions at scheduled meetings
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R3/7	M	Training should be updated for all key staff with assigned water management responsibilities (O).	Agreed	Chair of Water Safety Group	30/07/2019	na	
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R4/7	M	a) An audit trail should be maintained where routine checks are not completed, in cases where risk-based decisions dictate alternative monitoring/testing schedules will be applied. b) Key person dependency should be reviewed and removed, where possible, to facilitate the timely identification and completion of	Agreed	Director of Capital, Estates & Facilities	01/11/2019	pc	Statutory inspections ongoing, information being entered into MiCad, live database
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R5/7	H	a) For those clinical boards identified in this audit as being non-compliant with required flushing practices, the Chair of the WSG should request assurance from the clinical boards that practices have been improved. b) The Chair of the Water Safety Group should ensure that flushing guidance is re-issued to all clinical boards for full circulation to relevant staff (O).	Agreed	Director of Capital, Estates & Facilities	01/11/2019	na	
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R6/7	H	The risk assessment process, including preparation of appropriate prioritised action plans to address the identified risks, should be completed as soon as possible (D).	Agreed	Richard Hurton	30/07/2019	na	
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R7/7	M	Progress, including highlighting of any delays, should be regularly reported to the Water Safety Group (O).	Agreed	Richard Hurton	31/10/2019	na	
IA 1819	15/05/2019	UHB Core Financial Systems	Director of Finance	Reasonable		R3/5	M	Management should inform responsible staff to promptly notify eEnablement of changes to the Purchasing Oracle hierarchy list. The required forms should be completed to process updates.	Recommendation Accepted. The UHB's current procedure will be updated to clarify the responsibility to review approvers at the Clinical Board level and within Corporate Finance. NWSSP have developed a new Oracle User Accress Form which is now in use. NWSSP have now provided a user guide for the new Oracle Access form and the Oracle Purchase Hierarchy Report. The UHB will incorporate the guides within its budgetary control procedure by the end of October.	Paul Emmerson	31/07/2019	c	A list of actions were agreed with NWSSP Procurement eEnablement on the 21st June 2019. Actions included the establishment of a revised Oracle User Form which would include ESR position numbers which could be linked to Oracle responsibilities. **On the 15.06.2020 NWSSP confirmed that the user forms had been revised. The revised forms are now in use. Training on Oracle hierarchys delivered to Clinical Boards on November 13 2020.**
IA 1819	15/05/2019	UHB Core Financial Systems	Director of Finance	Reasonable		R4/5	M	Management should ensure that a standard procedural guide is produced to support staff in the maintenance of the Oracle Purchasing hierarchy. The guide should also state an appropriate agreed period for the review of the hierarchy.	Recommendation accepted. The UHB's current procedure will be updated to clarify respective responsibilities at the Clinical Board level and within Corporate Finance. The minimum expectation is that purchasing hierarchies will be reviewed quarterly. NWSSP have now provided a user guide for the new Oracle Access form and the Oracle Purchase Hierarchy Report. The UHB will incorporate the guides within its budgetary control procedure by the end of October.	Dr Matt Wise, Clinical Director / commenced April 2019 – completion by April 2020	01/04/2020	c	A list of actions were agreed with NWSSP Procurement eEnablement on the 21st June 2019. Actions included the establishment of a revised Oracle User Form which would include ESR position numbers which could be linked to Oracle responsibilities & an agreement to investigate whether Finance staff could be provided with read only access to hierarchies. The read only access to hierarchies was sucessfully tested and an amended "CVT Finance Inquiry" responsibility in Oracle PROD was applied with the following and provision of access to hierarhcies (as per email 27.11.2019) ; • Purchase Order Summary (assigned 'View Invoices' and
IA 1819	15/05/2019	UHB Core Financial Systems	Director of Finance	Reasonable		R5/5	M	Management should ensure that the required forms are completed, signed and forwarded to eEnablement for all additions to the Oracle Hierarchy. Management should also liaise with eEnablement to ensure there is an organised system for storing the Financial limit forms so they can be easily retrieved here an audit trail is required.	Recommendation accepted. The UHB's revised procedure will be updated to clarify respective responsibilities for establishing approvers and maintaining appropriate records for additions to the Oracle Hierarchy. NWSSP have now provided a user guide for the new Oracle Access form and the Oracle Purchase Hierarchy Report. The UHB will incorporate the guides within its budgetary control procedure by the end of October.	Daniel Farr	31/08/2019	c	A list of actions were agreed with NWSSP Procurement eEnablement on the 21st June 2019. Actions included the establishment of a revised Oracle User Form which would include ESR position numbers which could be linked to Oracle responsibilities & an agreement to investigate whether Finance staff could be provided with read only access to hierarchies. The read only access to hierarchies was sucessfully tested and an amended "CVT Finance Inquiry" responsibility in Oracle PROD was applied with the following and provision of access to hierarhcies (as per email 27.11.2019) ; **The revised oracle user template was received from NWSSP on August 8 2020 for testing. Plans to test are expected to be develeped by the end of August.On the 15.06.2020 NWSSP confirmed that the user forms had been revised. The revised forms are now in use. Training on Oracle hierarchys delivered to Clinical Boards on**
IA 1819	17/05/2019	Specialist Services Clinical Board – Medical Finance Governance	Chief Operating Officer	Reasonable	2	R1/2	H	Management should carry out a comprehensive review of the current and future consultant staffing levels to ensure that the Critical Care service can be sustainably delivered in the future. This should include review of the current service model.		Directorate Managers for Adult and MHSOP	01/04/2019	c	Active recruitment taking place and plan to be fully recruited to existing capacity by Nov 2020 succession planning being identified and models of care being reviewed
IA 1819	18/01/2019	Legislative/Regulatory Complaince	Director of Corporate Governance	Reasonable		R5/7	H	The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Agreed	Head of Health and Safety	01/02/2019	pc	It should be recognised that the current all Wales FRA tool used by all Welsh Health Boards and managed by SSP does not evidence completion of actions making evidance of
IA 1819	18/01/2019	Legislative/Regulatory Complaince	Director of Corporate Governance	Limited		R6/7	H	The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers.	Agreed	Head of Health and Safety	30/06/2019	na	This action if for the Fire Safety Manager to be followed up by end of June
IA 1819	14/02/2019	Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up	Chief Operating Officer	Limited		R2/6	H	Management should ensure that all members of staff within the directorate are fully compliant and up to date with their mandatory training. If staff members believe that ESR is not tracking when a module is completed, staff should print out the certificate available to provide proof and store it within their personal file.	Improved compliance for 85% of staff with completion of 100% mandatory and statutory training modules (44% improvement over 6 months). Staff to be allocated onto study leave planner and compliance monitored monthly via ESR and discussed with ward managers at 121s.	Dave Thomas	01/07/2019	c	Update August 2020 - Monthly IM Directorate Performance Review meetings are held on a monthly basis. There has been a challenge for the past four months with increased covid activity causing staff to be off sick and shielding. The Directorate plan has been developed by the Lead Nurses for the completion of all VBA and statutory and mandatory training to be completed by the end of the 2020 calendar year.
IA 1920	16/08/2019	Carbon Reduction Commitment	Director of Planning	Substantial	1	R1/1	M	The UHB should ensure that the strategy is agreed as soon as possible so that the surplus allowances can be sold for the best achievable price.	The UHB will be agreeing the strategy regarding the course of action to be adopted for surplus allowances during August 2019.	Head of Energy and Performance	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.

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IA 1920	23/09/2019	Legislative / Regulatory Compliance	Director of Corporate Governance	Reasonable		R5/7	M	The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Agreed	Head of Corporate Governance	01/02/2019	pc	It should be recognised that the current all Wales FRA tool used by all Welsh Health Boards and managed by SSP does not evidence completion of actions making evidance of closure a laborious resource intensive task. However CEF intend to develop an alternative electronic system to enable closure of actions to be carried out by the responsible person attributed to each action resulting in evidence that is both current and auditable.
IA 1920	23/09/2019	Legislative / Regulatory Compliance	Director of Corporate Governance	Reasonable		R6/7	M	The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers.	Agreed	Directorate Managers for Adult and MHSOP	01/05/2019	pc	This action if for the Fire Safety Manager to be followed up by end of June
IA 1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited	4	R1/6	H	Clinical Boards must ensure that all consultants complete a job plan or have their existing job plan reviewed on an annual basis.	1. Processes are in place to support the completion and reporting of job planning activity. There is monthly reporting of the annual job planning process via the Clinical Board Performance reviews. There has been recent improvement in a small number of Clinical Boards. Immediate steps will be taken by the Medical Director and the Director of Workforce to target those Clinical Boards with poor performance and those not significantly improving (5 out of 8) to request an improvement plan which will ask for reported improvement in annual job planning review rates over a period of three months. Clinical Board Directors should ensure that the Clinical Directors take responsibility for these being undertaken and have internal Clinical Board systems to monitor improvement. 2. The Medical Director and Workforce Director will present to the HSMB in June 2018 the outcome of the Internal Audit Report - outlining the actions to be taken and re-emphasise the information available to the Clinical Boards and Clinical Directorates.	1. Clinical Board Directors – Monitor compliance on a monthly basis through the Clinical Board Performance Reviews with joint review of improvement trajectorymonitored via the Medical Director /Director of Workforce. Immediate request for improvement plan, documenting improvement trajectory over three months. 2. 15th June 2018 Medical Director /Director of Workforce.		pc	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system.
IA 1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited		R2/6	H	The UHB job planning guidance should require consultants to use the standard Job Plan template contained within the guidance unless they can provide a valid reason for not doing so. Job Planning documentation should be completed in full and should include full details of the activities to be undertaken in each session. Line managers should ensure that the number and split of sessions recorded in ESR agrees to and is supported by a fully completed job plan.	1. Clinical Board Directors and Clinical Directors should ensure that summary job plans data are submitted to the Medical Workforce Team on a regular basis so that updates can be made in the ESR system. This will be recognised by implementation of actions in Management Recommendation 1 in terms of outcomes. 2. Medical Workforce to update ESR system with summary job plan data – this has been already reviewed by the Medical Director and Director of Workforce recently and there is no back-log of data to currently input into the system (maximum wait two weeks). Clinical Directors/DM will be able to submit to ESR and their data will be entered in a timely way. The previous guidance issued will be immediately reissued to Clinical Board Senior Teams for cascade to their Clinical Directorates.	1. Clinical Board Directors/Clinical Directors – one to three months. 2. Medical Director – Immediate.		pc	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system.
IA 1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited		R3/6	H	Clinical Board management must ensure that all consultants complete the outcome measures template contained within the UHB Job Planning guidance as part of the job planning process.	1. Review of job planning guidance with regard to job plan template and re-issue to Clinical Board Senior Teams for cascade to their Clinical Directorates. 2. The Medical Director and Workforce Director will present to the HSMB in June 2018 the outcome of the Internal Audit Report - outlining the actions to be taken and re-emphasise the information available to the Clinical Boards and Clinical Directorates.	1. Medical Director and AMD for Workforce and Revalidation - one month. 2. 15th June 2018 Medical Director/Director of Workforce.		pc	24/08/2020: First draft of procedure sent out to BMA for comments and to all CBDs and CDs for comments.Awaiting comments, this procedure will then go out for 28days consultation prior to approval. Procedure includes the need to complete the outcome forms
IA 1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited		R4/6	H	In accordance with the guidance, Clinical Board management should ensure that individual, personalised schedules are completed for all consultants that are on Team or Annualised Hours Job Plans.	Review of job planning guidance with regard to job plan template and re-issue to Clinical Board Senior Teams for cascade to their Clinical Directorates. This will emphasise the need for all members of a team to complete individually the team job plan.	Clinical Board Directors action - Issues by Medical Director and AMD for Workforce and Revalidation - one month.		pc	24/08/2020: First draft of procedure sent out to BMA for comments and to all CBDs and CDs for comments.Awaiting comments, this procedure will then go out for 28days consultation prior to approval. Procedure includes annualised job plans, with the annual job plan cycle aligned to the financial year. Please see procedure for details
IA 1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited		R5/6	L	The UHB should consider developing additional methods of communication and / or training for both line managers and consultants to improve the completion rate and quality of consultant job plans.	A planned schedule for training should be refreshed and communicated, including sources of information available to Clinical Directors. **Implemented.** Evidence was provided to confirm that a series of training sessions detailing the findings from the original audit was delivered by the Assistant Medical Director (Medical Workforce and Revalidation).	Assistant Medical Director Workforce Revalidation working with Medical Workforce Department/LED/Communications Team / Three months		na	24/08/2020: Training has been provided by the AMD for Workforce and implemented. In line with the implementation of the e-JP system, a revised training plan will be developed to update all CDs with how this will work with the new system.
IA1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited		R6/6	M	All completed job plans must be signed by the Consultant and the clinical manager responsible for agreeing them. The standard Job Plan documentation included in the UHB Job Planning guidance should be updated to incorporate the use of digital signatures.	1. The job plan review does not require an actual signature but there does need to be a record of the job plan being agreed by all parties and signed. 2. An electronic job planning system will be trialled in Cardio Thoracic should provide a seamless and electronic system solution in the future, pending evaluation of the pilot and consideration of costs. This will include the ability for electronic sign off.	1. Clinical Board Director/CD - 3 months. 2. Assistant Medical Director - Workforce - 3 months reviewpilot progress.		na	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system. The system will make use of digital signatures. Within procedure and system, noted that no response will be taken as assumed acceptance of JP.
IA 1920	24/02/2020	Brexit Planning	Director of Planning	Reasonable	4	R1/4	H	The business continuity arrangements within Mental Health should be further reviewed, scrutinised, approved and embedded within the Clinical Board.	Draft business continuity plans completed and circulated within Mental Health, and shared with EPRR Team. The Clinical Board is holding a Business Continuity Exercise for mental health leads, facilitated by EPRR (30.03.20); with aims to review local preparedness planning and enhance organisational resilience in case of disruption to the organisation's critical services. Business continuity also a standing agenda item on the MHCB Health and Safety meetings.	Ian Wile - Director of Operations June 20		na	
IA 1920	24/02/2020	Brexit Planning	Director of Planning	Reasonable	4	R2/4	M	Management information surrounding areas of lower compliance should be distributed to the clinical/service boards and staff should be encouraged to complete the nationality section on ESR.	Work will continue to address the information gap by encouraging Clinical and Service Boards to encourage their staff to update their information. The Head of Workforce Governance will provide, if required, information on a Directorate or Department basis of staff whose nationality is blank on ESR. In addition, Workforce and Organisational Development have determined the email addresses of 2,148 of the 4,467 staff. Individual emails, with a step by step guide, have been sent to the 2,148 staff encouraging them to update their nationality on ESR.	Andrew Crook - Head of Workforce Governance. October 20		na	
IA 1920	24/02/2020	Brexit Planning	Director of Planning	Reasonable	4	R3/4	M	Staff should be reminded to the importance for attending meetings.	Group members are committed to attending meetings. However, existing work commitments, no-notice issues and winter pressures have all contributed to a slight reduction in the expected attendance. If/when the group reconvenes later in 2020, the membership will be reviewed, deputies nominated, and the importance of regular representation emphasized again.	Abigail Harris – Executive Director of Planning. November 20		na	
IA 1920	24/02/2020	Brexit Planning	Director of Planning	Reasonable	4	R4/4	L	Going forward, if there is a requirements for daily reporting in the future; all required areas of the Health Board should complete the required forms.	UK/Welsh Government reporting focussed on the key areas of Medical Devices/Clinical Consumables, General Supplies and Workforce. As such – the key areas for concern were primarily Clinical Boards – hence the requirement for daily reporting. However, the recommendation is noted.	Abigail Harris – Executive Director of Planning. December 20		na	

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IA 1920	24/01/2020	Freedom of Information	Director of Transformation and Informatics	Reasonable	7	R7/7	L	FoI certification or additional FoI training should be available for team members whose role involves processing and answering FoI requests.	FOI lead in discussion with NWIS re national approach to training.	Information Governance Manager/ Q1 2020/21		pc	potential training opportunities discussed at local and national level;
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R1/6	M	The UHB Study Leave Procedure for Medical & Dental Staff should be reviewed and revised. The policy should more clearly specify: - roles and responsibilities – of Directorates, Managers, Consultants; - funding and budget guidance. - monitoring and compliance arrangements including KPIs; and - reporting arrangements.	UHB Study Leave procedure document will be reviewed and strengthened in the areas outlined in the report. This will require agreement with the Local Negotiating Committee (LNC) of the UHB.	Executive Director of Workforce and OD & Medical Director	01/07/2020	pc	Hilary Sharp met with the BMA in December 2020, actions were set. This work is ongoing.
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R3/6	M	Directorate administrative arrangements should be reviewed and strengthened in line with the revised Health Board Procedure and as a part of producing local operational procedures, particularly the recording of clinical authorisation on Intrepid. Procedures should include the checking of core data on an annual or rolling basis	Comprehensive Review of local processes Directorate by Directorate will take place to ensure consistency of process with UHB Procedures and guidance	Executive Director of Workforce and OD & Medical Director	01/09/2020	pc	Unfortunately these responses have not been received via email requests. They may well be inudated with emails due to Covid pressures. We will endeavour to link with the appropriate people directly.
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R4/6	M	The following arrangements are reviewed and strengthened:- - budget setting, monitoring and reporting; - payment of honorary staff expenses; and - ability to access Trust funds to support study leave budgets.	Capped annual or triannual budget allocations are to be introduced after discussion with the LNC. Honorary Academic Consultants are contractually entitled to 0.6 of this annual or triannual allocation as per contract terms and conditions. Once capped allocation agreed consistent budget line allocation will be anticipated against which spend can be measured.	Executive Director of Workforce and OD & Medical Director	01/09/2020	pc	Discussed in the LNC (w/c 11.01.21). Alison Edwards, Richard Skone and Hilary Sharp are to meet to discuss further. Ongoing.
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R5/6	M	Assess and review the use of Intrepid as a tool for managing activities other than junior doctors and formulate a plan going forward.	Intrepid approval system enables approver to view a 'team' leave view that facilitates approval only where cover for clinical services can be managed and Intrepid will not allow leave application unless cover has been agreed by a named colleague. The UHB is currently considering options for e rostering of Medical Staff etc within the Medical Productivity Project alongside e job planning.	Executive Director of Workforce and OD & Medical Director	01/12/2020	pc	E job planning - training and system is in place. Kirsten Mansfield is in post who is the lead on this work. E job planning should be operational by April 2021. E-Rostering - Julie Cassley looking at this with Alaa and Trisha (project managers). Workshop to be arranged in February with key stakeholders.
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R6/6	M	Develop the Intrepid User Group to co-incide with the introduction of the updated Health Board Procedure and local operational procedures.	Intrepid User Group will be refreshed with revised TOR and membership. Minutes of meetings and associated Action plans will be reviewed by the Medical	Assistant Medical Director (Workforce and Revalidation),	01/07/2020	pc	Two members from the BMA have been nominated. To be reviewed at the next
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R1/11	M	RAMS (where applicable) should be requested and retained prior to the contractor commencing the relevant activity on site (O)	Accepted. RAMS will now be incorporated within the database implemented in January 2020. It will be the Engineering Manager's responsibility to review the database on a weekly basis to ensure the required suite of RAMS is evident. A sample check of the database will be undertaken on a monthly basis by the Health & Safety and Asbestos Manager, to ensure compliance and reported to the Capital, Estates & Facilities Department Health & Safety Meeting. The first compliance check will be reported to the March 2020 meeting.	Health & Safety and Asbestos Manager	01/03/2020	na	
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R2/11	L	Management should undertake a data cleansing exercise of the Backtraq system (O)	Accepted. An initial review of the database, in consultation with the relevant officers within the Capital, Estates & Facilities department, will be undertaken to remove any contractors that have not been used in the past three years. The remaining contractors will then be reviewed accordingly.	Health & Safety and Asbestos Manager	01/10/2020	na	
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R3/11	M	Induction content should be reviewed and updated to reflect current practice (O)	Accepted. The presentation will be updated to reflect current practice. The audit-visual presentation will be audible version of the induction will be removed from use until any ambiguities in the narrative have been addressed. In the interim, physical presentations by UHB staff will be undertaken.	Health & Safety and Asbestos Manager	01/03/2020	na	
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R6/11	M	The functionality of the Backtraq system should be reviewed for the timeliness and detail of the management information provided. (D).	Accepted. Initial discussions have been held with the software provider re: potential enhancements to the existing system. However, it is accepted that a standalone system for sign in/out would be more effective. Different options will need to be reviewed to determine an appropriate direction of travel.	Head of Discretionary Capital & Compliance Health & Safety and Asbestos Manager	01/09/2020	na	
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R8/11	L	A Permit to Work procedure should be developed, ratified and communicated to all relevant officers (D)	Accepted. The procedure is currently out for consultation and will be presented to the Capital, Estates & Facilities department Health & Safety meeting for ratification at the March 2020 meeting.	Head of Discretionary Capital & Compliance Health & Safety and Asbestos Manager	01/03/2020	na	
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R9/11	M	Management should collate the output of the contractor monitoring forms for reporting to an appropriate forum; for actions to be taken where required. (O)	Accepted. In the role of Framework Manager, the Head of Discretionary Capital & Compliance, will initially hold six-monthly review meetings with all contractors addressing the recommendation requirements; and subsequent frequency will be dependent on how often the contractor is used by the UHB. However, all will have an annual review meeting.	Head of Discretionary Capital & Compliance	01/09/2020	na	
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R10/11	M	Formal post completion review meetings of contractor performance should be undertaken in accordance with HSE guidance (O)	Accepted, as per the response to recommendation 9.Accepted, as per the response to recommendation 9.	Head of Discretionary Capital & Compliance	01/09/2020	na	
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R11/11	M	An annual audit of compliance with the policy should be completed and reported to an appropriate forum. (O)	Accepted. Discussions will be held with the Head of Health & Safety with a view to enhance the data that is reported to the Health & Safety Committee within the Annual Report.	Health & Safety and Asbestos Manager	01/06/2020	na	
IA 1920	30/03/2020	Risk Management	Director of Corporate Governance	Reasonable	4	R1/4	M	We recommend that the risk management training framework is finalised and detailed training materials are developed for roll out across the health board.	A detailed plan will be developed but due to activities which Clinical Boards are dealing with in relation to COVID 19 the roll out of that programme will be delayed.	Head of Risk and Regulation	07/2020 - 12/2020	pc	Contact has been made with Clinical Boards to establish risk leads and a training programme is scheduled to be rolled out during November. A new Risk and Regulation Officer commenced work in October 2020 and will be tasked with progressing the training regime from the date of appointment.
IA 1920	30/03/2020	Risk Management	Director of Corporate Governance	Reasonable	4	R2/4	M	We recommend that training initiatives include the distinction between risks and issues and that the latter are addressed through an alternative allied management oversight activity.	Agreed – this will be picked up through the detailed training programme referenced above.	Head of Risk and Regulation	01/07/2020	na	To be addressed in training programme commencing November 2020
IA 1920	30/03/2020	Risk Management	Director of Corporate Governance	Reasonable	4	R3/4	M	We recommend that going forward the weaknesses observed in the recording of risk mitigating actions are addressed.	Agree this will initially be addressed through the training programme and then there will be a continuous review and support to ensure the weaknesses do not reoccur.	Head of Risk and Regulation	01/07/2020	na	To be addressed in training programme commencing November 2020
IA 1920	18/05/2020	UHW Neonatal Development	Director of Planning	Substantial	2	R1/2	L	The UHB should ensure KPI / performance management submissions are completed as per Framework guidance (O).	Agreed. Management will ensure that the Project Manager provides reminders to the key officers at the UHB facilitate submission of the KPIs as per the Framework guidance.	Director of Capital, Estates & Facilities	At Future Projects	pc	ongoing until the end of the prorject
IA 1920	18/05/2020	UHW Neonatal Development	Director of Planning	Substantial	2	R2/2	L	Assurances should be provided by the Cost Adviser that source documentation is reviewed routinely, not limited to final account, in confirming calculations of staff / labour costs attributed to the project (O).	Agreed. Management will write to the Cost Advisers setting out the requirements to provide assurances that source documentation has been appropriately reviewed prior to the sign off of the monthly certificates.	Director of Capital, Estates & Facilities	At Future Projects	pc	ongoing until the end of the prorject
IA 1920	18/05/2020	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	Reasonable	3	R1/3	M	Management, in consultation with their advisers, should seek approval of plans for financing the shortfall in the 2020/21 financial year. Continued scrutiny will be applied of the reasonableness for further changes requested / required to the project. (O)	Agreed. Any changes to the project are routinely scrutinised by Project Board. The potential project overspend has been reported at every Capital Management Group so Executives are fully aware of the position. This will continue to be monitored as the project moves towards closure with the expectation that any shortfall will be met from the UHB's discretionary capital programme.	Director of Capital, Estates & Facilities	ongoing to end of project	pc	ongoing to the end of the project. Changes to be agreed with project board and capital management group due to the UHB financial position
IA 1920	18/05/2020	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	Reasonable	3	R2/3	M	The risk register will be updated to extend consideration of mitigation actions for the ten open risk identified; and consideration will be given for new risks as they arise. (O)	Agreed. The Project Director will write to the Project Manager as custodian of the project risk register to ensure: a) It is completed appropriately; and b) It is considered at all progress meetings.	Director of Capital, Estates & Facilities	01/05/2020	pc	ongoing. Risk register reviewed at regular project team and project board meetings
IA 1920	18/05/2020	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	Reasonable	3	R3/3	M	All payments should be made in accordance with the terms of the contract. (O)	Agreed. The Capital Planning leads will be reminded to process payments within seven days of receipt of the Project Manager's certification.	Director of Capital, Estates & Facilities	01/05/2020	pc	Continuing monitoring of payments in accorance with the terms of the contract

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IA 1920	18/05/2020	Surgery CB - Enhanced Supervision	Chief Operating Officer	Reasonable	7	R7/7	L	Ward Managers should be provided with training relating to the use of theenhanced supervision facility on Clinical Workstation as it would provide 'real time' information and aid the active monitoring and management of patients	Awareness will be raised on the use of the icon on the Clinical Work station via professional nursing forums and by local communication routes	Director of Nursing for Surgery CB	01/09/2020	c	Action due to be completed Sept 2020
IA 1920	21/05/2020	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	5	R1/5	H	The UHB should ensure policies are reviewed and updated within appropriate timescales.	A plan will be put in place to review all out of date policies and to contact document owners to update their policies. Due to activities which colleagues are dealing with in relation to COVID 19 the roll out of that plan will be delayed until Health Board staff have substantially returned to a business as usual position.	Head of Corporate Governance	01/12/2020	na	
IA 1920	21/05/2020	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	5	R2/5	M	Review the 'register' for completeness. Assess if all policies, procedures and other written control documents available on the intranet and internet are current and then ensure they are all recorded appropriately in the 'register'.	A plan will be put in place to review the register for completeness and to consider that document alongside the written control documents available on the intranet and internet. It is assumed that not all documents available on the intranet and internet will fall to be monitored and maintained by the Corporate Governance team and plans will be put in place to correctly identify and collate those which are and those that will be monitored and maintained at a local level. Due to activities which colleagues are dealing with in relation to COVID 19 the roll out of that plan will be delayed until Health Board staff have substantially returned to a business as usual position.	Head of Corporate Governance	01/12/2020	na	
IA 1920	21/05/2020	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	5	R3/5	M	1. Review the readability of documents to make ways to write clearer, especially those available through internet to wider audience. From register, 372 out of 393, recorded as published on internet.	Recommendations are noted and agreed. A plan will be put in place to action the recommendations and circulate appropriate messages to document owners to address the issues raised.	Head of Corporate Governance	01/12/2020	na	
IA 1920	21/05/2020	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	5	R4/5	L	Review of record keeping process for when a request is made to create new written control document; from receipt of request to create, to issue of draft for consultation. Review of record keeping process for the consultation process; from request made, publishing and any feedback received.	Recommendations are noted and agreed. A plan will be put in place to action the recommendations and put in place appropriate processes.	Head of Corporate Governance	01/12/2020	na	
IA 1920	21/05/2020	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	5	R5/5	L	Review of record keeping process for notifying stakeholders of new, amended and exiting policies.	Review of record keeping process for notifying stakeholders of new, amended and exiting policies.	Head of Corporate Governance	01/12/2020	na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R1/10	H	Temporary Staffing Management should revise their current pre-employmentchecks procedures. The following highlighted areas should be considered for revision:				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R2/10	M	Health Board managers should be reminded that internal applicants cannot commence in post prior to pre-employment checks being fully completed. Managers should also be reminded to take notice of the weekly Trac update				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R3/10	M	Temporary Staffing Department management to familiarise themselves with the NHS Employment Checks Standards and implement appropriate procedural guidance, ensuring it satisfies all requirements/criteria of the Standards.				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R4/10	M	Management to review the process for Consultant reference checks to ensure it adheres to the relevant guidance.				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R5/10	L	Management to review the Employment Services SLA.				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R6/10	L	Management to review Internal and External Recruitment Process Flowcharts and determine if their content is relevant.				c	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R7/10	L	Management to review the apparent contradicting information found in the NHS Reference Standard and the NWSSP Reference Guidance and determine which is more relevant. Management should consider updating the guidance if necessary.				c	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R8/10	L	NWSSP Recruitment and Health Board recruiting managers to be reminded of the importance of considering validity of references when undertaking and approving pre-employment checks.				c	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R9/10	L	Management should review all supporting policies/procedures listed in the CVU Recruitment Policy. Management should review and consider updating the Secondment Policy to include the requirement for pre-employment checks to be completed before an employee can commence in a secondment post. Management should review the Recruitment of Locum Doctors and Dentists Policy, ensuring all terminology is relevant.				na	
IA 1920	19/05/2020	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	10	R10/10	L	Temporary Staffing Department management to review the standard letter sent with the conditional offer and ensure it complies with the Identification Check NHS Standard.				na	
IA 1920	27/09/2020	Strategic Planning - IMTP	Director of Planning	Reasonable	4	R1/4	M	Management should ensure that the business case procedural document (flowchart) is up to date and reflects the current system in place regarding the processing of projects/ schemes from the point of	Business Case procedural flowchart updated accordingly. Standard business cases template universally adopted and embedded within all clinical boards.	Marie Davies /Complete		c	
IA 1920	27/09/2020	Strategic Planning - IMTP	Director of Planning	Reasonable	4	R2/4	M	Management should ensure that all key staff required to sign the business case complete and evidence sign off at the required stage.	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		c	
IA 1920	27/09/2020	Strategic Planning - IMTP	Director of Planning	Reasonable	4	R3/4	M	Management should ensure that the due process and documentation required to document decisions of business cases are adhered to.	Each BCAG decision report and any required actions formally reported to Management Executive. Programme oversight for IMTP period continuously maintained.	Bob Chadwick and Marie Davies/Complete		c	
IA 1920	27/09/2020	Strategic Planning - IMTP	Director of Planning	Reasonable	4	R4/4	L	Management should ensure the ToR are reviewed and updated as required.	NHS Wales Audit and Assurance Services Page 15 of 16 Finding 4 - BCAG Terms of Reference (Operating effectiveness) Risk The Business Case Approval Group is responsible for the scrutiny and management of revenue based business cases and ensuring they are robust. They have ToR which govern the Group. The BCAG ToR was last reviewed in March 2017. It was stated within the ToR that they would be reviewed on an annual basis to ensure they remain relevant and up to date. Inappropriate service changes / developments are implemented Recommendation 4 Priority level Management should ensure the ToR are reviewed and updated as required. Low Management Response Responsible Officer/ Deadline	Marie Davies	01/11/2020	pc	
IA2021+U105 A97:U105	19/08/2020	Annual Quality Statement	Executive Director of Nursing	Substantial	2	R1/2	L	Management should ensure that all Welsh Government guidance is followed and incorporated in the report.	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	c	
IA2021	19/08/2020	Annual Quality Statement	Executive Director of Nursing	Substantial	2	R2/2	L	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.	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	c	
IA 2021	01/10/2020	Surgery Clinical Board - Theatres Directorate Sickness Absence Management	Chief Operating Officer	Reasonable	5	R1/5	H	Long term sickness within Trauma Theatres, UHW must be monitored, reviewed and documented appropriately and evidence retained on individual personal files in accordance with Section 4 of the NHS Wales Managing Attendance at Work Policy.	Immediate action has been taken in relation to the Trauma Theatre long term sickness reviews. A review of all documentation is underway with a completion deadline of 9th October 2020 – to be led by Jayne Thain, Theatre Manager for the area. The relevant actions and review will be held within the trauma team to ensure that the policy is implemented in full moving forwards. Regular sickness review meetings to be implemented for this area to be led by Jayne Thain, Theatre Manager.	Ceri Chinn, Lead Nurse –	09/10/2020		

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IA 2021	01/10/2020	Surgery Clinical Board - Theatres Directorate Sickness Absence Management	Chief Operating Officer	Reasonable	5	R2/5	M	Sickness Notification Form must be completed by Clinical Leaders and retained on respective personal files.	Required actions have been undertaken – reminder has been sent to Theatre Managers for dissemination to Clinical Leaders. A reminder session on sickness process will be held at the next Clinical Leader meeting.	Ceri Chinn, Lead Nurse –	09/10/2020		
IA 2021	01/10/2020	Surgery Clinical Board - Theatres Directorate Sickness Absence Management	Chief Operating Officer	Reasonable	5	R3/5	M	All episodes of sickness absence must be supported by accurately completed Self Certification Forms, Return to Work Interview Forms and where applicable GP Fit Notes.	Required actions have been undertaken – reminder has been sent to Theatre Managers for dissemination to Clinical Leaders. Jon Barada, Theatre Manager, will meet with the new interim clinical leaders in these areas (not in post during the period covered by the audit) to explain the findings of the report and ensure that the actions are picked up. A reminder session on sickness process will be held at the next Clinical Leader meeting.	Ceri Chinn, Lead Nurse –	09/10/2020		
IA 2021	01/10/2020	Surgery Clinical Board - Theatres Directorate Sickness Absence Management	Chief Operating Officer	Reasonable	5	R4/5	M	All short term sickness must be monitored, reviewed, documented appropriately and retained on individual personal files in accordance with Section 3 of the NHS Wales Managing Attendance at Work Policy.	Required actions have been undertaken – reminder has been sent to Theatre Managers for dissemination to Clinical Leaders. A reminder session on sickness process will be held at the next Clinical Leader meeting. The relevant actions and review will be held within the trauma team to ensure that the policy is implemented in full moving forwards.	Ceri Chinn, Lead Nurse –	09/10/2020		
IA 2021	01/10/2020	Surgery Clinical Board - Theatres Directorate Sickness Absence Management	Chief Operating Officer	Reasonable	5	R5/5	M	A formal monitoring and reporting process should be implemented within the Theatres Directorate highlighting sickness absence activity which is then reported up to the Clinical Board.	The process of collecting theatre sickness rates was previously through monthly confirm and challenge meetings, and also Perioperative Care Performance Meetings. These will be reinstated in due course, following COVID changes. The plan for escalating rates through Clinical Board will be discussed with Clinical Board members to agree – current options include Lead Nurse Meeting or GM and Lead Nurses Meetings.	Ceri Chinn, Lead Nurse –	09/10/2020		
IA2021	07/10/2020	Regional Partnership Board	Director of Planning	Reasonable	4	R2/4	M	Management should review the governance of the SLG to ensure appropriateness.	The governance of the Regional Partnership Board arrangements is currently under review and three new partnership boards are due to be established. This will impact on the TOR and membership of the SLG to ensure that there The governance of the Regional Partnership Board arrangements is currently under review and three new partnership boards are due to be established. This will impact on the TOR and membership of the SLG to ensure that there is appropriate representation. This work will be completed by the end of 20/21. 2. Meeting frequency has now increased to monthly.	Cath Doman, Director of Health and Social Care Integration	31/03/2021		
IA2021	07/10/2020	Regional Partnership Board	Director of Planning	Reasonable	4	R3/4	M	Management should ensure that governance arrangements are enhanced for the Integrated Care Fund Programme Board.	Much of the business originally intended for the ICF programme board is dealt with via the SLG and directly with SROs. This Programme Board will be reviewed along with the overarching RPB governance during this financial year.	Meredith Gardiner, Programme Manager	31/03/2021		
IA2021	07/10/2020	Regional Partnership Board	Director of Planning	Reasonable	4	R4/4	L	Management should consider formal reporting on outcomes from the RPBs activities into the Health Board, to allow for effective scrutiny.	CAVUHB is a partner in the Regional Partnership Board and does not hold a scrutiny role, however it is important that the Board is sighted on RPB business and can respond appropriately. Members of the CAVUHB Board are also members of the RPB, including the CEO, Chair, Exec Director of Strategy and Planning. A CAVUHB IM currently chairs the RPB. There are therefore existing strong controls and influence.	Abigail Harris, Executive Director of Planning	31/03/2021		
IA2021	03/11/2020	Environmental Sustainability Report	Acting Director of Finance	Reasonable	2	R1/2	M	Management should ensure a timetable is prepared annually and made available to all relevant staff prior to compiling the SDR. This should include the timeline for the first meeting of the task and finish group, data submission deadlines, the various stages of review and approval and submission to the Communications Team.	A preliminary timetable will be prepared annually with liaison with NHS Wales Shared Services Partnership Audit and Assurance Services regarding the indicative completion dates for each activity.	Energy Manager/Head of Energy and Performance	31/03/2021		
IA2021	03/11/2020	Environmental Sustainability Report	Acting Director of Finance	Reasonable	2	R2/2	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 also updated to reflect the actual review and approval process currently in place.	The evidence of the retrospective approval of the sustainability report by the Environmental Steering Group / Health & Safety Group and sign off by the Director of Capital Estates and Facilities is/will be provided to audit each year.	Energy Manager/Head of Energy and Performance	31/11/20		
IA2021	02/11/2020	Management of Serious Incidents	Executive Nurse Director	Reasonable	6	R1/6	H	Management should ensure that appropriate processes are in place for concluding investigations/Root Cause Analysis and the submission of closure forms to the Welsh Government in a timely manner.	The Patient safety team will work with Clinical Boards to improve the timeliness of the closure of serious incidents. In order to achieve this we will: Issue revised targets for monthly closure of incidents Train 100 additional staff in RCA and introduce a system of follow up whereby staff have to commit to undertaking RCAs x 2 within 12 months of completing training Review process for the commissioning of RCA investigations Introduce monthly Serious Incident tracker meetings with Clinical Boards	Assistant Director Patient Safety and Quality	31/12/20 31/12/21 31/03/21 31/01/21		
IA2021	02/11/2020	Management of Serious Incidents	Executive Nurse Director	Reasonable	6	R2/6	M	Management should remind staff surrounding the requirement for prompt reporting of Serious Incidents and submission of the SI1 form to Welsh Government.	Staff will be reminded of the importance of timely reporting and escalation of serious incidents The UHB will work with Welsh Government and the Delivery Unit to update the current All Wales SI Framework. This will include negotiation of the requirement to report SIs within 24 hours. The Patient Safety team will introduce a quality assurance and monitoring process to track the timeliness of reporting and to ensure that the delays for reporting are clarified on the Datix system	Assistant Director Patient Safety and Quality	31/10/20 31/01/21 31/03/21		
IA2021	02/11/2020	Management of Serious Incidents	Executive Nurse Director	Reasonable	6	R3/6	M	Management should ensure that all outstanding actions are completed.	The Patient Safety team, working with the Clinical Boards, will review the way in which outstanding actions are monitored within Clinical Boards and also within the corporate Patient Safety team The requirement for improved functionality in relation to the monitoring of action plans, will be fed in to development of the revised Once for Wales Concerns management System	Assistant Director Patient Safety and Quality	31/12/20 30/04/21		
IA2021	02/11/2020	Management of Serious Incidents	Executive Nurse Director	Reasonable	6	R4/6	L	Management should consider having key contacts for Quality and Safety issues with each Clinical Board	A review of existing structures and resources available for the support of QSE activity across the organisation will take place as part of the development of the QSE Framework 2021-2026.	Assistant Director Patient Safety and Quality			
IA2021	02/11/2020	Management of Serious Incidents	Executive Nurse Director	Reasonable	6	R5/6	L	Staff should be reminded to keep Datix as up to date as possible to ensure an effective audit trail.	All staff (in Clinical Boards and in the Corporate Patient Safety team) will be reminded of the need to keep Datix as up to date as possible	Assistant Director Patient Safety and Quality	31/11/20		
IA2021	02/11/2020	Management of Serious Incidents	Executive Nurse Director	Reasonable	6	R6/6	L	The review into the consistency of information supplied to Clinical Boards should be completed.	The consistency of information supplied to Clinical Boards will be reviewed and completed	Assistant Director Patient Safety and Quality	31/12/2020		
IA2021	23/10/2020	Governance Arrangements During the COVID-19 Pandemic	Director of Corporate Governance / Acting Director of Finance	Advisory	0	0	A	Advisory Report					

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

	Update February 2021				Update February 2021				Update February 2021			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Overdue under 3 months												
Overdue over 6 months under 12 months												
Overdue more than 12 months	2	1	1		8	1	7		3		2	1
Superseded												
Total	**2**	**1**	**1**		**8**	**1**	**7**		**3**		**2**	**1**

Total number of recommendations outstanding as of 27th January 2021 for financial year 2017/18 is **13** compared to the position in November 20 when a total number of outstanding recommendations of **15** were noted.

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

	Update February 2021				Update February 2021				Update February 2021			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached	4	1	1	2	3	3						
Overdue under 3 months												
Overdue by over 3 months under 6 months												
Overdue over 6 months under 12 months	1	1										
Overdue more than 12 months	3	1		2	8		2	6	3		1	2
Superseded												
Total	**8**	3	1	4	**11**	**3**	**2**	**6**	**3**		**1**	**2**

Total number of recommendations outstanding as of 27th January 2021 for financial year 2018/19 is **22** compared to the position in November 20 when a total number of outstanding recommendations of **25** were noted.

Saunders,Nathan
02/02/2021 15:47:14

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2019/20 (February 2021Update)

	Update February 2021				**Update February 2021**				**Update February 2021**			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Overdue under 3 months					3	3			1		1	
Overdue by over 3 months under 6 months	2			2	8		3	5	11	4	2	5
Overdue over 6 months under 12 months	5		4	1	17		6	11	5		1	4
Overdue more than 12 months	1		1		3		2	1				
Superseded												
Total	**8**		5	3	**31**	**3**	**11**	**17**	**17**	**4**	**4**	**9**

Total number of recommendations outstanding as of 27th January 2021 for financial year 2019/20 is **56** compared to the position in November 20 when a total number of outstanding recommendations of **71** were noted**.**

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2020/21 (February 2021Update)

	Update February 2021				Update February 2021				Update February 2021			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached	1			1		5		5				
Complete												
Overdue under 3 months									6	2		4
Overdue by over 3 months under 6 months	1			1		5	5					
Overdue over 6 months under 12 months												
Overdue more than 12 months												
Superseded												
Total	**2**			2		**10**	**5**	**5**	**6**	**2**		**4**

Total number of recommendations outstanding as of 27th January 2021 is **18**. It should be noted that an additional Advisory recommendation has also been made in relation to Covid-19 Governance Arrangements which will continue to be monitored.

Saunders,Nathan
02/02/2021 15:47:14

Report Title:	**Audit Wales Recommendation Tracking Report and Regulatory Tracker Report**								
Meeting:	Audit Committee						**Meeting Date:**	9th February 2021	
Status:	**For Discussion**		**For Assurance**		**X**	**For Approval**		**For Information**	
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

The purpose of the report is to provide Members of the Audit Committee with assurance on the implementation of recommendations which have been made by 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:

20 External Audit Recommendations were brought forward from November's Audit Committee. During November's Committee Meeting it was noted that a recommendation relating to Test Trace and Protect had incorrectly been referred to and that three entries relating to the Audit of Accounts Report Addendum Recommendations had been omitted from the documentation shared. The Audit of Accounts Report Addendum Recommendations have now been added to the attached External Audit Tracker.

Following November's Committee Meeting a further 3 recommendations have been added to the tracker which relate to the Effectiveness of Countefraud Arrangements (2) and the Structured Assessment 2020 (1).

The External Audit tracker demonstrates that a further 3 recommendations have completed since November, however, there are also 12 (of 23) recommendations that are partially complete. 8 actions of 23 have had no recorded action taken since November's committee meeting.

5 actions of the 23 are over 1 year old (of which 2 have completed) and 8 of 23 are over 6 months old. 10 actions of the 23 are less than three months old.

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

A review of all outstanding recommendations has been undertaken since November 2020 and this will continue and be reported at each Audit Committee to provide regular updates in the movement of recommendations.

The table at Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken in **17/18, 18/19, 19/20 and 20/21** as at 27th January 2021.

This report and appendices will also be discussed at Management Executives and HSMB so that the leadership teams of the Health Board have an overview of progress made against External Audit Recommendations.

Recommendation:

The Audit Committee Members are asked to:

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

Saunders Mathan 02/02/2021 15:47:14

Kind and caring / Caredig a gofalgar | Respectful / Dangos parch | Trust and integrity / Ymddiriedaeth ac uniondeb | Personal responsibility / Cyfrifoldeb personol

Audit Log Ref No.	Financial Year Fieldwork Undertaken	Final Report Issued on	Audit Title	Executive Lead for Report	No. of Recs Made	Rec No.	Recommendation Narrative	Management Response	Operational Lead for Recommendation	Agreed Implementation Date	Committee Implementation Monitored by	Updated Implementation Date	Recommendation Status [RAG Rating]	Please confirm if completed (c), partially completed (pc), no action taken (na)
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R1g/11	R7 [2017] The Health Board needs to ensure that the level of information reported to the Resource and Delivery Committee on its performance is sufficient to enable the Committee to scrutinise effectively. This should include: ensuring that the Committee receives more detailed performance information than that received by the Board. Consideration should be made to including a summary of the Clinical and Service Board dashboards used in the monthly executive performance management reviews; expanding the range of performance metrics to include a broader range of key performance indicators relating to workforce. Consideration should be made to revisiting the previous workforce KPIs reported to the previous People, Planning and Performance Committee.	Overall this recommendation has been partly addressed. The S&D Committee continues to receive a high-level performance dashboard, which is less detailed than the performance report received by the Board. Since September 2018, the S&D Committee receives six-monthly updates against the workforce plans, including key workforce metrics.	Head of Corporate Governance	Dec-19	Audit and Assurance Committee	Dec-19	Open over 6 months under 12 months	pc
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R3b/11	b. Review and update the Standing Orders and Standing Financial Instructions, ensuring these documents are reviewed and approved on an annual basis;	Agreed and timetabled to be undertaken on an annual basis going forward	Head of Corporate Governance	Mar-19	Audit and Assurance Committee	Dec-19	Open over 6 months under 12 months	pc
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R3d/11	d. Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date;	Agreed	Head of Corporate Governance	Oct-19	Audit and Assurance Committee	Dec-19	Open over 6 months under 12 months	pc
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R4/11	The Health Board should update its performance management framework to reflect the organisational changes that have taken place since 2013.	We accept that the performance management framework should be reviewed to ensure it fully supports the organisational business.	Director of Digital and Health Intelligence	Sep-19	Audit and Assurance Committee	Dec-19	Open over 6 months under 12 months	pc
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R11/11	The Health Board should routinely update IT Disaster Recovery plans after key changes to IT infrastructure and networks and at scheduled intervals and test plans to ensure they are effective	The CAV IT Disaster Recovery plan is reviewed annually at a minimum and in response to specific circumstances. Testing is undertaken (both Check list and Technical) and multiple system restores are performed successfully annually. Additional infrastructure and software have been put in place to improve this process. A schedule of testing is being developed as part of the technical roadmap work.	Director of Digital and Health Intelligence	Mar-19	Audit and Assurance Committee	Dec-19	Open over 6 months under 12 months	pc
WAO 16	2017-18	Dec-17	Discharge Planning	Chief Operating Officer	4	R4a	Explore developing an e-learning course for discharge planning which ward staff may find more accessible.	Work is ongoing with LED colleagues to develop a discharge planning focused e-learning resource.	Head of Integrated Care	Dec-18	Strategy and Delivery		Open over 18 months under 24 months	c
WAO 17	2019-20	Jun-19	Clinical Coding Follow-up From 2014 not yet completed	Director of Transformation and Informatics		R1	**Clinical Coding Resources:** Strengthen the management of the clinical coding team to ensure that good quality clinical coding data is produced. This should include: c) ensuring that there is capacity to allow band 4 coders to undertake mentoring and checking of coding of band 3 staff in line with job descriptions; d) revisiting the allocation of specialities across staff to ensure that there is sufficient flexibility within the existing capacity to cover periods of absence and succession planning is in place for staff who are due to retire in the next five to ten years; g) increasing levels of engagement between the different teams within the Health Board, to provide opportunities to raise issues, develop peer support arrangements and share knowledge; h) updating the clinical coding policy to reflect the current operational management arrangements; and k) increasing the range of validation and audit processes, including the consideration of the appointment of an accredited clinical coding auditor.	The UHB faces on-going challenges on the use of its resources in light of increasing demand for services and inflation surpassing investment. As a consequence the UHB made a difficult decision to reduce non direct clinical expenditure by 12.6% in 2018/19. However recognising the value of coding, there was a marginal increase in expenditure on the staff who do the coding when factoring in pay awards and increments, but this required an ongoing reduction in supervisory expenditure. The UHB faces on-going challenges on the use of its resources in light of increasing demand for services and inflation surpassing investment. As a consequence the UHB made a difficult decision to reduce non direct clinical expenditure by 12.6% in 2018/19. However recognising the value of coding, there was a marginal increase in expenditure on the staff who do the coding when factoring in pay awards and increments, but this required an ongoing reduction in supervisory expenditure. **k)** Unless affected by the present review which will lead to the restructuring of the Digital team, the intention is that a new Band 5 (Assistant coding manager) appointment will have an element of their time for audit.	James Webb		Digital & Health Intelligence Committee	Open over 12 months under 18 months		pc
WAO 17	2019-20	Jun-19	Clinical Coding Follow-up From 2014 not yet completed	Director of Transformation and Informatics		R2	**Medical Records:** R2 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include: a) reinforcing the Royal College of Physician (RCP) standards across the Health Board and developing a programme of audits which monitors compliance with the RCP standards; b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS); c) putting steps in place to ensure that notes that require coding are clearly identified at ward level and that clinical coding staff have early access to medical records, particularly at UHW; e) reducing the level of temporary medical records in circulation; f) considering the roll out of the digitalisation of health records to the Teenage Cancer Unit to allow easier access to clinical information for clinical coders; and g) revisiting the availability of training on the importance of good quality medical records to all staff.	**a)**Head of Clinical Coding to raise concerns with Patient Safety / Clinical Audit. **b)** The UHB is developing mobile tracking technology which would support an audit programme designed to determine levels of tracking compliance across departments. **g)** Head of Coding to discuss with Medical Directors to establish the most appropriate platform	James Webb		Digital & Health Intelligence Committee	Open over 12 months under 18 months		**a)** pc, **b)** pc, **g)** na
WAO 9	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R1	**1: the 'retire and return' arrangements require strengthening** The Health Board should strengthen its current guidance so that it clearly sets out all the key elements of the DoH guidance. The revised guidance should include all the DoH's employer-checks, which the Health Board should always apply and clearly evidence when assessing a business case for an employee to retire and return. The Health Board should ensure that its updated guidance is shared with all Clinical Boards and Departmental Heads.	The Health Board is currently reviewing the Retire and Return Procedure in partnership with Trade Unions. The purpose of this review is to reduce inconsistencies in the way that it is applied across the UHB by reducing the level of manager's discretion involved and ensuring that applications can only be rejected for robust business reasons. Reference will be made to the DoH guidance and checklist as appropriate. Reference will also be made to the other flexible retirement options to raise awareness of the flexibilities available.	Chris Lewis, Interim Finance Director	Feb-20	Audit and Assurance		Open over 12 months under 18 months	c

WAO 18	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R4	**4: the Phase 2 and Phase 3 continuing healthcare claims require concluding** The Health Board should establish the reason for the ongoing delay with each of the remaining Phase 2 and Phase 3 claims and it should seek to conclude them promptly	Phase 2 – awaiting grant of probate for one claim. Face to face meetings required for both claims Phase 3 –Work during the first quarter of 2019-20 has left 61 cases open; 6 are planned for reimbursement imminently, 25 have been reviewed but are not yet ready for reimbursement due to requiring further meetings, negotiation, panels etc.,30 are not yet reviewed, Good progress continues to be made as agreed within the available resource which includes additional staff employed, with the intent to continue to conclude cases promptly	Chris Lewis, Interim Finance Director	Mar-20	Audit and Assurance		Open over 12 months under 18 months	pc
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R1	**Long-term** Further enhance the profile of primary care by building upon the successes of existing promotional campaigns.	We will continue to build on the Primary Choice campaign to promote Primary Care.	Director of Operations, PCIC	Ongoing	Strategy and Delivery		Open over 6 months under 12 months	na
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R2	2 Develop a campaign to educate the public about what types of services will be available at each of the centres and hubs.	We have an active engagement programme for each of the Wellbeing Hubs and Health and Wellbeing Centres, we will continue to evolve our engagement working with local organisations, public health colleagues and community groups to promote the services in each centre.		Dec-21	Strategy and Delivery		Open over 6 months under 12 months	pc
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R5	**Prevention** 5 Undertake needs assessments on an ongoing basis and continually review services to ensure that centres and hubs remain current and fit for purpose.	Primary Care Clusters are required to produce plans to meet the needs of their populations, this will include considerations of Wellbeing Hub services once established. These plans will take into account evidence from wider needs assessments including future updates to the population assessment required under the Social Services and Wellbeing Act and the Wellbeing Assessment required under the WFG Act	Director of Operations, PCIC	Annually	Strategy and Delivery		Open over 6 months under 12 months	na
WAO 20	2019-20	**Nov-19**	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R6	6 Develop a clear plan to agree finances prior to centre and hub services commencing to prevent duplication of resources.	This will form part of the operating model of the Wellbeing Hubs.		Nov-21	Strategy and Delivery		Open under 3 months	na
WAO 20	2019-20	**Nov-19**	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R7	**Integration** 7 Undertake a community services mapping exercise for each of the localities to identify services it could signpost patients to if they fall outside of the services delivered by centres and hubs.	We will be undertaking this mapping on a locality and cluster basis in partnership with existing tools and services such as Dewis Cymru.		Oct-21	Strategy and Delivery		Open under 3 months	pc
WAO 20	2019-20	**Nov-19**	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R8	**Collaboration** 8 Develop some overarching principles for the centres and hubs operating model which allow for some local variation based on community need.	We will establish an overarching operating model for the Health and Wellbeing Centre and Wellbeing Hubs focussed on operating as single assets and supporting community ownership.		Oct-21	Strategy and Delivery		Open under 3 months	pc
WAO 20	2019-20	**Nov-19**	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R9	**Involvement** 9 Explore the best vehicles to engage marginalised citizens both in terms of planning future centres and hubs and in ensuring they are accessible to all when in operation. For example, by finding community leaders to help roll out key messages and engage with these groups on an ongoing basis.	We will ensure this forms part of the engagement plan for each project.		Oct-21	Strategy and Delivery		Open under 3 months	pc
WAO22	2019-20	**Aug-20**	Audit of Accounts Report Addendum - Recommendations	Director of Finance	3	R1	Some of the accounting processes and records need to be simplified, with far less use of manual adjustments to financial ledger outputs: The Health Board should reevaluate why so many manual adjustments are currently necessary and, in do so, liaise with us and consider engaging with a health boasrd that has the same finance system and avoids similar level of manual intervention	The Health Board agrees to review its manual adjustments and assistance from Audit Wales in identifying good practice would be very helpful.	Chris Lewis, Interim Finance Director	Apr-21	Audit and Assurance		Open under 3 months	na
WAO22	2019-20	**Aug-20**	Audit of Accounts Report Addendum - Recommendations	Director of Finance	3	R2	The quality of some of the Health Board's underlying working papers requires further improvement: The Health Board should review and simplufy its supporting records for certain areas of its annual financial statemnets, including the inappropriate use of manual data entry (rather than formulas) within spreadsheets. To aid the review the Health Board should liaise with us to understand hjow some of hte documentation affects our audit.	The Health Board will work with Audit Wales to review its supporting records with the aim of simplication to support the final accounts audit	Chris Lewis, Interim Finance Director	Apr-21	Audit and Assurance		Open under 3 months	na
WAO22	2019-20	**Aug-20**	Audit of Accounts Report Addendum - Recommendations	Director of Finance	3	R3	Related party declarations need to be signed and submitted after the end of each financial year: The Health Board shoud update it sannual related party declaration so that it specifies that the IM / SO must consider the whole financial year and therefore sign and submit it after 31 March, or on departure if that is relevant	The Health Baord will revrt to requesting returns after 31 March 2021. The Health Board will continue to obtain signed declarations from Ims and Sos at the time of departure. In addition,	Chris Lewis, Interim Finance Director	Apr-21	Audit and Assurance	Apr-21	Open under 3 months	na
WAO23	2020-21	**Aug-20**	Effectiveness of Counterfraud Arrangements	Director of Finance	2	R1	Counter-fraud training Implement mandatory counter-fraud training for some or all staff groups	As part of the Compliance & Competency section within the Heath Body's Electronic Staffing Record (ESR) Database, any such training, which is deemed as being mandatory, has to be agreed and by the Health Body's Workforce Department in conjunction with Staff Side Representation before it can be implemented.	Chris Lewis (Interim Finance Director) and Martin Driscoll (Director of Workforce &OD)	Ongoing with review date of 31st March 2021	Audit and Assurance		Open under 3 months	na
WAO23	2020-21	**Aug-20**	Effectiveness of Counterfraud Arrangements	Director of Finance	2	R2	Counter-fraud staff capacity Consider the Local Counter-Fraud Specialist capacity required to resource required levels of proactive and investigative work, including staff training, and build in resilience to the team.	Based on historical data, the Health Body is confident that the number of days in it's current work-plan meets the current requirements. In support of this, regular reviews of the ongoing CF work and resources used are carried out and reported to the A/C. However, should there be an increase in referrals, the need for any additional resource would be agreed with the Finance Director. The overall budget is reviewed in the annual budget setting exercise.	Craig Greenstock (LCFS) and Chris Lewis (Interim Director of Finance)	Ongoing with review date of 31st March 2021	Audit and Assurance		Open under 3 months	na
WAO24	2020-21	**Oct-20**	Structured Assessment 2020	Chief Executive Officer	1	R1	Recognising the numerous challenges the Health Board faced during the first Covid-19 peak, the Board should reflect on its experiences of governing during that period in order to strengthen future governance both generally and in the event of a second Covid-19 peak. In reflecting on its experiences, the Board should focus in particular on: a. considering what worked well and what didn't work so well, and identifying what it would do differently in the event of a second Covid-19 peak; b. establishing which new ways of working introduced during the pandemic it wants to retain going forward; c. supporting the development of the whole cadre of Independent Members as well as enhancing their role and input; and, d. enhancing Board reporting and transparency.	There has been a lot of work done on lessons learned within the Health Board covering many different functions and this learning has taken on board the comments made by WAO, Internal Audit and KPMG. This has included lessons learned from a governance perspective and the governance arrangements for the next wave, and future waves of Covid 19. A report is being presented to ME, Board Governance Group, Audit and the Board to ensure that this learning is taken forward and implemented. This report will cover off items a,b,c and d of the recommendation.	Director of Corporate Governance/Chief Executive/ Chair	Nov-20	Audit and Assurance		Open under 3 months	c

External Audit (WAO) Recommendations 2017/18 – 2020/21 (February 2021)

External Audit	Complete	No action	Partially complete	< 3 mths	> 3 mths	+6 mths	+ 1 year	Grand Total
Structured Assessment 2018	-	-	5	-	-	5	-	5
Clinical Coding Follow Up	-	-	2	-	-	-	2	2
Discharge Planning	1	-	-	-	-	-	1	1
Audit of Financial Statements	1	-	1	-	-	-	2	2
Implementation of the Wellbeing of Future Generations Act	-	3	4	-	-	7	-	7
Audit of Accounts Report Addendum - Recommendations	-	3	-	3	-	-	-	3
Effectiveness of Counterfraud Arrangements	-	2	-	2	-	-	-	2
Structured Assessment 2020	1	-	-	1	-	-	-	1
Total	**3**	**8**	**12**	**6**	**-**	**12**	**5**	**23**

From the above table it can be seen that since the last report to Committee in November 2020 3 of 23 outstanding WAO recommendations from November 2020 have been completed. It can also be seen that there are a further 8 of 23 recommendations where there has been no action a further and 12 of 23 where the recommendation is partially completed. 5 actions of 23 are over 1 year old and 12 of 23 are over 6 months old

Report Title:	Timetable For the Production of the 2020-21 Annual Report						
Meeting:	Audit Committee				**Meeting Date:**	09.02.2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Director of Corporate Governance and Interim Director of Finance						
Report Author (Title):	Head of Financial Accounting and Services						

Background and current situation:

The purpose of this report is to provide Members of the Audit Committee with the opportunity to discuss and comment on the draft timetable for the production of the 2020-21 Annual Report (see Appendix 1), prior to submission to the Board.

The Welsh Government has issued, as in previous years, guidance for the preparation of annual reports and accounts. This guidance is based on HM Treasury's Government Financial Reporting Manual (FReM)1 and is intended to simplify and streamline the presentation of the annual reports and accounts so that they better meet the needs of those who read and use them.

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

Part 1 The Performance Report, which must include:
• An overview

Part 2 The Accountability Report, which must include:
• A Corporate Governance Report
• A Remuneration and Staff Report
• A Parliamentary Accountability and Audit Report

Part 3 The Financial Statements
• The Audited Annual Accounts 2020-21

In response to the unprecedented COVID-19 situation and the effect it has had on government entities, HM Treasury has reviewed the financial reporting requirements for 2020-21.

For 2020-21 there will be no requirement to
• Prepare a separate Annual Quality Statement.
• Report in the Annual Report and Accounts against the Sustainability Reporting Requirements

The Final Annual Report including the Performance Report, Accountability Report and Financial Statements (Accounts) should be must be completed and submitted to Welsh Government by 11 June 2021 (draft 7 May 2021).

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

In 2019-20 a qualified 'limitation of scope' opinion was issued as the WAO was in their opinion unable to obtain sufficient appropriate audit evidence to support the Health Board's inventory balance of £16.784 million as at 31 March 2020 (Note 14.1 to the financial statements).

This qualification was not due to shortcomings in the Health Board's systems or actions, but because of the impact of Covid-19 on one of the key audit procedures. They were not reporting that they considered the inventory balance to be materially misstated, but rather that they did not know whether it was materially true and fair.

Due to the continuing impact of COVID-19 and the statutory lockdown arrangements, WAO are again expecting to be unable to observe and re-perform parts of the Health's Board's count of its inventories on or before 31 March 2021.

For a material inventory balance, a physical stock take by auditors is mandated by the professional Auditing Standards. Therefore according to the standards as they will be unable to determine whether the reported year-end inventory balance is materially true and fair, they will again have to limit the scope of their 'true and fair view' audit opinion accordingly.

(Stock takes will continue to be carried out by the health board, it is just the attendance of WAO and therefore their auditing standard requirements which are restricted).

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

The WAO has highlighted that due to the material, novel and complex nature of the COVID-19 Dragons Heart field hospital it does give rise to an inherent risk of misstatement. This will be a key part of audit testing the financial statements and the annual governance statement. As a result of this additional pre-audit guidance is being sort from WG and the WAO.

A detailed timetable for the production of the 2020-21 Annual Report is provided at Appendix 1

The suite of documents that make up the 2020-21 Annual Report will be presented at the Annual General Meeting scheduled for 29 July 2021.

Recommendation:

The Audit Committee is asked to:

REVIEW the proposed timetable and approach for the Annual Report 2020-21.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	X	Long term		Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

Appendix 1: DRAFT GOVERNANCE TIMETABLE FOR THE ANNUAL REPORT 2020-21

Main Tasks	Lead Exec	Jan	Feb	Mar	Apr	May	Jun	Annual General Meeting (AGM
Annual Report Part 1 Performance Report (including Wellbeing Statement Sustainability)	Steve Curry Chief Operating Officer (TBC)	Review content requirements and frame the scope of the report	Draft report, circulated for comment	Coordination and review of comments, updating of draft report. Draft report / update to be considered by Management Executive on 25 March 2021	Finalise Draft Internal Audit to receive draft report April 2021 (date TBC) to comment in respect of Sustainability elements – Internal Audit to return comments April 2021 (date TBC)	Audit Committee Workshop (date TBC) Endorse Sign off by Board Board Approve Accounts for Submission to WG & WAO Draft Report to Welsh Government by 7 May 2021	Comments back from WG to be incorporated for approval of the Final Report by Audit Committee on 10 June 2021 The Annual report including the performance Report and Financial Statements (Accounts) should be completed and submitted to Welsh Government by the 11 June 2021	The Annual Report and Audit Accounts will be presented at a Public Meeting (AGM) on 29 July 2021
Annual Report Part 2a Accountability Report Governance Statement	Nicola Foreman Director of Corporate Governance	Review content requirements and frame the scope	Draft report, circulated for comment.	Draft submitted to Internal Audit & Wales Audit Office by the 31 March 2021	Reviewed at Management Executive Meeting April 2021 (TBC). Internal Audit Sign off Draft Report in readiness for submission to Audit Committee April 2021 (TBC)	Audit Committee Workshop (date TBC) Endorse Sign off by Board Board Approve Accounts for Submission to WG & WAO Draft Report to Welsh Government by 7 May 2021	The Annual Report including the Performance Report, Accountability Report and Financial Statements (Accounts) should be completed and submitted to Welsh Government by the 11 June 2021	
Annual Report Part 2b Accountability Report, Remuneration and Staff Report	Rachel Gidman Interim Executive Director of Workforce & OD Catherine Phillips, Executive Director of Finance	Review Content requirements and frame scope		Draft submitted to Internal Audit & Wales Audit Office by the 31 March 2021	Reviewed by Management Executive April 2021 (TBC) Internal Audit Sign off Draft Report to Audit Committee April 2021 (TBC)	Audit Committee Workshop (date TBC) Endorse Sign off by Board Board Approve Accounts for Submission to WG & WAO Draft Report to Welsh Government by 7 May 2021	The Accountability Report, Remuneration and Staff Report should be completed and submitted to Welsh Government by the 11 June 2021	

Main Tasks	Lead Exec	Jan	Feb	Mar	Apr	May	Jun	Annual General Meeting (AGM
Annual Report Part 3 Audited Financial Statements (Annual Accounts)	Catherine Phillips, Executive Director of Finance	Review Content requirements and frame scope of report.			Draft Submission of Unaudited Accounts to Welsh Government by NOON on 30 April 2021	Audit Committee Workshop (date TBC) Endorse Sign off by Board Board Approve Accounts for submission to WG & WAO Submission to Welsh Government by 7 May 2021	Audited Financial Statements (Accounts) should be completed and submitted to Welsh Government by the 11 June 2021 WG to issue Debtor & creditor Matrix Income and expenditure matrix by 15 June 2021	The Annual Report and Audit Accounts will be presented at a Public Meeting (AGM) on 29 July 2021
Annual Report – Executive Summary	Nicola Foreman Director of Governance	Review Content requirements and frame the scope	Draft the Executive Summary	Issue draft for comment	Finalise Summary	Welsh Translation Equality Impact Assessment	The Annual Report including the Performance Report, Accountability Report and Financial Statements (Accounts) should be completed and submitted to Welsh Government by the 11 June 2021	

Report Title:	**Audit and Assurance Committee – Terms of Reference**								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	9th February 2021	
Status:	**For Discussion**	**x**	**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

In line with the UHB's Standing Orders, Terms of Reference for Committees of the Board, should be reviewed on an annual basis.

This report provides Members of the Audit and Assurance Committee with the opportunity to review the Terms of Reference prior to submission to the Board for approval.

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

The Terms of Reference for the Audit and Assurance Committee were last reviewed in March 2020 and approved by the Board in March 2020 therefore, only a few changes have been recommended.

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

The Terms of Reference for the Audit and Assurance Committee have been reviewed by the Director of Corporate Governance. There are a limited number of changes to the document, these have been tracked and left in the draft so Committee Members can identify the changes that have been made since approval by the Board in March 2020.

Recommendation:

The Audit and Assurance Committee is asked to:

APPROVE the changes to the Terms of Reference for the Audit and Assurance Committee and **RECOMMEND** the changes to the Board for approval.

Shaping our Future Wellbeing Strategic Objectives

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

1.	Reduce health inequalities		6.	Have a planned care system where demand and capacity are in balance	
2.	Deliver outcomes that matter to people	x	7.	Be a great place to work and learn	x
3.	All take responsibility for improving our health and wellbeing		8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4.	Offer services that deliver the population health our citizens are entitled to expect		9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

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

Audit and Assurance Committee

Terms of Reference

Reviewed by Audit and Assurance Committee: ~~3rd March 2020~~ 9th February 2021

Approved by the Board: ~~27th March 2020~~25th March 2021

AUDIT AND ASSURANCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The UHB Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the LHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In line with Standing Orders (3.4.1) and the UHB Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Audit and Assurance Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

2. PURPOSE

2.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the UHB's assurance framework - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the UHB's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its assurance framework may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- the adequacy of the UHB strategic governance and assurance framework and processes for risk management and internal control designed to support the Accountable Officer's statement on internal control, providing reasonable assurance on:

- the organisations ability to achieve its objectives;
- compliance with relevant regulatory requirements, standards and other directions and requirements set by the Welsh Government and others;
- the reliability, integrity, safety and security of the information collected and used by the organisation;
- the efficiency, effectiveness and economic use of resources; and
- the extent to which the organisation safeguards and protects all its assets, including its people
- the adequacy of the arrangements for declaring, registering and handling interests at least annually
- the adequacy of the arrangements for dealing with offers of gifts or hospitality

to ensure the provision of high quality, safe healthcare for its citizens;

- the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;
- the Schedule of Losses and Compensation;
- the planned activity and results of internal audit, external audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);
- the adequacy of executive and managements response to issues identified by audit, inspection and other assurance activity;
- anti-fraud policies, whistle-blowing processes and arrangements for special investigations; and
- any particular matter or issue upon which the Board or the Accountable Officer may seek advice

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by:

- reviewing the ***comprehensiveness*** of assurances in meeting the Board and the Accountable Officers assurance needs across the whole of the UHB's activities, both clinical and non-clinical;

- reviewing the ***reliability and integrity*** of these assurances; and

- considering and approving policies as determined by the Board.

3.3 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- there is an effective Internal Audit function that meets the standards set for the provision of Internal Audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- there is an effective Counter Fraud Service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Quality, Safety and Experience Committee;

- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees

- the work carried out by key sources of external assurance, in particular, but not limited to the UHB External Auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity

- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;.

- the systems for financial reporting to the Board, including those of budgetary control, are effective; and that

- the results of audit and assurance work specific to the UHB, and the implications of the findings of wider audit and assurance activity relevant to the UHB's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations governance arrangements.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- any other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.6 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit Committee.

3.7 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.8 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.9 The Committee may, subject to the approval of the UHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members, comprising:

Chair	Independent member of the Board
Vice Chair	Chosen from amongst the Independent members on the Committee
Members	At least one other independent members of the Board *[one of which should be the member of the Quality and Safety Committee (or equivalent)]*

The committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance

Chief Executive
Director of Finance (Lead Executive)
Director of Corporate Governance
Head of Internal Audit
Local Counter Fraud Specialist
Representative of External Auditor
Other Executive Directors will attend as required by the Committee Chair

4.3 By invitation — The Committee Chair may invite:

- any other UHB officials; and/or
- any others from within or outside the organisation
- to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 Secretary

- As determined by the Director of Corporate Governance

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair - taking account of the balance of skills and expertise necessary to deliver the committee's remit and subject to any specific requirements or directions made by the ~~Assembly~~ Welsh Government.

4.6 Committee members' terms and conditions of appointment, (including any remuneration and reimbursement) are determined by the Board, based upon the recommendation of the UHB Chair. {~~and on the basis of advice from the UHB's Remuneration and Terms of Service Committee}.~~

Support to Committee Members

4.7 The Director of Corporate Governance , on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of organisational development for committee members as part of the UHB's overall OD programme developed by the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the Committee, one of whom should be the committee Chair or Vice Chair.

Frequency of Meetings

5.2 Meetings shall be held no less than quarterly, and otherwise as the Chair of the Committee deems necessary – consistent with the UHB annual plan of Board Business.

Withdrawal of Individuals in Attendance

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

6. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the UHB overall framework of assurance.

6.5 The Committee shall embed the UHB's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of committee minutes and written reports throughout the year;
- bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive (and Accountable Officer) or

Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

7.2 The Committee shall provide a written, annual report to the board and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance framework, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

7.3 The Board may also require the Committee Chair to report upon the committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.4 The ~~Board Secretary~~Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the UHB Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- quorum (set within individual Terms of Reference)

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

Report Title:	**Draft Annual Report 2020/21 – Audit and Assurance Committee**						
Meeting:	**Audit and Assurance Committee**				**Meeting Date:**	**09/02/2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**X**	**For Information**
Lead Executive:	**Director of Corporate Governance**						
Report Author (Title):	**Corporate Governance Officer**						

Background and current situation:

An Annual Report from the Committee is produced to demonstrate that it has undertaken the duties set out in its Terms of Reference and to provide assurance to the Board that this is the case.

The purpose of the report is to provide Members of the Audit and Assurance Committee with the opportunity to discuss the attached Annual Report before being submitted to the Board for approval by the end of March 2021.

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

The Committee has achieved an overall attendance rate of 90% from the period 21/04/2020 - 09/02/2021 have met on seven occassions during the year.

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

The attached Annual Report 2020/21 of the Audit and Assurance Committee demonstrates that the Committee has undertaken the duties as set out in its Terms of Reference.

Recommendation:

The Audit and Assurance Committee is asked to:

- **REVIEW** the draft Annual Report 2020/21 of the Audit and Assurance Committee
- **RECOMMEND** the Annual Report to the Board for approval.

Shaping our Future Wellbeing Strategic Objectives

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

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X

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

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

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Annual Report of Audit and Assurance Committee 2020/21

1.0 INTRODUCTION

In accordance with best practice and good governance, the Audit Committee produces an Annual Report to the Board setting out how the Committee has met its Terms of Reference during the financial year.

2.0 MEMBERSHIP

The Committee membership is a minimum of three Independent Members one of which must have financial experience and one of whom must be a member of the Quality, Safety and Experience Committee. During the financial year 2020/21 the Committee comprised three Independent Members. In addition to the Membership, the meetings are also attended by the Director of Finance (Lead Executive), Director of Corporate Governance, Head of Internal Audit, Local Counter Fraud Specialist and a Representative of External Auditor (Audit Wales). Other Executive Directors will attend as required by the Committee Chair. The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

The Chair of the Board is not a Member of the Committee but attends at least annually after agreement with the Committee Chair.

3.0 MEETINGS AND ATTENDANCE

The Committee met seven times during the period 1 April 2020 to 31 March 2021. This is in line with its Terms of Reference.

At least two members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

The Audit Committee achieved an attendance rate of 90% (80% is considered to be an acceptable attendance rate) during the period 1st April 2020 to 31st March 2021 as set out below:

	21.04.20	28.05.20	29.06.20	07.07.20	08.09.20	12.11.20	09.02.21	Attendance
John Union (CC)	✓	✓	✓	✓	✓	✓	✓	100%
Eileen Brandreth (VC)	✓	✓	✓	✓	✓	✓	✓	100%
Dawn Ward (I.M. until 31/01/21)	✓	✓	✓	X	✓	✓	X	71%
Total	**100%**	**100%**	**100%**	**66%**	**100%**	**100%**	**66%**	**90%**

4.0 TERMS OF REFERENCE AND WORKPLAN

The Terms of Reference and work plan are to be reviewed and approved by the Committee on 09 February 2021 and be approved by the Board on 25th March 2021.

5.0 WORK UNDERTAKEN

During the financial year 2020/21 the Audit and Assurance Committee reviewed the following key items at its meetings:

PRIVATE AUDIT AND ASSURANCE COMMITTEE

APRIL, MAY, JUNE, JULY, SEPTEMBER, NOVEMBER 2020 & FEBRUARY 2021

Papers presented to the private session of the Audit and Assurance Committee are as follows:

- Counter fraud Progress Report
- Procurement Compliance Report
- Workforce and Organisational Development Compliance Report

PUBLIC AUDIT AND ASSURANCE COMMITTEE – SET AGENDA ITEMS

April 2020 - March 2021

- **Internal Audit Progress and Tracking Report & Internal Audit Plan 2020/21**

Internal Audit Reports were submitted to each of the Audit and Assurance Committee meetings with the exception of 29th June 2020 (which related to the Health Board's accounts). The reports presented provided details relating to outcomes, key findings and conclusions from the finalised Internal Audit assignments and specific detail relating to progress against the Audit Plan and any updates that occurred within the plan.

18 reports presented during the year 12 of which were from the 2019/20 Internal Audit Plan and a further 6 from the 2020/21 plan

From the 2019/20 plan 5 reports received a substantial rating, 7 a reasonable rating. Please refer to **Appendix 3** which provides an overview of internal audit reports presented to the Committee, as well as an overview of Committee matters for the year **Appendix 1 & 2**.

A Draft Internal Audit plan for 2020/21 has been developed following meetings and correspondence with the Health Board's Executive Directors, Chief Executive, and Chairman and also with the Clinical Board Directors of Operations. The draft plan was planned to be submitted to the Management Executive Team for comment. However, due to changes to the focus of the Management Executive Team in the current climate, the draft plan was issued to the Director of Governance for sharing with the Executive Directors where possible.

Following the delay in commencing delivery of the Internal Audit Plan, due to the COVID-19 situation, there were no audits completed in time for presentation to the July Audit Committee meeting.
However, at the time work had commenced on a small number of audits and the outcome of these audits, along with the others planned to be completed within Q2

were reported to the September and November meetings of the Audit and Assurance Committee.

The 20/21 Internal Audit plan was formally approved by the Audit & Assurance Committee at the April 2020 meeting. It was however noted that the content of the plan and the proposed timing of individual audits, would be subject to adjustment to reflect the Health Board's changing risk profile and the availability of key management and staff during the COVID-19 pandemic.

A first round of adjustments to the plan was formally approved by the Audit Committee in July. However, due to the impact of the pandemic to date and the likelihood of continued disruption through the winter, it was anticipated that the current revised plan would not be delivered. It was therefore proposed that a number of additional audits were removed from the plan. These reflected areas of lower risk or where the Health Board had identified that work couldn't progress at that time. Full details of the proposed updated Internal Audit plan were provided within Appendix of the November 2020 meeting.

- **Audit Wales Progress Reports**

The Audit Wales Progress Reports provide 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 Good Practice Exchange (GPX).

July 20 – Audit Wales advised the Committee that they were working very closely with Internal Audit and the Director of Corporate Governance to discuss progress on the Structured Assessment, governance, internal audit and KPMG work to ensure that Audit Wales were not placing additional burdens on the UHB. Audit Wales confirmed they would ensure that their work and the work of Internal Audit was aligned and advice would be taken on board from KPMG when made available. They advised that the governance review of WHSSC was now reinstated, a survey would be send to Chief Executives and Health Board Chairs, and once those tasks had been completed a draft report would be circulated.

September 20 – Update provided to the Committee with regards to the work undertaken for the Structured Assessment for 2020. It was explained how the approach had been adapted this year to consider governance arrangements, managing financial resources, and operational planning in the context of Covid-19. Audit Wales had worked closely with Internal Audit to coordinate work as much as possible to minimise the burden placed on the UHB and to provide added value from sharing work. This had resulted in a draft report being prepared and issued for consideration with a feedback meeting scheduled for the end of the month.

In regards to TTP a national high level piece of work would be undertaken, which would look at the whole systems governance arrangements, as well as the local Covid-19 response plans. Field work was currently underway and the Executive Director Public Health was also interviewed as part of the process, being the regional

lead for Cardiff and Vale. Audit Wales aimed to publish the report and its findings by October 2020.

For work in relation to Covid-19 learning and good practice exchange, a learning project was established to share learning during the pandemic and public bodies were encouraged to share information and new ways of working via a dedicated landing page on their website in various output forms such as blogs and articles.

November 20 - key issues from the regular update were reported. Audit Wales highlighted within the report work currently underway and plans for the reports to be submitted to the February meeting. Two of the projects related to local pieces of work:

- Follow-up of previous IM&T recommendations
- Follow-up of operating theatres audit;

The other pieces of work were National pieces of work and mentioned that the Orthopaedic Services – follow-up would come with a supplementary output to set out the local position of each Health Board.

There was also a Follow-up of radiology services, this was an additional piece of work to be taken up locally which AW.

- **Declarations of Interest including Declarations of Interest and sign off in relation to Ysbyty Calon Y Ddraig**

As 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. From the April 2020 Committee meeting the Committee were informed that the back log of forms had been added to the register, so the report was fully up to date which was positive. The Director of Corporate Governance mentioned that due to the current pandemic, all communications regarding declarations of interest had stopped, however the team were still monitoring declarations that were being received, and to date, nothing had been received which raised concern. A further update was provided in July 20 that outlined the end of year position and that Declarations of Gifts, Hospitality & Sponsorship had now moved to Risk & Regulation. The Director of Corporate Governance 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 received and the Bale Donation was going to be discussed at the Special Board of Trustee meeting at the end of July 2020. From September the number of declarations had been very low compared to the last report where good numbers of declarations had been received throughout the year and progress made on previous years. The reason for the lower numbers were due to the fact that the end of year chasers had not been sent due to Covid-19, this was usually done at the end of April but had been deferred to October, by which time the numbers should start to increase. At that point 109 Declarations had been received for the year

2020/21. Whilst it was accepted that this number would need to improve, assurance was provided to the Committee from the significant increase in returns since September's Committee meeting and the predicted increases expected over the coming months following the implementation of the Risk and Regulation Team's Communications Plan

- **Regulatory Compliance Tracking Report including Ysbyty Calon Y Ddraig**

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. The purpose of the Regulatory Compliance Tracking report was to provide Members of the Committee with assurance on the implementation of recommendations which had been made by Internal Audit by means of an internal audit recommendation tracking report.

Good progress had 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 was still some work to be done to ensure that the tracker was fit for purpose in providing assurance to the Audit Committee and the Board.

In April the Director of Corporate Governance confirmed that all trackers were up to date until COVID-19 and advised the Committee that there were no visits ongoing at that time, there were planned visits for June / July, however it was anticipated that these would not take place.

The overall number of outstanding recommendations had increased from 212 individual recommendations to 226 for the period March 2020 to June 2020. However, it could also be demonstrated that some actions were completed during the period.

In July it was reported that a review of all outstanding recommendations had been undertaken since the last meeting of the Audit Committee where the Internal Audit tracker had been presented (March 2020). Each Executive Lead had been sent the recommendations made by Internal Audit which fell within their remits of work. In addition to this the audits undertaken during the financial period 2019/20 had also been added to the tracker and progress reported.

In September 2020 the committee were made aware that work would be undertaken to improve the Regulatory and Legislative Compliance Tracker by the new Risk and Regulation Team which comprised a Head of Risk and Regulation plus two Risk and Regulation Officers. The onset of Covid-19 had temporarily stalled the Risk and Regulation Team's progress but the Committee were advised that the additional capacity secured would, moving forward, mean that there was capacity to further develop the Tracker in addition to supporting the roll out of the Departments Risk Management plans. The tracker continued to be updated throughout the organisation and reported to the Audit Committee at each meeting. Based on the information

contained within the tracker there had been a further 21 inspections reported since the 3rd March 2020 (including inspections that had taken place prior to the 3rd March but had not previously been reported).

Following onto the November meeting a further 9 inspections had been reported, including inspections that had taken place prior to the Committee but had not previously been reported. Inspections undertaken by the Community Health Council, which had not previously been included in the Regulatory and Legislative Tracker had also been added.

- **Internal Trackers and External Trackers**

The reports and trackers provided Members of the Audit and Assurance Committee with assurance on the implementation of recommendations which had been made by Internal Audit or Audit Wales by means of an internal / external audit recommendation tracking report and were able to view progress and improvements made from the Limited Assurance rating to Reasonable Assurance rating.

- **Losses and Special Payments**

As defined in the Standing Financial Instructions, the Audit and Assurance Committee is required to approve the write off of all losses and special payments within the delegated limits determined by Welsh Government. To assist the Audit and Assurance Committee with this task, the UHB has established a losses and special payments panel, under the chairmanship of the Director of Finance (delegated to The Deputy Director of Finance). This panel meets twice yearly and is tasked with considering the circumstances around all such cases and to make appropriate recommendations to the Committee.

The Panel met on 13 May 2020 and considered the period for the second part of the year. The Assessment section of the report made a number of recommendations. The Committee was advised that losses were included in the financial accounts for final sign off. The Interim Finance Director advised the Committee that there was a big number for Clinical Negligence Claims which related not to cost but the size of the loss. The large figure for ex-gratia payments was highlighted and the £250,000.00 relating to stock right off across areas, the Committee was advised that this figure was £461,000.00 the preceding year so was not out of sync with past years.

The Interim Finance Director informed the committee that as the connected losses were so large, this was not within the delegated authority of the Health Board to approve and therefore it had gone to Welsh Government who had approved the losses. This would therefore come to a future Committee for noting as it related to the new financial year.

On 23rd October 2020 the Interim Finance Director referred to the assessment area of the report that sets out those items which were recommended for write off.

The Interim Director of Finance highlighted 2 items:

Bad Debt Write-Offs –this item was particularly small for the first 6 months of the year as they had stopped referring to the debt collection agency given the hardship people were feeling during the pandemic, but the process would now restart.

Treforest Flood – by the time the process had been completed there was over £2,000,000 in damages. As this was above the delegated limit of the Audit committee this was sent to Welsh Government for specific approval which was granted.

6.0 REPORTING RESPONSIBILITIES

The Committee has reported to the Board after each of the Audit and Assurance Committee meeting by presenting a summary report of the key discussion items at the Audit Committee. As per the Committee's Terms of Reference the report is presented by the Committee Chair in which he must:

1) Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of Committee minutes and written reports throughout the year;
2) Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;
3) Ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

7.0 OPINION

The Committee is of the opinion that the draft Audit and Assurance Committee Report 2020/21 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

John Union

Committee Chair

	Apr-20	May-20	Jun-20	Jul-20	Sep-20	Nov-20	Feb-21
Committee Meeting Items	**Items for Review and Assurance**						
	Internal Audit Progress and Tracking Report	Internal Audit Progress and Tracking Report		Internal Audit Progress and Tracking Report	Internal Audit Progress and Tracking Reports	Internal Audit Progress and Tracking Reports	Internal Audit Progress and Tracking Reports
	Declarations of Interest and Gifts and Hospitality Tracking Report			Audit Wales Update	Audit Wales Update	Audit Wales Update	Audit Wales Update
	Regulatory Compliance Tracking Report				The 2019-20 Audit of Accounts Addendum Report	Annual Structured Assessment Report	Internal Audit Plan to Complete 2020/2021
	Internal Audit Tracking Report				Effectiveness of Counter-Fraud Arrangements Report	Management of Clinical Coding Across Wales	Doing it Differently, Doing it Right? Governance in the NHS During the COVID-19 Crisis
	Audit Wales Tracking Report					10 Opportunities for Planned Care	Follow-up of Operating Theatres
	Review the Risk Management System					The National Fraud Initiative in Wales 2018-20	
						Welsh Community Care Information System	
	Items for Approval / Ratification						
	Review and Approve Annual Internal Audit Plan	Report of the Losses and Special Payments Panel	A Report on the Annual Accounts of the UHB 2019-20	Declarations of Interest and Gifts and Hospitality Tracking Report	Declarations of Interest and Gifts and Hospitality Tracking Report including Declarations of Interest and sign off in relation to Ysbyty Calon Y Ddraig	Declarations of Interest and Gifts and Hospitality Tracking Report	Declarations of Interest and Gifts and Hospitality Tracking Report
			Wales Audit Office ISA 260 Report	Regulatory Compliance Tracking Report	Regulatory Compliance Tracking Report including Ysbyty Calon Y Ddraig	Regulatory Compliance Tracking Report	Regulatory Compliance Tracking Report
			The Head of Internal Audit Annual Report for 2019-20	Internal Audit Tracking Report	Internal Audit Tracking Report	Internal Audit Tracking Report	Internal Audit Tracking Report
			The Counter Fraud Annual Report for 2019-20	Audit Wales Tracking Report	Audit Wales Tracking Report	Audit Wales Tracking Report	Audit Wales Tracking Report
						Review Losses and Special Payments	Final Accounts Timetable And Plans
						Proposed Changes to Governance Arrangements	Review Committee Terms of Reference
							Audit Committee Annual Report
							Annual Work Plan
							Agree Audit Wales 2021 Audit Plan
							Audit Wales Annual Report
	Items for Noting and Information						
	Internal Audit Reports	Internal Audit Reports		Internal Audit Reports	Internal Audit Reports	Internal Audit Reports	Internal Audit Reports
	Annual Audit Plan 2020 – Impact of COVID-19	Good Governance During COVID-19				Business of other Committees and Review of Inter-relationships	
	National Clinical Audit Programme - Impact COVID-18					Self-Assessment of Committee Effectiveness	
						Job Planning Update	

Audit Committee Annual Summary		
	Internal Audit Progress and Tracking Report	Internal Audit Reports were submitted to each of the Audit and Assurance Committee meetings with the exception of 29th June 2020 (which related to the Health Board accounts). The reports presented provided details relating to outcomes, key findings and conclusions from the finalised internal Audit assignments and specific detail relating to progress against the audit plan and any updates that occurred within the plan. 17 reports reports presented during the year 12 of which were from the 2019/20 Internal Audit Plan and a further 5 from the 2020/21 plan. From the 2019/20 plan 5 reports received a substantial rating, 7 a reasonable rating and three received a Limited rating. (A table at the end of the report shows a link for the list of internal audit reports presented to the Committee - Overview 3 as well as an overview of Committee matters for the year.) Draft Internal Audit plan for 2020/21 has been developed following Meetings and correspondence with the Health Board's Executive Directors, Chief Executive, and Chairman and also with the Clinical Board Directors of Operations. The draft plan was planned to be submitted to the Management Executive Team for comment. However due to the changes to the focus of the Management Executive Team in the current climate, the draft plan was issued to the Director of Governance for sharing with the Executive Directors where possible. Following the delay in commencing delivery of the Internal Audit Plan, due to the COVID-19 situation, there are no audits that have been completed in time for presentation to the July Audit Committee meeting. However at the time commenced work on a small number of audits and. The outcome of these audits, along with the others planned to be completed within Quarter 2 will be reported to the September and November meetings of the Audit and Assurance Committee. The 20/21 Internal Audit plan was formally approved by the Audit & Assurance Committee at the April 20 meeting. It was however noted that the content of the plan and the proposed timing of individual audits, would be subject to adjustment to reflect the Health Board's changing risk profile and the availability of key management and staff during the COVID-19 pandemic. A first round of adjustments to the plan was formally approved by the Audit Committee in July. However, due to the impact of the pandemic to date and the likelihood of continued disruption through the winter, it is anticipated that the current revised plan will not be delivered. It is therefore proposed that a number of additional audits are removed from the plan. These reflect areas of lower risk or where the Health Board has identified that work can't progress at the current time. Full details of the proposed updated Internal Audit plan are provided within Appendix of the November 20 meeting.
	Declarations of Interest and Gifts and Hospitality Tracking Report including Declarations of Interest and sign off in relation to Ysbyty Calon Y Ddraig	As agreed by Audit & Assurance Committee an update on Declarations of Interest, Gifts, Hospitality & Sponsorship would be provided to each Audit Committee for information. From the April 20 Committee meeting the Committee were informed that the back log of forms had been added to the register, so the report was fully up to date which was positive. The DCG added that due to the current pandemic, all communications regarding declarations of interest had stopped, however the team were still monitoring declarations that were being received, and to date, nothing had been received that raised concern. A further update was provided in July 20 that 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 received and the Bale Donation was going to be discussed at the Special Board of Trustee meeting at the end of July 2020. From September the current number of declarations were very low compared to the last report where good numbers of DOI had been sent in throughout the year and progress made on previous years. The reason for the lower numbers were due to the fact that the end of year chasers had not been sent due to Covid-19, this was usually done at the end of April but had been deferred to October so by then the numbers should start to increase again through the reporting cycle. To date 109 Declarations have been received for the year 2020/21. Whilst it is accepted that this number will needs to improve, assurance should be taken from the significant increase in returns since September's Committee meeting and the predicted increases expected over the coming months following the implementation of the Risk and Regulation Team's Communications Plan
	Regulatory Compliance Tracking Report including Ysbyty Calon Y Ddraig	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. The purpose of these reports 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. 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. In April the DCG confirmed that all trackers were up to date until COVID-19 and advised the Committee that there were no visits ongoing currently, there were planned visits for June / July, however it was anticipated these would not take place. The overall number of outstanding recommendations has increased from 212 individual recommendations to 226 for the period March 2020 to June 2020. This is due to new internal audit recommendations been added for 2019/20 reports and also tracking of recommendations not taking place over the COVID 19 period although a letter was received on 6th July 2020 from HIW which set out how they plan to conduct visits going forward. However, it can also be demonstrated that some actions were completed during this period. In July it was reported that a review of all outstanding recommendations has been undertaken since the last meeting of the Audit Committee where the internal audit tracker was presented (March 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. In September the committee was aware that 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. 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. 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). Following onto the November meeting A further 9 inspections have been reported since September's Committee meeting, including inspections that had taken place prior to the Committee but had not previously been reported. Inspections undertaken by the Community Health Council, which have not previously been included in the Regulatory and Legislative Tracker have also been added.
	Internal Audit Tracking Report	The reports and trackers provided Members of the Audit and Assurance Committee with assurance on the implementation of recommendations which have been made by Internal Audit or the Wales Audit Office by means of an internal / external audit recommendation tracking report and were able to view progress and improvements made from the Limited Assurance rating to Reasonable Assurance rating.
	Audit Wales Tracking Report	The reports and trackers provided Members of the Audit and Assurance Committee with assurance on the implementation of recommendations which have been made by Internal Audit or the Wales Audit Office by means of an internal / external audit recommendation tracking report and were able to view progress and improvements made from the Limited Assurance rating to Reasonable Assurance rating.
	Audit Wales Update	The Wales Audit Office 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 Good Practice Exchange (GPX). **July 20** – Audit Wales 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. They advised that the governance review of WHSSC was now reinstated, a survey would be send to Chief Executives and Health Board Chairs, and once these had been completed a draft report would be circulated. **September 20** – Update provided to the Committee with regards to the work undertaken for the structured assessment for 2020. It was explained how the approach had been adapted this year to consider governance arrangements, managing financial resources, and operational planning in the context of Covid-19. Audit Wales had been working closely with Internal Audit to coordinate work as much as possible to minimise the burden placed on the UHB and provide added value from sharing work. This had resulted in a draft report being prepared and issued for consideration and a feedback meeting would be held at the end of the month. In regards to TTP a national high level piece of work which would look at the whole systems governance arrangements as well as the local Covid-19 response plans. Field work was currently underway and the Executive Director Public Health would also be interviewed as part of the process, being the regional lead for C&V. AW aimed to publish the report and its findings by October. For work in relation to Covid-19 learning and good practice exchange, a learning project had been established to share learning during the pandemic and public bodies were encouraged to share information and new ways of working via a dedicated landing page on their website in various output forms such as blogs, articles, etc. **November 20** - key issues from the regular update were reported, AW highlighted within the report work currently underway which they plan to bring reports for to the February meeting and mentioned that two of the projects relate to local pieces of works: • Follow-up of previous IM&T recommendations • Follow-up of operating theatres The other pieces of work are National pieces of work and mentioned that the Orthopaedic Services – follow-up will come with local supplementary output to set out the local position of each Health Board. There is now a Follow-up of radiology services, this is an additional piece of work to be taken up locally which AW is currently scoping that piece of work and yet to determine if they can bring this report to the committee.
	Internal Audit Reports	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 - summary table provided in Annual Report of Audit and Assurance Committee
Apr-20	Review the Risk Management System	The DCG advised the Committee that significant progress had been made within Risk Management and there was now a strategy and agreed risk appetite, along with systems in place to manage risks. The DCG explained that consistent scoring was the next phase of work to be undertaken, however this had been paused due to COVID-19. The DCG further explained that there was an expectation that risk registers would be maintained, however scoring would not be reviewed. The DCG advised that for COVID-19, a risk management register had been put in place and risk registers for the four hubs had been developed, the risk registers would be presented at the Board Governance Group and at the Board Meeting at the end of May 2020. Within the six key risks, one had been slightly amended from 'planning recovery' to 'risks to Cardiff & Vale IMTP'
Apr-20	Review and Approve Annual Internal Audit Plan	The Head of Internal Audit explained the audit plan had been produced following discussions with all Executives, UHB Chair and Chief Executive Officer. The HIA further explained that the Committee were being asked to approve the annual plan, but with the acknowledgement that it would need further adjustment and amendment to reflect the emerging risks coming from COVID-19. The HIA added that work was being undertaken with shared services to access potential additional support through agencies to catch up with work required after COVID-19.
Apr-20	Annual Audit Plan 2020 – Impact of COVID-19	Audti Wales advised the Committee that all audit work had been suspended for the time being due to COVID-19, however work was being undertaken to capture learning from the pandemic on an All Wales Level. They confirmed that in terms of accounts, the timetable had been altered to 22nd May – 30th June and the performance report had also been delayed to 31st August which allowed key staff to focus on current challenges. It was also explained that an Audit Committee and Board Meeting would be required either on 26th or 29th June to reflect the time table change. They also explained that FRS 16 –Leases, Change in Accounting Standards had been deferred for one year, into 2021-22 which was very helpful as that would be a significant amount of work for all Health Boards.
Apr-20	National Clinical Audit Programme - Impact COVID-18	Letter from Welsh Government confirming they have been in contact with HQIP and NHS England and all parties have agreed that during the Covid-19 period, all clinical audit data collection should be suspended and analysis and preparation of current reports left to the discretion of the audit providers.
May-20	Report of the Losses and Special Payments Panel	The Deputy Finance Director advised the Committee that the Losses and Special Payments Panel met twice a year and brought its recommendations to the Committee for approval as per the Scheme of Delegation. The Panel met on 13 May 2020 and considered the period for the second part of the year. The Assessment section of the report made a number of recommendations. The Committee was advised that losses were included in the financial accounts for final sign off. The Deputy Finance Director advised the Committee that there was a big number for Clinical Negligence which related not to cost but the size of the loss. The large figure for ex-gratia payments was highlighted and the £250k relating to stock right off across areas, the Committee was advised that this figure was £461k the preceding year so was not out of synch with past years. The Deputy Finance Director informed the committee that as the connected losses were so large, this was not within the delegated authority of the Health Board to approve and therefore it had gone to Welsh Government who had approved the losses so this would come to a future Committee for noting as it related to the new financial year
May-20	Good Governance During COVID-19	The report described the framework put in place initially (the structure resembled Gold Command), and where the Health Board were with Committees that had been cancelled. The Committee was advised that the Health Board were now starting to revert to business as usual and the Chair had asked Committees to look at their terms of references so that we do not fully revert to as we were before. The document would also be attached as part of the Chair's report to the Board to be ratified. The Director of Corporate Governance explained that the structure was constantly under review. The Operational meetings were still convening daily, and taking lessons from what worked well, this was likely to continue. The UHB had kept to the Scheme of Delegation and SFIs so reverting back would not be an issue.
Jun-20	A Report on the Annual Accounts of the UHB 2019-20	The Deputy Director of Finance confirmed the Annual Accounts also formed part of the Accountability Report. The DFD reminded the Committee that the report had previously been reviewed and scrutinised at the meeting held on 28th May 2020. Adjustments to the report were outlined on page 2, however these did not change the impact of the report on the financial position of the UHB.

Jun-20	Wales Audit Office ISA 260 Report	Audit Wales confirmed that the accounts were materially true, fair and prepared with the exception of stock, this was due to AW being unable to attend the stock take for 2019-20 due to COVID-19, therefore, this would not report negatively for the Health Board. AW advised the Committee of two emphasis of matter which were explained as: • **Valuation of Land** – The Health Board carried out 7 valuations during 2019-20, 4 of which were conducted during COVID-19. AW confirmed it was an emphasis of matter due to the unreliability around valuations due to market uncertainty. • **Pension Regulations** – This affected all Health bodies with the exception of HEIW. AW confirmed the narrative around this had been agreed with Audit Wales and Welsh Government. AW advised the Committee that the Auditor General intended to certify on the 2ndJuly 2020 and Welsh Government were expected to lay the accounts on the 3rd July 2020 which would include a press release.
Jun-20	The Head of Internal Audit Annual Report for 2019-20	The Head of Internal Audit introduced the report and confirmed that the Audit Annual Report for 2019-20 had been reviewed and scrutinised during the meeting held on 28th May 2020 and no changes had been made. The DCG confirmed that the Audit Annual Report for 2019-20 had also been presented to Management Executive and was also reflected through the Annual Governance Statement.
Jun-20	The Counter Fraud Annual Report for 2019-20	The Counter Fraud Manager introduced the report and confirmed the following: • The appointment of a Band 4 team member to assist with awareness training going forward; • 59 new investigations and 11 cases brought forward from 2018-19; • Collaborative working was being undertaken with HR colleagues to address identified policy weaknesses; • Self-assessment had been completed, signed off by the Executive Director of Finance (EDF) and submitted within the set deadline to the NHS Counter Fraud Authority on 31st March 2020; • All areas are **rated green** against areas set by NHS Counter Fraud Authority, this was positive, however it was important to note a challenging year ahead; • Total cost of running a Counter Fraud department for the UHB totalled £91,000.00, however, the UHB had recovered £27,000.00 in costs.
Sep-20	The 2019-20 Audit of Accounts Addendum Report	Audit Wales explained how this report is the final output that comes to Committee each year at the end of September in regards to the audit of the annual accounts. The report was shorter this year which reflected well on overall quality plans and underlying processes. This year only 3 areas were reported compared to 10 last year, indicating a positive outcome where recommendations were taken on board and implemented. The following areas were reported: **Area 1** – Level of manual adjustment that sits outside financial ledger This was reported on 2 years ago where the recommendations were partially accepted at the time. The report was similar to how it was two years ago with minor changes. **Area 2** – Information which sits outside of the Ledger AW described how some information rightly sat outside the ledger however a lot of the information was complex and inefficient to prepare and audit. The recommendation was just for the Health Board to simplify this information. **Area 3** – Premature Party Returns AW advised that last year's recommendations had all been implemented by management as intended which showed a positive outcome and reflected well on the UHB.
Sep-20	Effectiveness of Counter-Fraud Arrangements Report	The national report made 15 recommendations and built on the report from last year which provided a landscape description of arrangements in place to tackle fraud across the Welsh public sector, and highlighted variability in arrangements and found NHS Wales ranked the highest above other public bodies with local and national counter fraud arrangements. This year's National report was a more in depth review of how effective these arrangements were in practice (across all Welsh Public Bodies). Audit Wales advised that Public Bodies in general could do more in the following areas: 1. Strengthening strategic leadership, coordination and oversight for counter-fraud across the Welsh public sector; 2. Increasing counter-fraud capacity and capabilities, especially across local government, and exploring the potential for sharing resources and expertise across public bodies; 3. Getting the right balance between proactive and reactive counter-fraud activities; 4. Improving awareness-raising and staff training in counter-fraud; and 5. Better evaluation of fraud risks and sharing of fraud information, both within and across sectors. AW referred specifically to the last recommendation, aimed at all committees recognising this very wide variation of existing practice across the public sector, albeit NHS Wales is in a better place than others.
Nov-20	Annual Structured Assessment Report	AW mentioned that the work undertaken was in the context of the pandemic and had reshaped and re-focused the work to concentrate in 3 areas in particular • Governance Arrangements; • Managing Financial Resources • Operational Planning AW wanted to thank Board for their full cooperation and assistance whilst undertaking this work, he stated that they were appreciative of the fact that the Health Board was dealing with pressuring challenges at the time and would like to acknowledge Internal Audit work and felt that everyone worked well together to minimize burden on Health Board whilst undertaking the reviews. AW referred to the first section in regards to Governance arrangements. **Revised Governance arrangements** - were set up quickly and supported responsive decision-making responsive decision-making and effective operational management, but public scrutiny and assurance at Board-level could have been enhanced during the pandemic. They found that Board business was conducted in an open way but there was more scope for more detailed reporting in some areas. The board maintained effective communication with its stakeholders during the pandemic and was stable during period. He added that opportunities to support and enhance development of the Board members could have been pursued in full. **Managing financial resources** - they found that effective financial controls, monitoring and reporting have been maintained throughout the pandemic and arrangements were put in place to track Covid-19 expenditure. **Operational Planning -** they found that have been informed by robust data modelling and developed in a timely way and the Health Board responded quickly to ensure sufficient resources were replaced to deliver its planning commitments. AW made 1 recommendation which was to encourage learning from pandemic to strengthen future Governance arrangements
Nov-20	Management of Clinical Coding Across Wales	Audit Wales stated that this was a national report where local work undertaken in 2018/19 and its aim is to highlight the current challenges and opportunities for clinical coding, including the potential to use COVID-19 related changes to working practices to secure new and more sustainable ways of delivering coding work. He said that the report builds on local work undertaken to provide a national picture on the opportunities and challenges, highlighting the fact it is on the agenda for information.
Nov-20	10 Opportunities for Planned Care	Audit Wales stated that this was based on follow up work assessing progress against their 2015 report on waiting times for elective care. He mentioned that they refrained their findings and key messages in the context of Covid-19 to inform the emerging plans for restarting planned care and the wider discussions on what a post COVID-19 NHS needs to look like. In this report we present ten key opportunities & five longer-term opportunities to reset the system and five immediate opportunities to restart the system. He stated that again it was a national report and encouraged Health bodies to consider the report as part of their ongoing planning arrangements for recovery and restarting.
Nov-20	The National Fraud Initiative in Wales 2018-20	Audit Wales stated that this discusses the outcomes achieved since this was last reported on the NFI in Wales in October 2018. It Highlights the importance to maintain robust controls to minimise the risk of fraud during the pandemic. He added that recommendations are provided for Welsh Government as well as local Audit Committee's to consider as well.
Nov-20	Welsh Community Care Information System	Audit Wales stated that this was a national study that examines latest position relating to the implementation and rollout of the Welsh Information System. He highlighted section 2.6 of the report which sets out the Health Boards position. As part of the work they identified that the current version of the information system would not meet the Health Boards requirements and also felt that it would offered less in terms of its functionality and provides a significantly more costly option compared to existing arrangements. UHB Chair commented that this was a good report and highlighted this expensive rollout program which he feels is behind track and hasn't delivered on what was originally planned and is not surprised that C&V haven't signed up but is happy that this is discussed on a public domain to discuss improvements to help all Health Boards. The Interim Director of Finance commented that this would be a cost pressure to the Health Board if taken forward
Nov-20	Review Losses and Special Payments	Required under the Standing Financial Instructions to approve the write offs of Losses And Special Payment. To support it in this process there is a Losses And Special Payments Panel that meet twice a year and last met on 23rd October. He referred to the assessment area of the report that sets out those items which is recommended for write off. The Interim Director of Finance highlighted 2 items: **Bad Debt Write-Offs** – he mentioned that it was particularly small for the first 6 months of the year as they have stopped referring to the debt collection agency given the hardship people were feeling during the pandemic but are now restarting this process. **Treforest Flood** – by the time we had gotten to the end of the process there was over £2.0M in damages. As it is above the delegated limit of the Audit committee this was sent off for Welsh Government for specific approval which has been granted.
Nov-20	Proposed Changes to Governance Arrangements	Recommendations within report pick up outputs from the Audit Wales structured assessment and Internal Audit Work undertaken by the HIA to make the Governance throughout the pandemic more robust. She highlighted the KPMG report which is in the private part of the meeting at the request of KPMG as it was commissioned by Welsh Government as there are recommendations for the Health Board and Welsh Government. Appendix 1 provides a summary of Governance arrangements and proposals to put in place to strengthen the Governance around the pandemic and to also pick up on the recommendations made. Appendix 2 is a template report which is put in place as a result of ensuring we cover off those key areas of: • Quality • Workforce • Governance • Public Health • Operations The DCG mentioned that this will be going to Board as well, as work has been completed. She added that with this report it is to ensure there is no duplication of work. The DCG added that there is revised TORS for the Board Governance Group and have been revised to include all Independent Members where as previously it only included Independent members required for chairs actions but based on Audit Wales recommendations the changes had been implemented.
Nov-20	Business of other Committees and Review of Inter-relationships	The work undertaken by the DCG provided the committee with oversight on What Was In Place, Not In Place, What Had Been Done, & What Had Not Been Done She added that it also provides the committee with assurance that they know what has been completed since 2019-2020 and where we are going to. She stated that the purpose of this review is allow the Audit committee to be able to provide further assurance to the Board that the other committees are in place and are operating effectively, this assurance is provided by ensuring • TORS are in place • Annual report on TORS • Effectiveness review carried out The DCG highlighted that for this year some of these items have slipped due to some committee's being stood down due to Covid-19
Nov-20	Self-Assessment of Committee Effectiveness	The DCG said that this was done last year with most committee and said where we pick up action is where its adequate, needs improvement, or where the response is no. The next step is for the DCG to meet with the chairs of each committee to follow up on these actions and ensure they are completed so when the self-assessment needs to be done the following year actions would have been picked up from the previous assessment.

Nov-20	Job Planning Update	The Medical Director stated that he wanted to bring this back to the committee as previously they had received limited assurance grading in the previous internal audit for the Job Planning. He mentioned that this was due to come to the February meeting but had made significant progress and wanted to update on progress. He said in terms of the cycles they were going through now was the right time to bring this to the committee with further update in 6 months. The MD highlighted that the job planning component has 2 key work streams: **Job Planning Procedure -** Relates to the development of the Job Planning Procedure and commented that it is not a guideline as it is a procedure that they need people to do. He added that this is very detailed and provides the answers to all things that are not clarified in the national contracts. He mentioned that they are currently in negotiation with the BMA about this and that they fundamentally agree with most of this. The MD stated that he is unsure if we will get to point where we agree on everything with the BMA and may not be able to jointly put this out but are in agreeance with 90% of it. He said that this answers most of these questions and feel that the current consultant contract is poor, obfuscated, and leaves a lot of room for interpretation, so putting this procedure together allows for an equitable, transparent and fair job planning across the board that enables people to compare how they're being job planned to others. **E-Job Planning System (Allocate) –** this is currently in wide spread use across the UK but was modified for Welsh use because of the nuances of the Welsh contracts but is in use in other Health Boards. The MD stated that they are in the process of refining this for our local requirements being a core step. He said they had to make a number of decisions needed what they need to pick up as part of this and again agreed decisions with BMA to ensure its in line with the contract. **Progress was made in the following areas:** • Identification Of Champions • Training People With Its Use • Identification Of Super Users • Number Of Engagement Events • Shifting Of Data Into The System The MD said that they are now in a position where they can go live with the Electronic Job Planning Solution and can start job planning individuals in real life and upload the job plans to the centralized solution.
Feb-21	Internal Audit Plan to Complete 2020/2021	Meeting yet to commence at the time of writing the report, will be updated post committee approval
Feb-21	Doing it Differently, Doing it Right? Governance in the NHS During the COVID-19 Crisis	Meeting yet to commence at the time of writing the report, will be updated post committee approval
Feb-21	Follow-up of Operating Theatres	Meeting yet to commence at the time of writing the report, will be updated post committee approval
Feb-21	Final Accounts Timetable And Plans	Meeting yet to commence at the time of writing the report, will be updated post committee approval
Feb-21	Review Committee Terms of Reference	Meeting yet to commence at the time of writing the report, will be updated post committee approval
Feb-21	Audit Committee Annual Report	Meeting yet to commence at the time of writing the report, will be updated post committee approval
Feb-21	Annual Work Plan	Meeting yet to commence at the time of writing the report, will be updated post committee approval
Feb-21	Agree Audit Wales 2021 Audit Plan	Meeting yet to commence at the time of writing the report, will be updated post committee approval
Feb-21	Audit Wales Annual Report	Meeting yet to commence at the time of writing the report, will be updated post committee approval

	Apr-20	May-20	Sep-20	Nov-20	Feb-21
Internal Audit Reports submitted at each meeting	**SUBSTANTIAL RATING**				
	CD&T Laboratory Turnarounds	UHW Neonatal Development Project	Annual Quality Statement - **(2020/21 Plan)**	Pre-Employment Checks - (2019/20 Opinion)	Specialist CB – Patient Assessment and Provision of Equipment by ALAS - **(2020/21 Plan)**
	UHB Core Financial Systems	Service Improvement Programme Team			
	REASONABLE RATING				
	Risk Management	Rookwood Relocation Project	Strategic Planning / IMTP - **(2019/20 Opinion)**	Surgery CB – Theatres Directorate Sickness Absence Management - **(2020/21 Plan)**	
		Surgery CB – Enhanced Supervision		Regional Partnership Board - **(2020/21 Plan)**	
		Infection Prevention & Control		Sustainability Reporting - **(2020/21 Plan)**	Asbestos Management - **(2020/21 Plan)**
		Management of Health Board Policies		Management of Serious Incidents	
		Pre-Employment Checks (Draft)		Governance During COVID-19 (Advisory Review) - NOT RATED - **(2020/21 Plan)**	
		Strategic Planning / IMTP (Draft)			
	LIMITED RATING				
					Mental Health Outpatient Clinic Cancellations - **(2020/21 Plan)**
	ASSIGNMENTS WITH DELAYED DELIVERY				
	Health & Care Standards		Regional Partnership Board	IM&T Control & Risk Assessment	Compliance with the Nursing Staff Levels Act (Wales) 2016
	Strategic Performance Reporting		Governance During COVID-19 (Advisory Review)	Integrated Health Pathways	Integrated Health Pathways
	Data Quality Performance Reporting		Sustainability Reporting	CD&T CB – Ultrasound Governance	UHW Surge Hospital – Lakeside Wing
	IM&T Backlog		IM&T Control & Risk Assessment		IM&T Control & Risk Assessment
	Medicine Clinical Board QS&E		Asbestos Management		CD&T CB - Ultrasound Governance
	Medicine CB – Internal Medicine Follow-up				Claims Re-imbursement
	Facilities / Estates Service Board Governance				

Report Title:	**Audit and Assurance Committee – Annual Workplan 2021-22**								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	9 February 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

The purpose of the report is to provide Members of the Audit and Assurance Committee with the opportunity to review the Audit and Assurance Committee Work Plan 2021/22 prior to presentation to the Board for approval.

The work plan for the Committee should be reviewed on an annual basis to ensure that all areas within its Terms of Reference are being delivered.

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

The work plan for the Audit and Assurance Committee has been developed based upon the requirements set out in its Terms of Reference (also on the agenda). It ensures that the Committee will advise and assure the Board and the Accountable Officer on whether effective governance and assurance arrangements are in place. The Terms of Reference are also in line with standards of Good Governance determined by the NHS Wales.

Recommendation:

The Audit and Assurance Committee is asked to:

REVIEW the Work Plan 2021/22;
APPROVE the Work Plan 2021/22;
RECOMMEND approval to the Board.

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

				sectors, making best use of our people and technology	
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	x	Collaboration	x	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.*

Audit Committee Work Plan 2021 - 22							
A -Approval D- discussion I - Information	**Exec Lead**	**06-apr.**	**10-jun.**	**06-jul.**	**07-sep.**	**09-nov.**	**08-feb.**
Agenda Item							
Governance							
Review the system of assurance	NF	D				D	
Review the risk management system	NF		D				D
Note the business of other Committees and review inter-relationships	NF						D
Review Draft AGS	NF	D	A				
Review Draft Quality Statement	RW	D	A				
Review the UHB Annual Report	NF	D	A				
Review of Standing Orders	NF						D
Report on Declarations of Interest and Gifts and Hospitality	NF	D		D	D	D	D
Receive relevant reports from Regulatory Bodies	NF	D		D	D	D	D
Receive tracking report from Regulatory Bodies	NF	D		D	D	D	D
Receive tracking report from internal audit recommendations	NF	D		D	D	D	D
Receive tracking report from Audit Wales recommendations	NF	D		D	D	D	D
Financial Focus							
Agree final accounts timetable and plans	CP						A
Review of audited annual accounts and financial statements	CP		A				
Review changes to SFIs and changes to accounting policies	CP/NF	D					
Review losses and special payments	CP	D	A			A	
Single Tender Actions	CP	D		D	D	D	D
Review of Draft Charitable Funds Annual Report and Accounts	CP					D	
Internal Audit							
Review and approve annual internal audit plan	IA	A					
Review the effectiveness of internal audit	IA					D	
Review of internal audit progress reports	IA	D		D	D	D	D
Receive internal audit reports undertaken during the period	IA	D		D	D	D	D
Receive annual internal audit report and associated opinions (HoIA)	IA		A				
Audit Wales							
Agree Auditor General's Audit Plan	AW						A
Review the effectiveness of external audit	AW					D	
Review External Audit Progress Reports	AW	D		D	D	D	D
Receive the Auditors report to those charged with governance	AW		A				
Receive the Auditors Annual Audit Report	AW						A
Receive Annual Structured Assessment Report	AW					D	
Clinical Audit							
Review annual Clinical Audit Plan	SW					D	
Counter Fraud							
Review and approve annual counter fraud plan	CF	A					
Review counter fraud progress reports	CF	D		D	D	D	D
Review the effectiveness of Counter Fraud Specialist	CF					D	
Receive counter fraud annual report	CF	D	A				
Audit Committee							
Annual Work Plan	NF						A
Self assessment of effectiveness	NF	D					
Induction Support for Committee Members	NF	D					
Review Terms of Reference	NF						A
Produce Audit Committee Annual Report	NF						A
Minutes of Audit Committee Meeting	NF	A	A	A	A	A	A
Action log of Audit Committee Meeting	NF	D	D	D	D	D	D

Archwilio Cymru
Audit Wales

2021 Audit Plan – Cardiff & Vale University Health Board

Audit year: 2021-22

Date issued: January 2021

Document reference: 2247A2021-22

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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

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2021 Audit Plan

About this document

1 This document sets out the work I plan to undertake during 2021 to discharge my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

Impact of COVID-19

2 The COVID-19 pandemic continues to have an unprecedented impact on the United Kingdom and the work of public sector organisations.

3 Audit Wales staff will continue to work pragmatically to deliver the audit work set out in this plan. In response to the government advice and subsequent restrictions, I will continue to work remotely until such time that it is safe to resume on-site activities. I remain committed to ensuring that the work of Audit Wales staff will not impede the vital activities that public bodies need to do to respond to on-going challenges presented by the COVID-19 pandemic.

4 This audit plan sets out an initial timetable for the completion of my audit work. However, given the on-going uncertainties around the impact of COVID-19 on the sector, some timings may need to be revisited.

Audit of financial statements

5 I am required to issue a report on the Health Board's financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. In preparing such a report, I will:

- give an opinion on your financial statements;
- give an opinion on the proper preparation of key elements of your Remuneration and Staff Report;
- give an opinion on regularity, in that in all material respects the expenditure and income have been applied to the purposes intended by the Senedd and the financial transactions conform to the authorities which govern them; and
- assess whether your Annual Governance Statement and other information presented with the financial statements are prepared in line with guidance and consistent with the financial statements.

6 I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities, along with further information about our work.

7 I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be

material will be reported to the Audit Committee and the Board prior to completion of the audit.

8 I judge any misstatements below a trivial level (set at 5% of materiality) as not requiring consideration by those charged with governance and I therefore will not report them.

9 I also audit your charitable funds' accounts. This year I might provide a separate audit plan and audit fee for this audit. I will be discussing this matter with the Director of Finance before I decide whether to make the separation.

10 I can confirm that to date there have been no limitations imposed on me in planning the scope my audit work.

Audit of financial statement risks

11 The following table sets out the significant risks that I have currently identified for the audit of your financial statements. You should note that my auditing planning is currently ongoing.

Exhibit 1: audit of financial statement risks

Financial audit risks	Proposed audit response
Significant risks	
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	I will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business; and • add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.

Financial audit risks	Proposed audit response
Under the NHS Finance (Wales) Act 2014, health boards ceased to have annual resource limits with effect from 1 April 2014. They instead moved to a rolling three-year resource limit, for revenue and capital net expenditure, with the first three-year period running to 31 March 2017. The Health Board has exceeded its rolling three-year revenue limit in the past four years, and I therefore qualified my regularity opinion on its financial statements for those years. For 2020-21 the Health Board expects to break even. If achieved, the Health Board would still have a cumulative deficit of £9.8 million for the three years to 31 March 2021 because of the deficit of £9.8 million in 2018-19.	I will continue to monitor the Health Board's financial position for 2020-21 and the cumulative three-year position to 31 March 2021, for the both revenue and capital-resource limits. This review will also consider the impact of any relevant uncorrected misstatements over those three years. If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2020-21 financial statements. I may also place a substantive report on the financial statements to explain the basis of the qualification and the circumstances under which it had arisen.
The COVID-19 national emergency continues and the pressures on staff resource and of remote working may impact on the preparation and audit of accounts. There is a risk that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.	I will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and monitor the accounts preparation process. I will help to identify areas where there may be gaps in arrangements.

Financial audit risks	Proposed audit response
The increased funding streams and expenditure in 2020-21 to deal with the COVID-19 pandemic will have a significant impact on the risks of material misstatement and the shape and approach to our audit. Examples of issues include accounting for field hospitals and their associated costs; fraud, error, and regularity risks of additional spend; valuation of year-end inventory, including PPE; and estimation of annual leave balances.	I will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.
With regard to the Health Board's inventory at the financial-year-end, last year I qualified my audit opinion, stating that: *'Due to the impact of the COVID-19 pandemic and the statutory lockdown arrangements that took effect from 23 March 2020, I was unable to observe and re-perform parts of the Health's Board's count of its inventories on 31 March 2020. As I have been unable to obtain the required audit assurance by alternative means, I am therefore unable to determine whether the Health Board's reported year-end inventory balance of £16.784 million is materially true and fair.'* If the Health Board's inventory remains material, and I am again unable to attend parts of the Health Board's count of its inventories, I would expect again qualify my opinion. It is important to emphasise to you, as I did last year, that qualification would not be due to shortcomings in the Health Board's systems or actions, but because of the impact of COVID-19 on one of our key audit procedures.	I will continue to assess the impact of the COVID-19, and lockdown arrangements, on my audit of the Health Board's year-end inventory.

Financial audit risks	Proposed audit response
The Dragon's Heart field hospital is material to the financial statements, with an estimated cost of some £70 million. The hospital was commissioned in Spring 2020 and it is now being decommissioned and 'made good'. This work is scheduled to be done during 2020-21. The novel and complex nature of this project, together with its high value, does give rise to an inherent risk of misstatement in the financial misstatements.	I have engaged regularly with the Health Board to keep abreast of the key issues. The Health Board has flagged that it expects to provide me with all its documentation in March, for my review. Further to this audit review, the hospital will be a key part of my testing of the financial statements and the annual governance statement.
Last year, as a result of COVID-19, and in accordance with specific guidance issued by their professional institute, the Health Board's property valuer declared a 'material valuation uncertainty' in four of their valuation reports. The four reports had a total valuation of £65 million as at 31 March 2020. The Health Board had used these valuation reports to inform the measurement of certain of its property asset values in the financial statements at that date. Last year I included an 'Emphasis of Matter' paragraph in my audit opinion drawing attention to your disclosure of the material uncertainty. There could be similar valuations this year that contain the valuer's material uncertainties due to COVID-19.	I will review all valuations during 2020-21 of the Health Board's land and property and consider the impact on my audit of any reported material-uncertainties.
The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year I included an 'Emphasis of Matter' paragraph in my audit opinion drawing attention to your disclosure of the contingent liability. However, if any expenditure is made in-year, I would consider it to be irregular as it contravenes the requirements of 'Managing Welsh Public Money'.	I will review the evidence one year on in respect of the take-up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.

Financial audit risks	Proposed audit response
I audit some of the disclosures in the Remuneration Report, such as the remuneration of senior officers and independent members, to a low level of materiality. The disclosures are therefore inherently more prone to material misstatement. In past audits I have identified material misstatements in the remuneration report submitted for my audit, which the Health Board then corrected. I therefore judge the 2020-21 disclosures to be at risk of misstatement.	I will review all entries in the Remuneration Report to verify that the Health Board has reflected all known changes to senior positions, and that the disclosures are complete and accurate.
Area of audit attention	
Introduction of IFRS 16 Leases has been deferred until 1 April 2022 and may pose implementation risks. There is considerable work required to identify leases and the COVID-19 national emergency may pose implementation risks.	I will undertake some early work to review preparedness for the introduction of IFRS 16 Leases. See **Appendix 2, Exhibit 6** for more detail.

Performance audit work

12 In addition to my Audit of Financial Statements, I must also satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

13 Where appropriate, I will also take opportunities to assess the extent to which the Health Board is acting in accordance with the sustainable development principle[1] as per my duties set out in the Well-being of Future Generations (Wales) Act 2015. This work will be informed by the responses to my recent consultation on how I approach my duties in respect of the Act. I will be writing to the public bodies

[1] The Act defines the sustainable development (SD) principle as acting in a manner: '…which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs'

designated in the Act setting out the results of the consultation and how I intend to approach this work over the reporting period 2020-25.

14 My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit. Exhibit 2 sets out my current plans for performance audit work in 2021.

Exhibit 2: My planned 2021 performance audit work at the Health Board

Theme	Approach/key areas of focus
NHS Structured Assessment	Structured assessment will continue to form the basis of the work auditors do at each NHS body to examine the existence of proper arrangements for the efficient, effective and economical use of resources. The plans for 2021 structured assessment work reflect the ongoing arrangements of NHS bodies in response to the COVID-19 emergency. My 2021 work will be undertaken in two phases. Phase 1 will review the effectiveness of operational planning arrangements to help NHS bodies continue to respond to the challenges of the pandemic and to recover and restart services. Building on last year's work, Phase 2 will examine how well NHS bodies are embedding sound arrangements for corporate governance and financial management, drawing on lessons learnt from the initial response to the pandemic.
All Wales Thematic Reviews	**Unscheduled care arrangements** My 2020 audit plans included a thematic review examining different aspects of the unscheduled care system. However, this work was paused during the early stages of the pandemic and then ultimately replaced to allow resources to be diverted to a high-level review of the Test, Trace and Protect (TTP) programme. My planned work on unscheduled care will now be delivered as part of my 2021 programme. It will include an analysis of national data sets, a high-level commentary of the performance of the unscheduled care system. This will be followed by more detailed work focusing on the mechanisms for managing demand for unscheduled care and patient flow through the system.

Theme	Approach/key areas of focus
	COVID-19 related outputs I also plan to use an element of the 2021 audit fee to respond to aspects of the pandemic where my insight and knowledge across Wales will provide value to NHS bodies. The precise focus of this work will be kept under review and will be reflected in the regular updates that are produced for the Audit Committee.
Locally focused work	Where appropriate, I will also undertake thematic performance audit work that reflects issues specific to the Health Board. The precise focus of this work will be agreed with executive officers and the Audit Committee and will be reflected in the regular updates that are produced for the Audit Committee.
Implementing previous audit recommendations	My structured assessment work will include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having. Expectations on the implementation of previous audit recommendations will be adjusted as appropriate to take account of the impact on COVID-19.

15 The performance audit projects included in last year's audit plan, which are either still underway or which have been substituted for alternative projects in agreement with you, are set out in **Appendix 1**.

Fee, audit team and timetable

16 My fees and the planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided to the agreed timescales, to the quality expected and have been subject to quality assurance review;

- information provided to support the financial statements is in accordance with the agreed audit deliverables document[2];
- appropriate facilities and access to documents are provided to enable my team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accounting Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete, and management has responded to issues that may have affected the financial statements.

Fee

17 My statutory 2021-22 Fee Scheme is due to be published soon. My fee-estimates to audited bodies are then assessed and set. My audit team will therefore write to the Health Board soon with:

- my fee estimate for 2021; and
- my fee outturn for 2020, and any additional cost to be invoiced or rebate to be paid.

18 The fee letter will be presented to you at your next meeting. My planning will be ongoing and changes to our programme of audit work, and therefore the fee, may be required if any key new risks emerge. I shall make no changes without first discussing them with the Director of Finance.

19 Further information on my fee scales and fee setting can be found on our website.

Audit team

20 The main members of the audit team, together with their contact details, are summarised in Exhibit 3.

[2] The agreed audit deliverables documents set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.

Exhibit 3: My local audit team

Name	Role	Contact number	E-mail address
Anthony Veale	Audit Director (Financial Audit), and Audit Wales Engagement Director for the Health Board	02920 320585	Anthony.Veale@audit.wales
Dave Thomas	Audit Director (Performance Audit)	02920 320604	Dave.Thomas@audit.wales
Mark Jones	Audit Manager (Financial Audit)	02920 320631	Mark.Jones@audit.wales
Darren Griffiths	Audit Manager (Performance Audit)	02920 320591	Darren.Griffiths@audit.wales
Rhodri Davies	Audit Lead (Financial Audit)	02920 320637	Rhodri.Davies@audit.wales

21 I can confirm that team members are all independent of you and your officers. In addition, I are not aware of any potential conflicts of interest that I need to bring to your attention. However, I need to draw your attention to the fact that Dave Thomas' partner works in the Health Board as a Radiology Department Assistant. Dave has made the necessary declarations in respect of auditor independence to our Law and Ethics Team, and he will not have any involvement with audit work concerning radiology services at the Health Board.

Timetable

22 The key milestones for the work set out in this plan are shown in Exhibit 4. As highlighted earlier, there may be a need to revise the timetable in light of developments with COVID-19.

Exhibit 4: Audit timetable

Planned output	Work undertaken	Report finalised
2021 Audit Plan Issued each year while my audit planning is ongoing, per paragraph 11.	December 2020 to April 2021	February 2021
Audit of Financial statements work: • Audit of Financial Statements Report • Opinion on Financial Statements • Audit of Financial Statements Addendum Report	January to June 2021	June 2021 June 2021 August 2021
Performance audit work: • Structured Assessment • Unscheduled Care • COVID-19 outputs • Local project work	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	
2022 Audit Plan	December 2021 to January 2022	February / March 2022

Appendix 1

Performance audit work in last year's audit plan still in progress

The following table summarises the status of the audit work in last year's audit plan which is still in progress.

Exhibit 5: Performance audit work still in progress.

Performance audit project	Status	Comment
Review of Welsh Health Specialised Services Committee	Reporting	A national report is due to be published in early 2021.
Unscheduled Care	Fieldwork	This work was paused as a result of the pandemic and replaced with a review of the Test, Trace and Protect (TTP) programme. Unscheduled care work has been carried forward to feature in this year's plan.
Test, Trace and Protect	Reporting	A national report is due to be published in early 2021.

Appendix 2

Other future developments

Forthcoming key IFRS changes

This table details the key future changes to International Financial Reporting Standards

Exhibit 6: changes to IFRS standards

Standard	Effective date	Further details
IFRS 16 Leases	1 April 2022	IFRS 16 will replace the current leases standard IAS 17. The key change is that it largely removes the distinction between operating and finance leases for lessees by introducing a single lessee accounting model that requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. It will lead to all leases being recognised on balance sheet as an asset based on a 'right of use' principle with a corresponding liability for future rentals. This is a significant change in lessee accounting.
IFRS 17 Insurance Contracts	2023-24 at earliest	IFRS 17 replaces IFRS 4 *Insurance Contacts*, which permitted a variety of accounting practices resulting in accounting diversity and a lack of transparency about the generation and recognition of profits. IFRS 17 addresses such issues by requiring a current measurement model, using updated information on obligations and risks, and requiring service results to be presented separately from finance income or expense. It applies to all insurance contracts issued, irrespective of the type of entity issuing the contracts, so not relevant only for insurance companies. Entities will need to consider carefully whether any contractual obligations entered into meet the definition of an insurance contract. If that is the case, entities will need to determine whether they are covered by any of IFRS 17's specific scope exclusions.

Future changes to UK GAAP: applicable to charitable funds accounts

Following the introduction of the new UK GAAP accounting regime in 2015-16, and the replacement of the Financial Reporting Standard for Smaller Entities (FRSSE) by Section 1A of FRS 102 in 2016-17, there were only limited changes to FRS 102 in 2019-20.

More significant amendments are expected from 2022-23, reflecting recent changes in International Financial Reporting Standards, including accounting for financial instruments and leases.

Good Practice Exchange

Audit Wales' Good Practice (GPX) helps public services improve by sharing knowledge and practices that work. Events are held where knowledge can be exchanged face to face and resources shared online. This year the work has focused on COVID-19 learning. Further information on this can be found our website.

Brexit: The United Kingdom's future outside the European Union

The United Kingdom left the European Union on 31 January 2020 under the terms of the Withdrawal Agreement. Between then and 31 December 2020, the UK entered a transition period, during which it continued to participate in EU programmes and follow EU regulations. On 31 December 2020, the transition period ended, and a new relationship between the UK and EU started, on the basis of a new free trade agreement.

The new agreement means some substantial changes in the trading relationship between the UK and the EU. There will also potentially be changes in administrative areas previously covered by EU law. In the short term, the UK has incorporated EU rules into domestic law. However, it is likely than in some key areas, such as public procurement, agricultural support and state aid, the UK will seek to diverge over time. In changing these rules, there will be some important constitutional issues around the relationship between the UK Government and devolved governments.

The wider opportunities and risks for Wales' economy, society and environment will become clearer as public services move from managing the short-term risks, especially around disruption to supply chains, to adapting to a different relationship with the EU and the wider world. I am also awaiting further details on the UK Government's plans to replace EU funding schemes for regional development and rural development.

The Auditor General will continue to keep a watching brief over developments. In November, he wrote to the Chair of the External Affairs and Additional Legislation Committee setting out some observations on the latest position with respect to preparations for the end of the transition period. His letter can be found here. His previous report on public bodies Brexit preparations can be found here with his follow up on progress here.

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

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Annual Audit Report 2020 – Cardiff and Vale University Health Board

Audit year: 2019-20

Date issued: January 2021

Document reference: 2170A2020-21

This document has been prepared for the internal use of Cardiff and 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 to the Senedd 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.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

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

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Summary report

About this report

1 This report summarises the findings from my 2020 audit work at Cardiff and Vale University Health Board (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Health Board, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts.
- Arrangements for securing economy, efficiency and effectiveness in the use of resources.

3 This year's audit work took place at a time when public bodies were responding to the unprecedented and ongoing challenges presented by the Covid-19 pandemic. Given its impact, I re-shaped my planned work programmes by considering how to best assure the people of Wales that public funds are well managed. I considered the impact of the current crisis on both resilience and the future shape of public services and aimed to ensure my work did not hamper public bodies in tackling the crisis, whilst ensuring it continued to support both scrutiny and learning. All on-site audit work was suspended whilst we continued to work and engage remotely where possible through the use of technology. This inevitably had an impact on the delivery of some of my planned audit work but has also driven positive changes in our ways of working.

4 The delivery of my audit of accounts work was not without its challenges, not only in how and where we undertook the work, but also in taking account of new considerations for financial statements arising directly from the pandemic. The success in delivering to the amended timetable reflects a great collective effort by both my staff and the Health Board's officers to embrace and enable new ways of working and remain flexible to and considerate of the many issues arising.

5 At the onset of the pandemic I suspended the publication of some performance audit reports nearing completion, reflecting the capacity of audited bodies to support remaining fieldwork and contribute to the clearance of draft audit outputs. I have also adjusted the focus and approach of some other planned reviews to ensure their relevance in the context of the crisis. New streams of work have been introduced, such as my review of the Test, Trace and Protect programme, and my local audit teams have contributed to my wider Covid-19 learning work.

6 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1)**. I also include a summary of the status of planned work currently being re-scoped.

7 **Appendix 2** provides an update on the audit-fee estimate that I set in my 2020 Audit Plan, and when I expect to be able to confirm the actual fee for the year.

8 **Appendix 3** sets out the financial audit risks set out in my 2020 Audit Plan and how they were addressed through the audit.

9 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. My audit team will present it to the Audit Committee on 9 February 2021. The Board will also receive the report and every independent member will receive a copy. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

10 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

11 I concluded that the Health Board's accounts were properly prepared and materially accurate, except for the inventory balance as at 31 March 2020. I therefore issued a qualified limitation-of-scope opinion on the accounts.

12 This qualification was necessary because I had been unable to obtain sufficient appropriate audit evidence to support the Health Board's material inventory-balance of £16.784 million as at 31 March 2020. I would like to highlight that the qualification did not arise due to shortcomings in the Health Board's systems or actions, but because the UK's Covid-19 lockdown had prevented my audit team from undertaking their year-end inventory count, being a mandated audit procedure for a material inventory-balance. I would also like to highlight that I did not consider the inventory balance to be materially misstated, but rather that I could not establish whether it was materially true and fair.

13 My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my audit). However, I placed Emphasis of Matter paragraphs in my audit report to draw attention to two disclosures in the accounts, relating to:

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

14 I also brought three important issues to the attention of officers and the Audit Committee. The issues, and my audit recommendations, related to some of the Health Board's accounting processes and underlying records.

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

Arrangements for securing efficiency, effectiveness and economy in the use of resources

16 My programme of Performance Audit work has led me to draw the following conclusions:

- there has been good operational management and agile decision-making during the pandemic despite some limitations in the transparency of scrutiny, assurance, and oversight of overall governance;
- effective financial controls, monitoring and reporting have been maintained throughout the pandemic, but the impact of Covid-19 is creating a significant risk to the Health Board's ability to break even;
- operational plans have been informed by robust data modelling and developed in a timely way, and the Health Board is seeking to more fully engage stakeholders in future planning. However, risks remain in the event of a second Covid-19 peak, and arrangements to monitor delivery of the plan need strengthening;
- the Health Board demonstrates a commitment to counter-fraud, has suitable arrangements to support the prevention and detection of fraud and is able to respond appropriately where fraud occurs.

17 These findings are considered further in the following sections.

Detailed report

Audit of accounts

18 This section of the report summarises the findings from my audit of the Health Board's financial statements for 2019-20. These statements are how the organisation shows its financial performance and sets out its net assets, net operating costs, recognised gains and losses, and cash flows. Preparing the statements is an essential element in demonstrating the appropriate stewardship of public money.

19 My 2020 Audit Plan set out the financial audit risks for the audit of Health Board's 2019-20 financial statements. **Exhibit 6** in **Appendix 3** lists these risks and sets out how they were addressed as part of the audit.

20 My responsibilities in auditing the Health Board's financial statements are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2019-20 financial statements

21 I concluded that the Health Board's accounts were properly prepared and materially accurate, except for the inventory balance as at 31 March 2020. I therefore issued a qualified limitation-of-scope opinion on the accounts. In doing so I emphasised that the qualification was not due to shortcomings in the Health Board's systems or actions, but because of the impact of Covid-19 on one of my mandated audit procedures. I therefore reported that I did not consider the inventory balance to be materially misstated, but rather that I did not know whether it was materially true and fair.

22 My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my audit). However, I placed Emphasis of Matter paragraphs in my report to draw attention to two disclosures in the accounts relating to:

- The first disclosure related to the impact of the Covid-19 pandemic on the valuation of land and buildings as at 31 March 2020. As a result of Covid-19, and in accordance with specific guidance issued by their professional institute, the Health Board's valuer declared a 'material valuation uncertainty' in four of their professional valuation reports, with a total valuation of £65 million. All four valuation reports were dated 31 March 2020. The Health Board used these valuation reports to inform the measurement of certain of its property asset values in the financial statements at that date.
- The second disclosure related to the impact of a Ministerial Direction in 2019 to the Permanent Secretary of the Welsh Government, instructing her to fund NHS clinicians' pension tax liabilities incurred by NHS Wales bodies in respect of the 2019-20 financial year. This arrangement means that

clinicians who are members of the NHS Pension Scheme and who, as a result of work undertaken in the 2019-20 tax year, face a tax charge on the growth of their NHS pension benefits, may opt to have this charge paid by the NHS Pension Scheme, with their pension reduced on retirement. The Health Board will then pay the clinician a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction. This scheme will be fully funded by the Welsh Government with no net cost to Health Board.

23 I brought three important issues to the attention of officers and the Audit Committee, summarised below:

- weaknesses in some of the Health board's accounting processes, with some underlying accounting records being unnecessarily complex and held outside of the financial ledger;
- weaknesses in some of the Health Board's audit evidence, which were also unnecessarily complex and very difficult to audit; and
- the premature request and receipt of the signed 2019-20 related-party declarations from the Health Board's independent members and senior officers.

24 The Health Board submitted its draft Accountability Report and Financial Statements by the Welsh Government's 22 May deadline, and my audit and certification also accorded with the Welsh Government timetable

25 I must report issues arising from my work to those charged with governance before I issue my audit opinion on the accounts. My audit team reported these issues to Health Board Audit Committee and its Board on 29 June 2020. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues identified in the Audit of Financial Statements Report

Issue	Auditors' comments
Uncorrected misstatements	There was one uncorrected misstatement in respect of the Health Board's accounting treatment for its pooled-budget balances as at 31 March 2019 and 2020. The balances affected by the misstatement were significant but not material, and their non-correction therefore did not affect my audit opinion on the accounts.
Corrected misstatements	I reported the five most significant corrected misstatements. They mainly related to accounting classifications and disclosures. Two of the corrections

	related to the Health Board's receipt of more up-to-date information, which it did not have at the time of preparing the draft accounts for audit.
Other significant issues	No other significant matters arose, further to the matters already highlighted in this report in respect of my qualified opinions and my emphasis-of matter reporting.

26 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position at 31 March 2020 and the return was prepared in accordance with the Treasury's instructions.

27 My separate audit of the Health Board's Charitable Funds Account is currently ongoing. I am scheduled to report my findings to trustee members on 28 January 2021 and, if the account is approved and signed, to certify it on 29 January.

Regularity of financial transactions

28 The Health Board failed to achieve financial balance for the three-year period ending 31 March 2020 and I therefore issued an unqualified opinion on the regularity of the financial transactions within the Health Board's 2019-20 accounts.

29 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive the income and incur the expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

30 Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion. **Exhibits 2 And 3** show that while the Health Board had met its capital resource allocation, it had failed to meet its revenue resource allocation.

Exhibit 2: financial performance against the revenue resource allocation (£'000s)

	2017-18 £'000	2018-19 £'000	2019-20 £'000	Total £'000
Operating expenses	899,060	945,419	1,025,612	2,870,091
Revenue resource allocation	872,207	935,547	1,025,670	2,833,424

Under (over) spend against allocation	(26,853)	(9,872)	58	(36,667)

Exhibit 3: financial performance against the capital resource allocation (£'000s)

	2017-18 £'000	2018-19 £'000	2019-20 £'000	Total £'000
Capital charges	47,033	48,413	58,070	153,516
Capital resource allocation	47,121	48,487	58,159	153,767
Under (over) spend against allocation	88	74	89	251

Source: 2019-20 financial statements

31 I have the power to place a substantive report on the Health Board's accounts alongside my opinions where I want to highlight issues. Due to the Health Board's failure to meet its financial duties, alongside my audit opinion I placed a substantive report setting out the factual details, in that the Health Board had failed its duty to achieve financial balance (as set out above).

Arrangements for securing efficiency, effectiveness and economy in the use of resources

32 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively and economically;
- reviewing the effectiveness of the Health Board's counter-fraud arrangements;

33 My conclusions based on this work are set out below.

Structured assessment

34 My structured assessment work was designed in the context of the ongoing response to the pandemic. I ensured a suitably pragmatic and relevant approach to

help me discharge my statutory responsibilities, whilst minimising the impact on NHS bodies as they responded to the next phase of the Covid-19 pandemic. The key focus of the work was on the corporate arrangements for ensuring that resources are used efficiently, effectively and economically. Auditors also paid attention to progress made to address previous recommendations where these related to important aspects of organisational governance and financial management especially in the current circumstances.

35 The structured assessment grouped our findings under three themes:

- governance arrangements;
- managing financial resources; and
- operational planning: to support the continued response to the pandemic balanced against the provision of other essential services.

Governance arrangements

36 My work considered the Health Board's ability to maintain sound governance arrangements while having to respond rapidly to the unprecedented challenges presented by the pandemic. My work found that there has been good operational management and agile decision-making during the pandemic despite some limitations in the transparency of scrutiny, assurance, and oversight of overall governance.

37 The Health Board quickly adapted its governance arrangements to support agile and rapid decision-making and ensure effective operational management during the pandemic. Reasonable steps were taken to conduct Board business in an open way. However, there was scope for more detailed reporting in public during the pandemic, and to have spent more time on scrutiny and assurance of relevant matters particularly in the areas of quality, safety and workforce.

38 Opportunities to build knowledge, understanding and resilience across its cadre of Independent Members were not pursued by the Health Board in full by, for example, actively encouraging the members of committees which were stood down to participate in other committees during the period. Furthermore, there was scope for the Health Board to make greater use of Board Champions to support its response to the pandemic.

39 Communication with staff, the public, and partners during the pandemic was effective.

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

Managing financial resources

41 I considered the Health Board's financial performance, changes to financial controls during the pandemic and arrangements for monitoring and reporting financial performance. I found that effective financial controls, monitoring and reporting have been maintained throughout the pandemic, but the impact of Covid-19 is creating a significant risk to the Health Board's ability to break even.

42 The Health Board achieved financial balance for 2019-20. But, with a cumulative deficit of some £37 million for the period 2017-2020, the Health Board failed to meet its statutory duty to have a three-year breakeven position or better. The Health Board has clear intentions to break even over the next three-years. At the time of undertaking our structured assessment work, the year-end position for 2020-21 was likely to be in significant deficit as a result of Covid-19 unless the Health Board secured additional funding. However, the Health Board has since received additional funding from Welsh Government and is now forecasting an in-year breakeven position.

43 Effective financial controls, monitoring and reporting were maintained during the pandemic. Arrangements were also put in place to clearly track Covid-19 expenditure, yet there is scope for monitoring and reporting to be increasingly more transparent.

Operational Planning

44 My work considered the Health Board's progress in developing and delivering quarterly operational plans to support the ongoing response to Covid-19 and to provide other essential services and functions in line with Welsh Government planning guidance. At the time of our work, the focus was on essential services with the aim of restoring normal and routine activities when it is safe and practicable to do so. My work found that operational plans have been informed by robust data modelling and developed in a timely way, and the Health Board is seeking to more fully engage stakeholders in future planning. However, risks remain in the event of a second Covid-19 peak, and arrangements to monitor delivery of the plan need strengthening.

45 The Health Board's quarterly plans have been informed by robust data modelling and developed in a timely way, albeit with limited stakeholder engagement. The Board Governance Group considered the quarter one and two plans prior to submission, and retrospectively approved by the Board.

46 The Health Board responded quickly to ensure sufficient resources were in place to deliver quarter one planning objectives. However, continued exclusive use of an independent hospital is a key dependency in the delivery of planned activity during quarter two, and risks remain in the event of a second Covid-19 peak.

47 Streamlined performance reporting to the Board has operated during the pandemic. However, as performance management measures begin to be

reinstated, there is a need to develop the Board reporting and scrutiny arrangements around the delivery of the operational plans.

Effectiveness of counter-fraud arrangements

48 In June 2019, I published an overview for the Public Accounts Committee describing counter-fraud arrangements in the Welsh public sector. My team then undertook a more detailed examination across a range of Welsh public sector bodies to examine how effective counter-fraud arrangements are in practice and to make recommendations for improvement. In July 2020 I published Raising Our Game – Tackling Fraud in Wales setting out a summary of my findings and seven 'key themes' that all public bodies need to focus on in raising their game to tackle fraud more effectively.

49 Whilst this work was not included in the Health Board's audit plan, I also published an additional report setting out the Health Board's specific arrangements for preventing and detecting fraud. I found 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.

Appendix 1

Reports issued since my last annual audit report

Exhibit 4: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2020.

Report	Month
Financial audit reports	
Audit of Financial Statements Report	June 2020
Opinion on the Financial Statements	July 2020
Audit of Accounts Report Addendum	August 2020
Performance audit reports	
Structured Assessment 2020	October 2020
Effectiveness of counter-fraud arrangements	August 2020
Other	
2020 Audit Plan	February 2020

Exhibit 5: performance audit work still underway

There are a number of performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Orthopaedics	January 2021
Review of Welsh Health Specialised Services Committee	February 2021
Test, Trace and Protect	February 2021
Unscheduled care	Phase 1 – February 2021 Further work to be included as part of 2021 plan
Follow-up of previous IM &T recommendations	February 2021
Follow-up of operating theatres	February 2021
Quality Governance arrangements	April 2021
Follow-up of radiology services	April 2021

Appendix 2

Audit fee

The 2020 Audit Plan set out the proposed audit fee of £390,652 (excluding VAT). I should be able to confirm my actual chargeable fee in February 2021, once I have audited and certified the Health Board's 2019-20 Charitable Funds Account. Trustee Members are due to consider the audited accounts and my audit report on 28 January 2021, and my certification is scheduled for 29 January. I will report my actual fee to the Audit Committee in my 2021 Audit Plan.

Appendix 3

Financial audit risks

Exhibit 6: financial audit risks

My 2020 Audit Plan set out the financial audit risks for the audit of the Health Board's 52019-20 financial statements. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business; and • add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.	I reviewed a number of the accounting estimates and a sample of transactions that included journal entries. My audit findings were satisfactory.
Under the NHS Finance (Wales) Act 2014, health boards ceased to have annual resource limits with effect from 1 April 2014. They instead moved to a rolling three-year resource	My audit team will continue to monitor the Health Board's financial position for 2019-20 and the cumulative three-year position to 31 March 2020. This review will also consider the impact of	As set out in this report, my audit confirmed that the Health Board met its three-year capital allocation but failed its revenue allocation. I therefore qualified my regularity opinion, which I explained in my

limit, for revenue and capital net expenditure, with the first three-year period running to 31 March 2017. The Health Board has exceeded its rolling three-year revenue limit in 2016-17, 2017-18 and 2018-19 and I therefore qualified my regularity opinion on the Health Board's financial statements for those years. For 2019-20 the Health Board expects to break even, but this would nonetheless result in a cumulative deficit of £36.7 million for the three years to 31 March 2020.	any relevant uncorrected misstatements over those three years. If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2019-20 financial statements. As in previous years, I would also expect to place a substantive report on the statements to explain the basis of the qualification and the circumstances under which it had arisen.	accompanying substantive report.
I audit some of the disclosures in the Remuneration Report, such as the remuneration of senior officers and independent members, to a far lower level of materiality due to their sensitivity. These disclosures are therefore inherently more prone to material misstatement. In recent past audits I have identified material misstatements in the remuneration report submitted for my audit, which the Health Board then corrected. These past misstatements mean that I judge the	My audit team will review all entries in the Remuneration Report to verify that the Health Board has reflected all known changes to senior positions, and that the disclosures are complete and accurate.	I substantively tested the Remuneration Report as intended. My audit results were satisfactory.

2019-20 disclosures to be at risk of further misstatement.		
I also audit the Health Board's related party disclosures to a far lower materiality. In recent years I have reported weaknesses in the Health Board's related party arrangements, which led to material misstatement in the draft accounts. As a result of my audit findings, the Health Board undertook remedial work and corrected its related-party disclosures, prior to my certification. These past misstatements mean that I judge the disclosures to be at risk of further misstatement for 2019-20.	My audit team will review and test the completeness and accuracy of the related-party disclosures.	I substantively tested related parties and the audit results were satisfactory. I did however report weaknesses in the Health Board's processes and I raised a recommendation for improvement, which management accepted.
On 18 December 2019 the First Minister issued a formal Ministerial Direction to the Permanent Secretary requiring her to implement a 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff.	We are considering the accounting treatment and audit implications of the direction (the first in Wales since 1999) in conjunction with the NAO who are currently addressing the same issue in NHS England.	I tested the accounting for and regularity of this Direction. My audit results were satisfactory, although as set out in this report I included an 'emphasis of matter' narrative in my audit certificate.

For 2019-20 there is an increase of 6.3% (to 20.3%) in an employer's pension contributions, which represent a significant additional cost to the Health Board. We understand that the Welsh Government will bear the 2019-20 cost of this increase.	My audit team will test these additional costs to confirm whether the Health Board has disclosed and accounted for them correctly.	I substantively tested this matter, with a satisfactory audit conclusion.
The Introduction in 2020-21 of 'International Financial Reporting 'Standard 16 Leases' may pose implementation risks if the Health Board has not made good progress to date with its preparatory work.	My team will undertake some early work to review preparedness for the introduction of IFRS 16 Leases	The introduction of this accounting standard was subsequently postponed for public bodies to 2021-22, and I therefore postponed my review.

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

Cardiff and Vale University Health Board

Mental Health Outpatient Clinic Cancellations

Final Internal Audit Report

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

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Auditor:	Geoffrey Woolley, Principal Internal Auditor
Executive sign off:	Steve Curry, Chief Operating Officer
Distribution:	Ian Wile, Head of Operations and Delivery, Mental Health Clinical Board Mark Jones, Directorate Manager, Adult Mental Health Joanne Wilson, Directorate Manager, Mental Health Services for Older People
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cardiff and Vale University Health Board, no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

Our review of Mental Health Outpatient Clinic Cancellations was completed in line with the 2020/21 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').

The Mental Health Clinical Board works in collaboration with Local Authority colleagues, charity and third sector agencies to co-create services, the majority of which are now provided closer to home, supporting people within the local community.

The staff and service users have a long-term vision for increasing community care and shared care models. There are community teams, primary mental health services and inpatient services, as well as managing specialist services such as Addictions, Low Secure and Younger Onset Dementia care.

It covers adult mental health services and older persons' mental health services and works to break down the stigma of mental health, which affects 1 in 4 people in the UK.

Adult mental health services and older persons' mental health services operate traditional outpatient clinics whereas Psychology operates a system of individual appointments.

The relevant lead for the review was the Chief Operating Officer.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the management of Mental Health Outpatient Clinic Cancellations.

The review sought to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives are managed appropriately.

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

- There are up-to-date written procedures covering Mental Health Outpatient Clinic Cancellations which cover all appropriate areas and are followed by all directorates.
- Mental Health Outpatient Clinics are only cancelled where there's no alternative following due consideration of all factors and options and full details leading to the cancellation are recorded.
- Mental Health Outpatient Clinics are only cancelled following senior level authorisation.
- The impact of Mental Health Outpatient Clinic Cancellations on patients and colleagues is taken into consideration, they are promptly informed and replacement clinics / appointments are promptly booked.

- Detailed records are maintained for Mental Health Outpatient Clinic Cancellations which record full details regarding cancellations including date cancelled, by whom, approval and reason for the cancellation.
- An appropriate reporting system is in place to monitor Mental Health Outpatient Clinic Cancellations on a regular basis, promptly identify issues and take corrective action to prevent recurrence.

The review covered the clinic cancellation processes in place prior to the Covid-19 pandemic.

3. Associated Risks

The potential risks considered in the review were:

- A lack of up-to-date written procedures may lead to uncertainty regarding action required and inconsistency between the various teams.
- A lack of adequate consideration may lead to cancellations occurring when better options were possible.
- A lack of senior level authorisation may lead to inappropriate cancellations.
- A lack of sufficient consideration of the impact on colleagues may adversely impact the use of resources.
- A lack of sufficient consideration of the impact on patients and not promptly rebooking clinics may adversely impact their mental health.
- A lack of detailed database and appropriate reporting system may lead to issues not being identified and corrective action taken to prevent recurrence.

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 Mental Health Outpatient Clinic Cancellations is **Limited Assurance**.

RATING	INDICATOR	DEFINITION
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.

There is no monthly reporting and monitoring of Mental Health Outpatient Clinic Cancellations and there is a lack of knowledge regarding cancellations reports available in the PARIS Patient Management System and so they are not used.

The date, clinician and reason for a cancellation must be recorded in pre-set cells in the PARIS Patient Management System. However the reason is simply a short statement from a drop-down menu of possible reasons and so does not indicate fully what factors and options were considered by the clinician before concluding that there was no alternative to cancelling the clinic.

The PARIS Patient Management System is not used consistently across Mental Health as Adult Mental Health and Mental Health Services for Older People use different modules to record Outpatient Clinic appointments. Furthermore, there are no written procedures to ensure consistency across the various Mental Health Outpatient Clinics.

Testing a sample of Outpatient Clinic Cancellations indicated that the delay until replacement clinic appointments generally appeared reasonable.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

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

Assurance Summary					
1	Written procedures	✓			
2	Cancellations		✓		
3	Senior level authorisation		✓		
4	Impact on patients / colleagues		✓		
5	Records			✓	
6	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 five issues that are classified as weaknesses in the system control / design for Mental Health Outpatient Clinic Cancellations.

Operation of System/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the operation of the designed system / control for Mental Health Outpatient Clinic Cancellations.

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: There are up-to-date written procedures covering Mental Health Outpatient Clinic Cancellations which cover all appropriate areas and are followed by all directorates.

The following finding was noted:

- There were no written procedures covering Mental Health Outpatient Clinic Cancellations.

Objective 2: Mental Health Outpatient Clinics are only cancelled where there's no alternative following due consideration of all factors and options and full details leading to the cancellation are recorded.

The following finding was noted:

- There is currently a lack of evidence retained within the PARIS booking system used by the Community Mental Health Teams and the manual bound books used by Mental Health Services for Older People to confirm that all options have been explored prior to cancelling clinics.

Objective 3: Mental Health Outpatient Clinics are only cancelled following senior level authorisation.

The following finding was noted:

- Cancellations are at the discretion of the clinic leads according to their competing commitments. There is currently no process in place to provide further senior level authorisation prior to the cancellation of clinics.

Objective 4: The impact of Mental Health Outpatient Clinic Cancellations on patients and colleagues is taken into consideration, they are promptly informed and replacement clinics / appointments are promptly booked.

The following were noted:

- Outpatient Clinic Cancellations are at the discretion of the clinic leads according to their competing commitments. We did not have sufficient information to assess to what extent the impact on patients and colleagues is taken into consideration when they make their decision.

- Informing patients and colleagues and promptly booking replacement clinics / appointments has been considered as part of Objective 5: Records.

Objective 5: Detailed records are maintained for Mental Health Outpatient Clinic Cancellations which record full details regarding cancellations including date cancelled, by whom, approval and reason for the cancellation.

The following areas of good practice were noted:

- Appropriate information including the date, clinician and reason for a cancellation must be entered into pre-set cells in the PARIS system before it can be submitted.
- Testing a sample of 23 cancellations indicated that the delay until replacement clinic appointments generally appeared reasonable.

The following finding was noted:

- The PARIS system is not used consistently across Mental Health as Adult Mental Health and Mental Health Services for Older People use different modules to record Outpatient Clinic appointments.

Objective 6: An appropriate reporting system is in place to monitor Mental Health Outpatient Clinic Cancellations on a regular basis, promptly identify issues and take corrective action to prevent recurrence.

The following findings were noted:

- There is no monthly reporting and monitoring of Outpatient Clinic Cancellations.
- There is a lack of knowledge among staff regarding cancellations reports available in the PARIS reports module and so they are not used.

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	**2**	**3**	**0**	**5**

Finding 1 - Written procedures (Control design)	Risk
There were no written procedures / guidance available for staff regarding the operation of Mental Health Outpatient Clinic Cancellations.	A lack of up-to-date written procedures may lead to uncertainty regarding action required and inconsistency between the various teams.
Recommendation	**Priority level**
Written procedures / guidance should be developed and distributed to all staff regarding the operation of Mental Health Outpatient Clinic Cancellations.	**High**
Management Response	**Responsible Officer/ Deadline**
The clinical board are leading on an Outpatient Transformation project currently. It is envisaged that as part of this working group output would be a written procedures/ guidelines for the operational streamlining and consistent working of mental health outpatient clinics across Cardiff and Vale UHB. In the interim, the clinical board will urgently source operating procedures from elsewhere in the UHB. MHCB local guidance will be produced in draft for their January 2021 meeting and approved through the transformation project steering group in March/April 2021. Completion date April 21st 2021	Dr. Neil Jones – Dep CBD Jo Wilson – Directorate Manager MHSOP Dr. Mark Jones – Directorate Manager Adult Services Ian Wile – Director of Ops

Finding 2 – Lack of evidence to support cancellations (Control design)	Risk
The PARIS Booking system used by the Community Mental Health Teams includes a cell to record the reason for the outpatient clinic cancellation which must be completed in order to submit the cancellation. However this is simply a short statement from a drop-down menu of possible reasons and does not indicate fully what factors and options were considered before concluding that there was no alternative to cancelling the clinic. The manual bound books initially used by the Mental Health Services for Older People Teams to record outpatient clinics allows any relevant notes to be included. However this is again generally short statement reasons which does not indicate fully what factors and options were considered before concluding that there was no alternative to cancelling the clinic. When they subsequently update the PARIS Referral system, this is again limited to short statements regarding the cancellations. It is acknowledged that the Clinicians are likely to be considering these issues before cancelling clinics but there is currently no evidence to support this.	A lack of adequate consideration may lead to cancellations occurring when better options were possible.
Recommendation	**Priority level**
Management must ensure that sufficient evidence is retained to confirm that all available options have been effectively considered before clinics are cancelled	**Medium**

Management Response	Responsible Officer/ Deadline
Following reaching an agreement to the operational workings of outpatient clinics from the Outpatient Transformation project, consistent Paris cancellation lists can be generated and inputted onto the system by working closely with the Paris lead manager. This record will contain a fuller explanation for the cancellation, alternatives considered, and if these were not used, why not. In the interim, manual operating processes will be drafted for discussion and implementation in the January 21 meet of the steering group for implementation from February 21 onwards until PARIS accommodates this. Completion date April 21st 2021	Dr. Neil Jones – Dep CBD Michelle Lewis – Information Lead - MH Jo Wilson – DM MHSOP Dr. Mark Jones – DM Adult Dr Tracey Tye – Locality Lead North Dr. Rakesh Pankajakshan – Locality Lead Vale Dr. Bhushan Vaidya – Locality Lead - South

Finding 3 – Authorisation of clinic cancellations (Control design)	Risk
The decision to cancel outpatient clinics is currently taken by the lead clinician and there is no further senior level authorisation provided prior to cancellation. The lack of any documented procedure, as highlighted in finding 1, means that there is currently no confirmation of any requirement for further authorisation.	A lack of senior level authorisation may lead to inappropriate cancellations
Recommendation	**Priority level**
Management should determine if the current cancellation process is sufficient or there is a requirement for additional senior level authorisation. This should then be reflected within the written procedures / guidance when they are produced.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Following reaching an agreement to the operational workings of outpatient clinics from the Outpatient Transformation project, then a decision can be made in the longer term regarding the requirement for senior authorisation of clinic cancellations. In the interim, from mid-January 2021 all cancelled outpatients will be authorised by the relevant locality medical lead in working age adult services and the Clinical Director in Older Peoples Services. These arrangements will be finalised on 6th January 2021.	Dr. Neil Jones – Dep CBD Michelle Lewis – Information Lead - MH Jo Wilson – DM MHSOP Dr. Mark Jones – DM Adult Dr Tracey Tye – Locality Lead North Dr. Rakesh Pankajakshan – Locality Lead Vale

	Dr. Bhushan Vaidya – Locality Lead – South Dr. Paul Cantrell – CD Adult Dr. Arpita Charabharti – CD MHSOP

Finding 4 - PARIS is used inconsistently between Mental Health Directorates (Control design)	**Risk**
The PARIS Patient Management System is currently used inconsistently between the Mental Health Directorates. The Community Mental Health Teams use the PARIS Booking system to control Outpatient Clinic appointments whereas Mental Health Services for Older People initially control Outpatient Clinic appointments using manual bound books at each location. They then subsequently update the details for each patient in the PARIS Referral Module which is different / separate to the PARIS Booking Module. We were informed that the intention is to move to using the Booking module at some stage in the future.	Inefficiencies and inconsistencies may occur from using different PARIS modules in different Directorates within Mental Health.
Recommendation	**Priority level**
Mental Health Services for Older People should fulfil its intention of moving to using the PARIS Booking Module as soon as possible so that consistent systems apply throughout Mental Health.	**Medium**

Management Response	Responsible Officer/ Deadline
Following reaching an agreement to the operational workings of outpatient clinics from the Outpatient Transformation project, consistent Paris usage across the clinical board will be achieved. The Directorate Manager for MHSOP has further explored with the Information lead, timescales for achieving this and in mid-January 21 their South Locality will commence use, with the Vale and North localities following in February 2021.	Michelle Lewis – Information Lead - MH Jo Wilson – DM MHSOP Dr. Arpita Chakrabharti

Finding 5 - Monitoring of Outpatient Clinic Cancellations (Control design)	Risk
Appropriate information including the date, clinician and reason for a cancellation must be entered into pre-set cells in the PARIS Patient Management System before it can be submitted. However there is no monthly reporting and monitoring of this information to promptly identify trends and issues and take corrective action on a timely basis. In particular: Community Mental Health Teams. • Cancellations are not included as part of the monthly performance reporting although comparable areas such as Attendance / DNA (Did not attend) were included. • There was a lack of knowledge regarding the cancellations report CAVREPU262 which is available in the PARIS reports module. Mental Health Services for Older People.	Trends and issues regarding Outpatient Clinic Cancellations may not be promptly identified and corrective action may not be taken on a timely basis.

• Mental Health Services for Older People's monthly performance reporting does not include Outpatient Clinic Cancellations. • The equivalent ad hoc report available in the PARIS reports module is not used.	
Recommendation	**Priority level**
1. Monthly reporting which covers Outpatient Clinic Cancellations should be developed which covers as a minimum the total monthly number and percentage of Mental Health Outpatient Clinic Cancellations and the equivalent results for the year to date. Where poor results are reported, the reasons should also be identified. Consideration should also be given to whether additional drill down of the results should be included. For example Directorate or clinic level. 2. All relevant staff should be reminded of the existence of the cancellation reports in the PARIS reports module including instructions how to locate and use them.	**High**
Management Response	**Responsible Officer/ Deadline**
Following reaching an agreement to the operational workings of outpatient clinics from the Outpatient Transformation project, consistent Paris recording and production of robust reports can be generated by working closely with the Paris lead manager in the medium term.	Dr. Neil Jones – Dep CBD Michelle Lewis – Information Lead - MH Jo Wilson – DM MHSOP Dr. Mark Jones – DM Adult

In the short term monthly reporting on numbers of cancellations and number as a percentage of the total will be collated monthly following a baseline assessment in early January 2021. This activity will be discussed within the Directorate performance meets with the MHCB as well as in local directorate meetings with their teams. Internal performance monitoring processes for completion date April 21st 2021	Ian Wile – Director of Operations

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.

Specialist CB - Patient assessment and provision of equipment by ALAS

Final Internal Audit Report

2020/21

November 2020

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

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Executive sign off:	Steve Curry, Chief Operating Officer
Distribution:	Paul Rogers, Directorate Manager ALAS Mark Inker, Project Manager ALAS Catherine Wood, Acting Director of Operations
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.

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1. Introduction and Background

Our review of Patient Assessment and Provision of Equipment within ALAS was completed in line with the 2020/21 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').

ALAS (Artificial Limb and Appliance Service) provides a variety of specialist assessment and diagnostic services to maximise users' ability to rehabilitate into their community. Specifically:

- Artificial Limb Service.

  Manufacture and provision of prosthesis and training in their use.

- Orthotics Service.

  Manufacture and provision of products to support weakened or deformed regions of a person's body.

- Electronic Assistive Technology (EAT) Service.

  Provision of equipment such as environmental control systems, communication aid equipment and equipment to overcome problems accessing computer technology.

- Orbital Prosthetics (Artificial Eye) Service.

  Provision of eye prosthetics to restore a more normal anatomical structure and correct defects.

- Wheelchair Service.

  Provision of mobility equipment ranging from a standard wheelchair to assessment for a specialised and powered chair.

ALAS employs 158 staff including medical, nursing, scientific, therapy, engineering, psychology, technical and administrative. They work as a multi-disciplinary team in conjunction with sub-contractors and other suppliers to deliver the best solution to each users' needs.

WHSSC commission the Artificial Limb and Appliance Service on an all Wales basis. The service is sub-divided between North and South Wales services. The South Wales ALAS service, hosted by Cardiff and Vale University Health Board, is based out of 2 centres; the Artificial Limb and Appliance Centre (ALAC) on the Rookwood Hospital site and the Posture and Mobility Centre (PMC) in Treforest. Some services are further sub-divided between South East and South West Wales, with the Prosthetics and Rehabilitation Engineering Teams having both a South West presence, out of Morrison Hospital, and a presence out of Cardiff (the ALAC and PMC centres respectively).

Two systems are used by ALAS for patient assessment and provision of equipment:

- ALAS uses BEST Patient Management System ('Bringing Equipment Services Together', supplied by SoftOptions) to manage the integrated patient and equipment record: Clinicians use BEST to record the clinical note and communicate any equipment requirements to the stock controller who allocates the equipment from stock and/or places an order on Oracle. The BEST-Oracle Interface allows the stock controller to transfer requisitioning information from BEST via electronic transfer to Oracle.
- ALAS uses Oracle for placing orders: Oracle instructions are available on the Cardiff and Vale University Health Board intranet, orders are processed by Procurement staff and Oracle is managed by Shared Services Partnership Procurement.

The relevant lead Executive for the review was the Chief Operating Officer.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place covering the patient assessment and provision of equipment by ALAS. The review sought to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives are managed appropriately.

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

- The processes from patient assessment through to placing the order using the BEST Patient Management System are undertaken by appropriate staff, are clearly documented, justified and recorded and are adequately monitored.
- There's an adequate linkage mechanism through to Oracle to ensure that all transactions are accurately recorded and that any problems are promptly identified and corrected.
- There's adequate controls over non-catalogue spend so that value for money is achieved whilst quality / supply problems are avoided.

3. Associated Risks

The potential risks considered in the review are:

- Orders for equipment are made by unauthorised staff risking committing the Health Board to inappropriate expenditure.

- Patient assessments are not adequately documented and don't justify the reason for supplying the equipment risking the challenge of wasting money.
- Information regarding patients and equipment supplied is not adequately recorded risking not knowing what equipment has been supplied, breaching the Medical Device Regulations from May 2021 and the challenge of wasting money.
- The processes from patient assessment through to placing the order are not adequately monitored risking equipment supply delays and errors not being promptly identified and resolved.
- Not all transactions are accurately and promptly recorded in Oracle risking incorrect monitoring and decision making by the Health Board.
- Controls over non-catalogue spend are inadequate risking poor value for money and quality/supply problems.

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 Specialist CB - Patient assessment and provision of equipment by ALAS is **Substantial Assurance**.

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

The BEST Patient Management System used by ALAS is a comprehensive integrated system which records and links all relevant patient and equipment information and maintains a full audit trail of who did what, when and why.

There's a reconciliation mechanism to ensure that all transactions are accurately recorded in Oracle and the transactions tested were appropriately approved.

ALAS places contracts with its main suppliers on fixed term cycles following a procurement process which is overseen by Shared Services Partnership Procurement. However it has experienced problems due to supplier catalogues not being updated on Oracle.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

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

Assurance Summary					
1	Patient assessment through to placing the order using BEST				✓
2	Linkage mechanism through to Oracle			✓	
3	Controls over non-catalogue spend			✓	

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

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system control / design for Specialist CB - Patient assessment and provision of equipment by ALAS.

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 Specialist CB - Patient assessment and provision of equipment by ALAS.

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 processes from patient assessment through to placing the order using the BEST Patient Management System are undertaken by appropriate staff, are clearly documented, justified and recorded and are adequately monitored.

The following areas of good practice were noted:

- Staff are only given access to BEST following submission of a new user application to the BEST IT Team which is checked to confirm that it is from an appropriate person with a valid reason to require access.
- All information is clearly documented within BEST's organised standard file structure and so can be readily identified as required. Once entered, it cannot subsequently be amended or deleted, and so a full audit history is available.
- Full details of patient assessments are recorded by clinicians which conclude with a summary of equipment required which links directly and can be traced to the subsequent purchases or allocations from stock held.
- Having the full history recorded within BEST means that it can be readily monitored including the rationale for why actions were taken, who made the decision and when they occurred.
- Equipment needs identified from patient assessments are immediately passed to the stock control section of BEST for ordering and the status of all open orders is readily available to monitor their progress.
- In addition to the full history in BEST which enables monitoring of equipment for an individual patient, the monthly overall financial monitoring report for each activity enables high level issues to be identified.

The following finding was noted:

- The quality of written policies or procedures varied widely across the activities within ALAS.

Objective 2: There's an adequate linkage mechanism through to Oracle to ensure that all transactions are accurately recorded and that any problems are promptly identified and corrected.

The following areas of good practice were noted:

- There's a reconciliation mechanism to ensure that all transactions are accurately recorded in Oracle and that any problems are promptly identified and corrected.
- The vast majority of the Oracle transactions tested were approved by the ALAS Deputy Director.

The following finding was noted:

- The reconciliation mechanism to Oracle could be improved by Oracle order numbers feeding back automatically into BEST rather than manually as currently occurs and submitting as many orders as possible to Oracle electronically rather than manually to avoid duplication by having to input details twice.

Objective 3: There's adequate controls over non-catalogue spend so that value for money is achieved whilst quality/supply problems are avoided.

The following area of good practice was noted:

- ALAS places contracts with its main suppliers on fixed term cycles following a procurement process which is overseen by Shared Services Partnership Procurement. (As oversight for this falls outside ALAS, we have not undertaken any testing).

The following finding was noted:

- ALAS has experienced problems due to supplier catalogues not being updated on Oracle.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**1**	**2**	**3**

Finding 1 - Written policies or procedures (Operating effectiveness)	Risk
The quality of written policies or procedures varied widely across the activities within ALAS ranging from very good to limited or non-existent. We identified that the best example is the BEST User Guidance which has the following good practice characteristics: • Flowcharts and / or numbered steps which enable the overall structure of the process to be easily understood. • Example screen prints with detailed instructions which link clearly to the relevant part of the screen. • Sufficient detail so that the procedure can be correctly and consistently followed by all employees. • A version history which indicates when changes were made, by whom and when the next review should be undertaken. The following characteristic should be avoided: • Brief bullet points which cannot be easily understood without further information.	Staff members do not consistently follow required processes and controls when assessing patients and ordering equipment.
Recommendation	**Priority level**
The quality of all written policies or procedures should be reviewed and raised to the standard of the best within ALAS. As stated above, this would be the BEST User Guidance.	**Low**

Management Response	Responsible Officer/ Deadline
Accepted. The variable standard of policy and procedures within ALAS is subject to an on-going programme of review and improvement and is part of our ISO 9001:2015 Business Management System.	Paul Rogers Directorate Manager ALAS March 2021

Finding 2 - Reconciliation mechanism to Oracle (Control design)	Risk
The orders for each patient are requested in BEST by the clinician and are submitted to Oracle electronically or manually depending on the item or activity by the stock controller who will subsequently review the orders in Oracle and manually record the Oracle order number in BEST when approved. In this way, any orders in BEST without an Oracle order number will be identified and action taken to resolve the problem. The Oracle order numbers currently have to be copied manually back into BEST. However going forward the intention is to update the systems so that the Oracle order numbers feedback automatically. Orders submitted to Oracle are currently a mixture of manual and electronic across the various activities within ALAS. Going forward, further work should be undertaken so that as many orders as possible can be submitted electronically and so avoid duplication by having to input details twice.	Not all transactions are accurately and promptly recorded in Oracle risking incorrect monitoring and decision making by the Health Board.

Recommendation	Priority level
Further work should be undertaken to integrate BEST and Oracle so that the Oracle order numbers feedback automatically into BEST. Further work should be undertaken so that as many orders as possible can be submitted electronically from BEST to Oracle and so avoid duplication by having to input details twice.	**Low**
Management Response	**Responsible Officer/ Deadline**
Accepted. The recently approved Oracle-BEST upgrade will fully address this recommendation. Both Oracle and SoftOptions (supplier of BEST) have agreed to make changes to their respective systems to resolve this issue.	Paul Rogers Directorate Manager ALAS March 2021

Finding 3 - Controls over non-catalogue spend (Operating effectiveness)	Risk
ALAS has experienced problems due to supplier catalogues not being updated on Oracle and has raised this repeatedly at the All Wales Procurement Meetings.	Controls over non-catalogue spend are inadequate risking poor value for money and quality/supply problems.

Recommendation	Priority level
ALAS should continue to work with Shared Services Partnership Procurement to resolve problems where items are not included on the Oracle catalogue.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Accepted. Although not under our direct control, ALAS will continue to work with Procurement to resolve this.	Paul Rogers Directorate Manager ALAS March 2021

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Asbestos Management

Final Internal Audit Report 2020/21

Cardiff & Vale University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance


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Appendix A Management Action Plan
Appendix B Summary of Audit Findings
Appendix C Audit Assurance Ratings

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Executive sign off	Abigail Harris, Executive Director of Strategic Planning Chris Lewis, Interim Executive Director of Finance
Distribution	Geoff Walsh, Director of Capital, Estates and Facilities Tony Ward, Head of Discretionary Capital & Compliance Phil Mackie, Health & Safety and Asbestos Manager Owen Davies, Estates Health, Safety & Asbestos Support Officer
Committee	Audit Committee

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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1. Introduction and Background

Large amounts of asbestos-containing materials (ACMs) were used for a wide range of construction purposes in new and refurbished buildings until 1999 when all use of asbestos was banned. Noting the period within which many of the buildings within Cardiff & Vale University Health Board (the UHB) were constructed and refurbished, we sought to determine how robust arrangements for managing asbestos were within its estate.

The audit undertook an assessment of the controls and practices in place within the UHB to ensure that the key asbestos regulatory requirements (Control of Asbestos Regulations 2012) were adequately addressed and ensure that appropriate management arrangements are embedded within the organisation.

Noting the impact of Covid-19, the delivery of this assignment included an increased element of remote working and therefore we did not undertake compliance testing at any of the UHB sites.

2. Scope and Objectives

The review was undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of the UHB for the management of capital projects, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

The scope of the audit was limited to Capital, Estates & Facilities and its associated schemes.

Accordingly, the focus of the current audit was directed to the following areas:

- **Governance:** To ensure appropriate executive ownership and that a suitably qualified individual has been allocated for the day-to-day management of asbestos. An approved Asbestos Policy had been implemented and operated effectively.

- **Identification:** Appropriate surveys have been undertaken to identify the presence of asbestos and the potential exposure risk to staff/ public.

- **Records:** The UHB holds a fully comprehensive asbestos register to identify the locations of ACMs on all sites.

- **Risk Management:** Risk assessments have been completed for all ACMs identified. The UHB had appropriate management and control action plans in place for the ACMs.

- **Operational Delivery:** Compliance with Control of Asbestos Regulations 2012 was demonstrated through operational activities including, but not limited to:
    - Plans of work;
    - Licensing of work with asbestos;
    - Notification of work with asbestos;
    - Information, instruction and training;
    - Prevention or reduction of exposure to asbestos;
    - Use and maintenance of control measures;
    - Provision and cleaning of protective clothing;
    - Arrangements to deal with accidents, incidents and emergencies;
    - Air monitoring; and
    - Removal of waste.

3. Associated Risks

The potential risks considered in the review were as follows:

- Lack of visible Executive support and coordination of asbestos issues.
- Asbestos issues not adequately identified and understood.
- Records are inadequate to allow effective decision making.
- Management actions are ineffective or inappropriate.
- UHB duties not discharged in accordance with regulations.

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 UHB has, in the last few years, migrated its asbestos data from an Access database to the MiCAD electronic property management system, providing a more robust and comprehensive asbestos register. Management has identified and reported (to the monthly Capital & Estates Health & Safety forum and the Asbestos Management Group) some issues remaining to be resolved, in respect of the new system. These include:

- The migration of data, and historical survey issues, resulted in a high number of areas classed as 'non-compliant' within MiCAD, i.e. areas

for which asbestos data was not available. Risk-prioritised survey work in the last year has seen these numbers significantly reduce, with further work planned to ensure full compliance where possible; and

- Usage of MiCAD by contractors and UHB staff is lower than expected, suggesting this key record is not always being reviewed prior to work commencing.

Being cognisant of the work that has been invested by the UHB and the observations made, general compliance was noted with the established control frameworks in each of the objective areas sampled, including:

- an up to date Asbestos Policy and supporting Asbestos Management Plan, in line with the requirements of the Control of Asbestos Regulations (2012);
- an appropriate governance structure including the Asbestos Management Team and Asbestos Management Group, with robust monitoring and reporting arrangements operating;
- third party surveyors had been appointed appropriately and surveys have been undertaken as required, in line with the Asbestos Regulations;
- a comprehensive asbestos register was held within the MiCAD system; and
- an appropriate risk-based management plan was in place for identified ACMs.

However, the audit identified the following control weaknesses:

- training (Asbestos awareness and Category B) had lapsed for a significant proportion of staff during the period reviewed; and
- there was lack of compliance with the signing-in/authorisation sheet process at community sites; and

In addition, certain enhancements have been recommended in respect of:

- reporting of the Asbestos risk register to the Asbestos Management Group;
- completion of the compliance auditing targets for the year;
- retention of waste consignment notes generated from asbestos jobs; and
- retention of Risk Assessment/Method Statement (RAMS) for asbestos jobs undertaken.

Against the context of the matters detailed above, the overall level of assurance given as to the effectiveness of the system of internal control in

place to manage the risks associated with asbestos management is **reasonable.**

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

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

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

Assurance Summary					
1	Governance			✓	
2	Identification				✓
3	Records			✓	
4	Risk Management				✓
5	Operational Delivery			✓	

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

Design of Systems/Controls

The findings from the review highlighted **no** issues that are classified as a weakness in the system control/design for asbestos management within the responsibility of the Capital, Estates & Facilities function.

Operation of System/Controls

The findings from the review highlighted **five** issues that are classified as weaknesses in the operation of the designed system/control for asbestos management within the responsibility of the Capital, Estates & Facilities function.

6. Summary of Audit Findings

Governance

That appropriate Asbestos Governance arrangements are applied, including executive ownership, suitably qualified individuals assigned management responsibilities and that an approved Asbestos Policy has been implemented and operates effectively.

The Asbestos Policy (the Policy) was last updated and approved in 2018, and remained in date at the time of the current review.

The Policy was supported by the Asbestos Management Plan (AMP), which underwent a thorough review in 2019. The AMP provides comprehensive operational guidance in line with the Control of Asbestos Regulations (2012) (the Regulations) and the HSE Approved Code of Practice.

The current asbestos management structure evidenced during the review included:

- The Chief Executive, with overall responsibility as the Duty Holder;
- An Asbestos Management Team, compromising experienced and professionally qualified individuals, led by the Asbestos Manager, (the 'Appointed Persons'), reporting to the Director of Capital, Estates and Facilities; and
- Externally appointed asbestos surveyors, supporting the Asbestos Management Team with technical requirements.

The Asbestos Management Group (AMG), comprising appropriate representatives from within Capital, Estates and Facilities (CEF) and Health & Safety, has responsibility for the oversight of asbestos management (and compliance with the AMP) within the UHB. The AMG met with appropriate frequency and representation from the agreed group membership during the period reviewed (November 2019 to September 2020). Whilst a

comprehensive range of information was presented to the AMG for scrutiny, the additional reporting of the Asbestos Risk Register has been recommended for completeness (**recommendation 1**).

Comprehensive compliance monitoring and reporting was evidenced via the monthly 'Asbestos Update' reports, presented to the monthly CEF Health & Safety forum and twice-yearly AMG meetings.

The AMP sets out the annual audit requirements for asbestos activities, with results to be reported to the AMG. It was noted however, that a small number of required compliance audits have yet to take place and the status position had not been reported (**recommendation 2**).

Training requirements were appropriately defined within the AMP, in accordance with the Regulations and compliance monitored via a training matrix. Since January 2020, training had not taken place (in part due to the restrictions presented by the ongoing Covid-19 pandemic). At the time of the audit, therefore, a significant proportion of required training updates had lapsed:

- Asbestos awareness training: there are 101 UHB employees for which this training is applicable. Training had expired for 47% (based on the training matrix's requirement for annual refresher training); and
- Category B training: applicable for staff undertaking non-licensed asbestos work. Training had expired for all 21 employees identified on the matrix.

It is recognised that the Regulations do not legally require annual asbestos awareness training to take place, and that mitigating controls were in place at the UHB to ensure staff could not undertake Category B work where training had expired. However, to ensure compliance with the requirements of the AMP, training should be brought up to date as soon as possible (**recommendation 3**).

Recognising the governance arrangements in place and compliance with the Regulations, **reasonable assurance** has been determined in this area.

Identification

That appropriate surveys have been undertaken to identify the presence of asbestos and the potential exposure risk to staff/ public.

The UHB has appointed, via formal tender, a selection of licensed asbestos companies to undertake surveys on its behalf. The process of re-tender (for the period 2020-2024) was underway during the audit, with an appropriate selection criteria evidenced.

Re-inspection surveys have been undertaken on a cyclical twelve-month programme, in line with the Regulations. During 2019, the focus of the

surveys was risk-prioritised to address the backlog of previously un-surveyed areas (also refer to the 'Records' section).

Refurbishment and demolition surveys were additionally instructed as required or when opportunity presented (i.e. when areas were vacated).

The UHB has undertaken considerable work over the past few years, to migrate its asbestos data from an Access database to the online MiCAD property management system. MiCAD is accessible to both staff and contractors, and provides 'live' access to risk-assessed asbestos information (including drawings and photographs) at varying levels from site to individual rooms to specific items e.g. pipes.

Survey results have been reported in line with the Regulations, and uploaded directly, by the surveyors, to MiCAD. The AMP requires quality assurance to be undertaken on 3% of the surveys annually. However, recognising other priorities during the period under review, the requirement had not been achieved in the current year (see **recommendation 2**).

Following the upload of survey results, the data is subject to review and adjustment by the Asbestos Management Team (AMT), where necessary, to ensure that:

- the assigned risk ratings adequately reflect issues such as risk of exposure; and
- the risk categorisations align with those used by MiCAD.

Management provided assurance that this process was supported by a full audit trail, and was undertaken by an experienced and qualified member of the AMT working within the parameters of the Survey Guide (HSG 264). It is acknowledged there are four qualified members (to P405 - 'Managing Asbestos in Buildings') of the AMT who have the ability to complete this task.

Recognising the above, **substantial assurance** has been determined in this area.

Records

That the UHB holds a fully comprehensive asbestos register to identify the locations of ACMs on all sites.

The UHB's asbestos register is held within the MiCAD electronic property management system (refer to the 'Identification' section).

The management information included at the register is routinely monitored and reported by the AMT. Key areas flagged via this process (based on the July 2020 Asbestos Update report) include:

- The UHB had a high number (circa 9,000) of 'non-compliant' areas within MiCAD, at the start of 2019 i.e. areas for which no asbestos information was held. This resulted from data legacy issues transferred from the old system, and inadequacy of prior survey information.

  Management confirmed that the number of un-surveyed areas has now reduced to circa 2,000 via a programme of risk-prioritised re-inspections over the past year. Work remains ongoing in this area to further reduce this number.

- Usage of MiCAD by contractors and UHB staff is lower than expected, suggesting this key record is not always being reviewed prior to work commencing, as required. This matter was being appropriately monitored by the AMT and had been captured on the Asbestos Risk Register, with appropriate mitigating actions identified.

Work at the UHB community sites was not always undertaken by contractors controlled by CEF and, as such, they will not always have appropriate asbestos information available to them (via MiCAD). The AMT has provided physical copies of the asbestos register to such sites, with workers required to sign an authorisation sheet prior to commencing work. Whilst recognising that this system had only been recently implemented, the review of a sample of sheets noted low compliance in completion (**recommendation 4**).

Recognising that there are some areas requiring further improvement in terms of MiCAD compliance, these matters are being robustly monitored and reported by the AMT to the CEF Health & Safety forum and the AMG. Accordingly, **reasonable assurance** has been determined in this area.

Risk Management

That risk assessments have been completed for all ACMs identified. The UHB has appropriate management and control action plans in place for the ACMs.

The risk assessment process for identified ACMs is documented within the AMP (refer to the 'Identification' section).

Risk information is clearly presented in MiCAD, from the overarching risk profile of the estate / site to the individual risk scores for ACMs.

The current risk profile for the UHB included no high-risk materials that have not already been sealed-off with access prevented.

Medium and low risk ACMs identified within the general UHB estate will be dealt with as and when permitted by the operational priorities of the area, or when wider projects are undertaken. The AMT had an annual budget

(£400k for 2020/21) to enable remedial / emergency works to be undertaken as required (in addition to the funding of surveys).

A comprehensive Asbestos Risk Register was evidenced, regularly reviewed with a defined action plan to address the risks identified. Enhancements to the monitoring of the register have been recommended (see **recommendation 1**). In line with the risk profile of asbestos within the UHB it is not defined as a separate risk at Corporate Risk Register level.

Noting the risk management processes in place, **substantial assurance** has been determined.

Operational Delivery

That compliance with the Control of Asbestos Regulations 2012 is demonstrated through a sample of operational activities.

A sample of eight externally contracted asbestos jobs (five non-notifiable, non-licensed jobs and three 'Refurbishment and Demolition' surveys) were reviewed for compliance with the Regulations. A summary of the audit findings for the sampled jobs is set out within **Appendix B**.

Recognising the nature of the sample, (all minor asbestos jobs), the full level of monitoring and certification was not required. However, two issues were noted:

- The risk assessment and method statement was not available at one job, having not been retained electronically at the time of issue. Noting that similar issues were identified at the 2019/20 Control of Contractors audit, the recommendation has not be replicated at this report; and
- Waste consignment notes had not been retained by the UHB at four of the five applicable jobs (**recommendation 6**). Whilst not all required evidence was available at the date of audit fieldwork, information was provided retrospectively.

Noting the above **reasonable assurance** has been determined for this area in respect of the sample reviewed.

7. Summary of Recommendations

The audit findings, 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
Current year recommendations	-	2	3	**5**
Recommendation included in the Control of Contractors report (2019/20)	-	1	-	**1**
Total recommendations	-	3	3	**6**

Finding 1: Asbestos Management Group	Risk
The UHB has established an Asbestos Management Group (AMG) with appropriate terms of reference in place. The AMG was found to be operating as required during the period under review (November 2019 to September 2020). Whilst noting the AMG receives a range of appropriate reports / updates for scrutiny / discussion, it does not currently receive the Asbestos Risk Register. It is recognised that key matters contained within the Asbestos Risk Register receive separate attention at the AMG; however specific inclusion of the Register itself on the agenda would enable central oversight of the key asbestos risks, including the monitoring of assigned mitigating actions.	The AMG may not receive relevant information to enable it to fully deliver its remit.
Recommendation 1	**Priority level**
The Asbestos Risk Register should be reported to, and monitored at, the AMG (**O**).	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed. Whilst noting that a number of the AMG membership will already have seen the risk register, we recognise the benefit of including it as a specific agenda item.	Health, Safety & Asbestos Manager At the next AMG meeting

Finding 2: Compliance Auditing	Risk
The Asbestos Management Plan (AMP) (section 6.2) states: *"Auditing will be used to measure progress across the full range of asbestos related activities and this information will be fed back to the Asbestos Management Group to monitor progress of the success of the AMP."* Areas requiring auditing include: • access to MiCAD/community registers, • 3% (or 2 per annum of surveys, and • 3% of air monitoring certificates. Robust monitoring and reporting of audit findings was evidenced in a number of key areas, via the monthly 'Asbestos Update' reports (reported to the CEF Health & Safety forum and also discussed at Asbestos Management Group meetings). Reports included comprehensive information on surveys, removal work, planned work, incidents, MiCAD compliance, MiCAD usage; and community asbestos information. It was confirmed however that, due to notable pressures this year resulting from the ongoing Covid-19 situation, priorities of work had been affected. As such the 3% survey and 3% air monitoring audits had not yet taken place. Management advised that procedures were in development for the air monitoring analytical work, based on four-stage clearance audits already completed.	Management may not be aware of the potential non-achievement of the standards required by the Asbestos Regulations.

Recommendation 2	Priority level
a) Compliance auditing should take place in line with the AMP, for surveys and analytical work. b) The achievement of /progress towards compliance audit targets should be reported to the AMG (**O**).	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed. Following the conclusion of audit fieldwork, we have already made further progress by addressing the air monitoring requirements. We aim to report the final position for 2020 to the final AMG of the year (to take place towards the end of November / early December), by which point we aim to have concluded the final elements of auditing.	Health, Safety & Asbestos Manager December 2020

Finding 3: Training	Risk
The Asbestos Management Plan (aligned with the Regulations/ Code of Practice) sets out the training requirements for the various categories of staff involved in asbestos management, as follows: • Category A: Asbestos awareness training. For all staff deemed likely to come into contact with asbestos as part of their everyday role. • Category B training. For staff undertaking non-licensed asbestos work - to be refreshed annually, with full training required every 24 months. The UHB maintains a training matrix, showing compliance for the above categories. The training position at the time of the audit was as follows: • Asbestos Awareness training – total of 101 employees identified. Training had expired for 47 (47%) and 2 (2%) recorded as not having received training. These results were based on the expectation of annual refresher training to be received.; and • Category B training – total of 21 employees identified, all of whom were shown as having expired training. It is recognised there may be some distinction here between the full 24 month training and an interim refresher, however the matrix did not separately present this data. The Regulations require annual refresher training as a minimum. The Regulations do not require annual asbestos awareness training: *"There is no legal requirement to repeat a formal refresher awareness training course every 12 months. However some form of refresher awareness should be*	Potential risk to staff health and safety. Potential non-compliance with Asbestos regulations.

given, as necessary, to help prevent … workers … putting themselves or others at risk in the course of their work." Management confirmed that staff with expired Category B training would not be permitted to work on asbestos jobs (as controlled via the Permit to Work system). Instead there would be the option of appointing an external contractor if work needed to progress. It is noted there would be a financial implication of this approach. It is acknowledged that, during the period under review, delivery of training has been affected by Covid-19, and at the date of this report, plans were underway for training to re-commence. Whilst asbestos compliance reporting (to the CEF Health & Safety Forum and the Asbestos Management Group (AMG)) was otherwise comprehensive, it did not include training compliance data. In determining the priority rating of this recommendation, noting that the training position was not in accordance with the best practice sought by the UHB, no aspects of non-compliance with the Regulations had been identified.	
Recommendation 3	**Priority level**
a) Management should ensure all expired training is brought up to date as soon as possible. b) The training matrix should be reviewed and enhanced to ensure full training information is presented. c) Monthly asbestos compliance reporting, and reporting to the AMG, should incorporate training compliance data (**O**).	**Medium**

Management Response	Responsible Officer/ Deadline
a) Agreed. Arrangements are in place for Asbestos Awareness training to be undertaken during November 2020, via an online programme. The delivery of Category B training has been more difficult due to the current environment, noting this is a classroom-based course, but work has been undertaken since the audit fieldwork to start to deliver the required training sessions. In the meantime, mitigating controls are in place to ensure those staff who have yet to receive their Category B training are not permitted to undertake asbestos work. b) Agreed. We intend to review and enhance the training matrix. c) Agreed. We will incorporate training compliance data into the monthly H&S compliance reporting, and to the AMG. This will better demonstrate ongoing compliance throughout the year.	Health, Safety & Asbestos Manager a) November 2020 (Asbestos Awareness) / December 2020 (Cat B) b) December 2020 c) December 2020

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Finding 4: Community Logs	Risk
Where contractors are appointed by other departments, they will not have access to MiCAD. Therefore, to manage these instances, and mitigate the risk of undertaking work where asbestos may be present, paper registers have been provided to each community site. Management acknowledged that there were no controls in place to confirm that asbestos registers had been reviewed at such locations. Site log books, including job authorisation sheets, have therefore been introduced across the sites within the last six months, to be completed by contractors and in-house maintenance staff when undertaking work at the sites. The forms require the worker to confirm they have checked the asbestos register and understood the information presented in relation to the job to be undertaken. The Asbestos Management Team (AMT) confirmed they had plans to audit the sheets approximately every six months to monitor compliance. A review of the sheets completed at two sites (Park Road and Woodlands House) noted that a number of contractors and Estates staff had not completed the required entries. It is acknowledged that, as this was a relatively new system, the AMT had not had an opportunity to review compliance across sites / take appropriate remedial action, prior to this audit. For Estates staff, management confirmed that it is not currently mandatory for the sheets to be completed, although is considered good practice for lone working purposes. However, noting the concerns reported by the AMT in terms of whether supervisors are using MiCAD appropriately to enable accurate information to be	Potential exposure to asbestos if registers are not checked and understood.

passed to their team, use of these forms would provide an audit trail and checking mechanism to better monitor compliance for in-house staff.	
Recommendation 4	**Priority level**
a) Contractors should be reminded of the need to complete the community job authorisation sheets. b) Estates staff should also be required to complete the authorisation sheets, to provide an audit trail demonstrating that they have received the required asbestos information via their supervisor (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
a) Agreed. We intend to revisit the latest signing-in sheets from the last few months to assess current compliance, and identify non-compliant contractors. We will then write to all non-compliant contractors to inform them that they will be removed from access to future UHB work if they do not comply with UHB procedures. We are also reviewing a range of apps, which whilst not related to the asbestos management process, will enable signing in/out electronically. b) Agreed. This is viewed as a lower risk issue, noting under the current system workers are provided with asbestos information by the supervising officer. The matter will be raised at the next H&S meeting with managers asked to remind supervisors of the importance of their staff signing in on site.	Health, Safety & Asbestos Manager December 2020

Finding 5: – Risk Assessments & Method Statements	Risk
A sample of eight externally-contracted asbestos jobs for the period October 2019 to August 2020, were reviewed during the audit to assess compliance with the Asbestos Management Plan and the Regulations: • Five non-licensed asbestos jobs; and • Three asbestos surveys. See **Appendix B** for a summary of the audit findings. The contractors' risk assessments and method statements (RAMS) was not available for one of the eight jobs reviewed: • Job ref 19001-035 (UHL): Mechanical repairs in kitchen crawl way – December 2019 Management confirmed that a paper copy of the RAMS was viewed on site but an electronic copy had not been provided to the UHB. It is noted that the retention of RAMS had been raised as a recommendation within the Control of Contractors report (issued February 2020) with the agreed action that all RAMS will be incorporated into the database prior to proceeding with works. The recommendation will not be replicated in this report; and is recognised that since the date of the report, management have undertaken monthly audits of the Job Request Form process. The latest results found 98% compliance with the RAMS requirements.	Management cannot verify that contractors have planned their work appropriately to adequately protect the UHB's employees and visitors. Non-compliance with HSE requirements.

Recommendation 5	Priority level
See Control of Contractors report issued February 2020 (recommendation 1)	

Finding 6: Waste Removal	Risk
The Asbestos Management Plan states: *"Waste produced through the work of a licensed contractor will be the responsibility of the licensed contractor to remove from site and the costs of this should be included within their submitted costs. A waste consignment notice will be required for each job to be filed in the MiCAD filing system."* Noting the above, copies of waste consignment notes for four of the five jobs reviewed had not been retained by the UHB. These were subsequently requested, and made available following audit fieldwork. Management advised that due to the small nature of these jobs, small amounts of waste generated were taken by the contractor to their base, with collated waste then being centrally removed at a later point. These central waste consignment notes were not then shared with the UHB.	The UHB may not be able to demonstrate compliance with asbestos regulations.
Recommendation 6	**Priority level**
Contractors should be reminded of the need to share copies of waste consignment notes with the UHB where relevant (**O**).	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed. Whilst noting that only one of the sampled jobs involved removal of ACMs (with the waste note retained for that job), we recognise that other jobs may involve a minor element of removal of contaminated waste (such as overalls). We agree it would be good practice to retain copies of waste notes in	Health & Safety and Asbestos Manager December 2020

such cases, and will ensure this is better monitored at each job going forward. Whilst noting that this evidence will not be linked to MiCAD, we propose to check at invoice-stage that all required documentation has been provided to the UHB, and retain the documents within the departmental electronic filing structure.	

Summary of audit findings: Operational Delivery testing

Job Description	Job ref	RAMS	Notification if required?	Monitoring procedures documented in RAMS?	Air monitoring certificate?[1]	Clean up / reoccupation certificates?[1]	Waste Notes retained?
Asbestos jobs (all non-licensed)							
Mechanical repairs in kitchen crawl way	19001/035 (UHL)	**N**	n/a	unknown	n/a	n/a	**N**[2]
Emergency site attendance and decontamination	19001/032 (UHW)	Y	n/a	Y	n/a	n/a	**N**[2]
Removal of firebreak and encapsulation	20003/001 (UHW)	Y	Y	Y	Y	Y	Y
Covid-enabling work	20003/002 (UHW)	Y	n/a	Y	n/a	n/a	**N**[2]
Removal of asbestos cement panel	20003/004 (Park Road)	Y	n/a	Y	n/a	n/a	**N**[2]
Asbestos surveys							
R&D survey of Ward West 1	20002-003 (UHL)	Y	n/a	Y	n/a	n/a	n/a
R&D survey of Whitchurch Lodge	20002-011 (Whitchurch)	Y	n/a	Y	n/a	n/a	n/a
R&D survey of Chapel & ground floor hub room	20002-006 (CRI)	Y	n/a	Y	n/a	n/a	n/a

[1] Where certification is marked as 'n/a' in the table, management has advised that noting the minor nature of the jobs reviewed, full documentation was not typically required.
[2] Whilst waste notes were ultimately obtained during the audit, they had not been provided by the contractor at the time of the job.

Audit Assurance Ratings

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

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

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

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

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

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

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

Report Title:	**Update on Covid 19 Governance Arrangements**								
Meeting:	Audit and Assurance Committee					**Meeting Date:**	09.02.21		
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**	**X**	
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

At the November Audit and Assurance Committee Members received the outputs of audit reports in relation the Covid-19 including the Health Board's responses to those audits. These included:

(a) The Structured Assessment
(b) Internal Audit Review
(c) KPMG Review of the Principality Stadium.

At that time there was also a further review being undertaken by the Health Boards Internal Auditors on the Lakeside Wing. This report has not yet been finalised.

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

As the Health Board are now well into the peak of the second wave it is important for Audit and Assurance Committee Members to note the Governance arrangements which have been implemented and are operating in response to the Audits which were undertaken during the first wave:

(a) The Board is now meeting in Public on a monthly basis. The Board meeting, held before the Board Development session, is a 90 minute meeting and primarily directed towards Covid 19 issues, updates and concerns.

(b) The new Covid 19 report has been successfully introduced and used to report at each meeting of the Board since November 2020. The report is split into the key headings of Quality, Workforce, Governance, Operational framework and Public Health. Executive Directors are keen to ensure there is no duplication between this report and routine items reported to the Board in these respective areas.

(c) The Covid Board Governance Group continues to meet and now includes all Independent Members. The Terms of Reference were amended and approved to reflect this.

(d) There is an additional paper at each Audit Committee to update Members on Covid 19 Governance arrangements.

(e) There is an additional paper at each Quality, Safety and Experience Committee to outline the impact of Covid 19 on patient safety.

(f) The Strategy and Delivery Committee had a specific focus at their last meeting on workforce (12th January 2021).

(g) The Chair has completed his one to one sessions with IMs to ensure that their input was being maximised and a meeting was also held with the Chair and IMs where key messages were fed back to the IMs from the Chair as a result of the one to ones.

Other Governance arrangements include:

(a) The Chair of the Board has requested that the Committees of the Board continue to meet during the second wave of the pandemic. However, the Committee agendas are being reviewed with the Chairs of each Committee and the Director of Corporate Governance to ensure that they are reduced to only essential items to allow Executive time spent at the Committees to be minimised.

(b) The Management Executive Meeting continues to meet on a Monday each week and there are standing items on the agenda linked to Covid 19 such as Policy Updates etc. The Management Executive are also considering other key areas which require Executive Director discussion such as Mass Vaccination.

(c) There is a twice weekly Covid 19 Operational Meeting which is Chaired by the Chief Operating Officer with 40+ Clinical Board staff attending in addition to the Executive Directors.

(d) The actions from the KPMG review continue to be implemented.

(e) The Corporate Governance Directorate are now considering arrangements and work required for any Public Inquiry which will take place. The Director of Corporate Governance is reporting to the Management Executives on these arrangements on the 1st February and will update the Committee verbally at the meeting on 9th February.

(f) The Corporate Risk Register and Board Assurance Framework continue to be reported to the Board and both document include risks in relation to Covid 19.

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

Implementing these arrangements provides additional scrutiny and further strengthens our governance arrangments in relation to Covid 19 providing assurance to the Board and Members of the Public.

Recommendation:

For Members of the Audit and Assurance Committee to note the update on Covid 19 Governance arrangements.

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

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

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