# Bundle Audit and Assurance Committee 3 December 2019

Agenda attachments

00 - Agenda Public Dec 2019.docx

1 Welcome and Introductions
*John Union*

2 Apologies for Absence
*John Union*

3 Declarations of Interest
*John Union*

4 Minutes of the Meeting held on 30 September 2019
*John Union*
4 - Audit Mins Sep 2019 - AF Final.docx

5 Action Log - 30 September 2019
*John Union*
5 - Action Log Sep 2019.docx

6 Chair's Action taken since last meeting
*John Union*

7 ITEMS FOR REVIEW AND ASSURANCE

7.1 Internal Audit Progress and Tracking Report
*Ian Virgil*
7.1 - A&A Progress Report cover December 2019.docx
7.1.1 - IA Progress Report.pdf

7.2 Integrated Care Fund Report
*Wales Audit Office*
7.2 - cardiff_vale_regional_partnership_board_english.pdf

7.3 Audit Committee Update
*Wales Audit Office*
7.3 - CVUHB Audit Committee Update.pdf

7.4 Structured Assessment
*Stuart Walker*
7.4 - 1527A2019-20 C&V Structured Assessment Report 2019.pdf
7.4.1 - 1604A2019-20 C&V Structured Assessment management response 2019.pdf

7.5 Implementing the Wellbeing of the Future Generations Act
7.5 - 1509A2019-20_implementing_wfg_report_Cardiff_and_Vale.pdf

7.6 Effectiveness of Clinical Audit Report
7.6 - Clinical Audit - 03.12.19.docx

7.7 Declarations of Interest and Gifts and Hospitality Tracking Report
*Nicola Foreman*
7.7 - Declarations of Interest, Gifts, Hospitality & Sponsorship.docx
7.7.1 - Declarations of Interest Register 3 Dec 2019.pdf

7.8 Tracking Report from Recommendations
*Nicola Foreman*
7.8 - Legislative and Regulatory Compliance - cover report.docx
7.8.1 - Regulatory Heat Map. Nov19.xlsx

7.9 Internal Audit Tracking Report
*Nicola Foreman*
7.9 - Internal Audit Tracker Report - Covering Report.docx
7.9.1 - Internal Audit Summary Tables - Appendix 1.docx

7.9.2 - Audit Recommendation Tracker - Internal Audit.xlsx

7.10 Wales Audit Tracking Report

*Nicola Foreman*

7.10 - External Audit Tracker Report - Covering Report.docx

7.10.1 - External Audit Summary Table - Appendix 1.docx

7.10.2 - WAO.Nov.xlsx

8 ITEMS FOR APPROVAL / RATIFICATION

8.1 Review of Losses and Special Payments

*Robert Chadwick*

8.1 - Losses and Special Payments Report November 19.docx

8.1.1 - Appendix 1- Minutes of the November 2019 Losses Special Payments Panel.doc

8.2 Counterfraud and Corruption Policy

8.2 - Counterfraud and Corruption Policy Report.doc

8.2.1 - CF Policy - 18.11.19.doc

8.2.2 - Counter Fraud and Corruption Procedure (v3 - 31st October 2019).doc

8.2.3 - EHIA - Counter Fraud Policy - October 2019.doc

9 ITEMS FOR NOTING AND INFORMATION

9.1 Internal Audit Reports

*Ian Virgil*

9.1.1 - MH CB 3rd Sector Contracts Final Report.pdf

9.1.2 - Claims Reimbursement Final Report.pdf

9.1.3 - Private Overseas Patients Final report.pdf

9.1.4 - Surgery CB Medical Finance Governance Follow-Up Final.pdf

9.1.5 - Depriviation of Liberty Safeguards Final report.pdf

9.1.6 - Charitable Fund Final Report.pdf

9.1.7 - PCIC Business Continuity Final report.pdf

9.1.8 - Wellbeing at Maelfa_1920_Final Report.pdf

9.1.9 - (a) PCIC CHC Adults Follow-Up Final report.pdf

9.1.10 - (b) CW CB CHC Children Follow-Up Final report.pdf

10 Items to bring to the attention of the Board / Committee

11 Review of meeting

*John Union*

12 Date and time of next Committee meeting:

*Tuesday, 25 February 2020, at 9.00am, Coed y Bwl, Woodland House*

**Audit & Assurance Committee**
**Tuesday, 3 December 2019 at 9.00am**

**Coed y Bwl, Woodland House, Maes y Coed Road, Heath, Cardiff, CF14 4HH**

# AGENDA

| | | |
|---|---|---|
| **1.** | Welcome & Introductions | John Union |
| **2.** | Apologies for Absence | John Union |
| **3.** | Declarations of Interest | John Union |
| **4.** | Minutes of the Committee Meeting held on 30 September 2019 | John Union |
| **5.** | Action Log – 30 September 2019 | John Union |
| **6.** | Chairs Action taken since last meeting | John Union |
| **7.** | **Items for Review and Assurance** | |
| **7.1** | Internal Audit Progress and Tracking Report | Ian Virgil |
| **7.2** | Integrated Care Fund Report – Cardiff and Vale Regional Partnership Fund | WAO |
| **7.3** | Audit Committee Update | WAO |
| **7.4** | Structured Assessment | WAO |
| **7.5** | Implementing the Wellbeing of the Future Generations Act | WAO |
| **7.6** | Effectiveness of Clinical Audit Report | Stuart Walker |
| **7.7** | Declarations of Interest and Gifts and Hospitality Tracking Report | Nicola Foreman |
| **7.8** | Tracking Report from Recommendations | Nicola Foreman |
| **7.9** | Internal Audit Tracking Report | Nicola Foreman |
| **7.10** | Wales Audit Tracking Report | Nicola Foreman |
| **8.** | **Items for Approval / Ratification** | |
| **8.1** | Review Losses and Special Payments | Robert Chadwick |
| **8.2** | Counterfraud and Corruption Policy | Craig Greenstock |
| **9** | **Items for Noting and Information** | |
| **9.1** | **Internal Audit Reports**<br><br>**Assignment** **Assurance Rating** | Ian Virgil |
| **10** | **Items to bring to the attention of the Board / Committee** | |
| **11** | **Review of the Meeting** | |
| **12** | **Date and time of Committee meeting:**<br>Tuesday, 25 February 2020, at 9.00am, Coed y Bwl, Woodland House | |

**UNCONFIRMED MINUTES OF THE AUDIT COMMITTEE**
**HELD ON MONDAY, 30 SEPTEMBER 2019**
**COED Y BWL ROOM, GROUND FLOOR, WOODLAND HOUSE**
**MAES Y COED ROAD, HEATH, CARDIFF CF14 4HH**

**Present:**

| | | |
|---|---|---|
| John Union | JU | Chair – Audit |
| Dawn Ward | DW | Independent Member – Trade Union |

**In attendance:**

| | | |
|---|---|---|
| Robert Chadwick | RC | Director of Finance |
| Simon Cookson | SC | Director of Internal Audit Shared Services |
| Nicola Foreman | NF | Director of Corporate Governance |
| Scott Lavendar | SL | Post Payment Verification Manager |
| Urvisha Perez | UP | Wales Audit Office |
| Mike Usher | MU | Wales Audit Office |
| Elizabeth Vincent | EV | Senior Internal Auditor |
| Ian Virgil | IV | Interim Head of Internal Audit |

**Secretariat:** Glynis Mulford

**Apologies:**
Eileen Brandreth

| | | |
|---|---|---|
| **AC: 19/09/001** | **WELCOME AND INTRODUCTIONS**<br><br>The Chair welcomed everyone to the meeting. | **ACTION** |
| **AC: 19/09/002** | **APOLOGIES FOR ABSENCE**<br><br>Apologies for absence were noted. | |
| **AC: 19/09/003** | **DECLARATIONS OF INTEREST**<br><br>The Chair invited Members to declare any interests in the proceedings. None were declared. | |
| **AC: 19/09/004** | **MINUTES OF THE AUDIT COMMITTEE HELD ON 23 AND 30 MAY 2019**<br><br>The Committee reviewed the Minutes of the meeting held on 23 and 30 May 2019.<br><br>**The Committee resolved that:**<br><br>The Committee received and approved the minutes of the meeting held on 23 and 30 May 2019. | |
| **AC: 19/09/005** | **ACTION LOG FOLLOWING THE LAST MEETING**<br><br>The Committee reviewed the action log and noted that the following | |

amendments should be made:

**AC: 18/071 – Wales Audit Report Medical Equipment:** Chair to discuss off line with the Executive Director of Therapies and Health Science. **COMPLETE**

**The Board resolved – that:**

a) the action log be noted.

**AC: 19/09/006** **CHAIRS ACTION TAKEN SINCE LAST MEETING**

No actions have been taken.

**AC: 19/09/007** **BREXIT UPDATE**

This item had been updated in detail at the recent Board meeting. Members asked for an update to be brought to a future meeting of the Audit Committee. AH

Mike Usher, WAO provided an update on Brexit from the Auditor General's presentation to Welsh Government. The following comments were made:

- **To Sustain collective working:** Planning had been significantly strengthened and collaboration was seen across services.
- **Strengthening communications with public**: Clear and consistent messages must be communicated to the public and the public should know what to do / what not to do in terms of medicine, fuel and food.
- **Enhanced independent scrutiny:** Wales' public bodies needed to enhance their scrutiny of Brexit preparations.
- **To be collectively ready to respond to the unexpected:** Respond to things that had not been anticipated and for these issues to be escalated swiftly.
- **Plan and prepare for longer term impacts:** for public bodies to think of the immediate consequences of a no deal Brexit and prepare for its longer term effects.

**AC: 19/09/008** **INTERNAL AUDIT PROGRESS REPORT**

Mr Ian Virgil, Acting Head of Internal Audit presented an overview of the progress report on the Internal Audit Plan. The following comments were made:

- Three of the five planned audits were in draft stage with a reasonable rating. Two were a work in progress and were relatively positive.
- In providing detail of the outcomes, three reports related to the 2018/19 plan. Although they were included in last year's opinion, they were unable to be put into the final report. No significant issues were identified.

- Seven reports had been finalised from the 2019/20 schedule. Three reports at draft stage were of substantial assurance. There were no limited assurance reports issued. There had been a delay in delivering a few reports but these would be presented at the next meeting.
- Three reports were follow-ups from 'limited' audits last year. The Standards of Behaviour audit had made significant progress with all actions completed and achieved a substantial assurance rating. The Mental Health Clinical Board, Sickness Management and Regulatory Compliance audits had increased to reasonable assurance. Work was ongoing with the CDT Clinical Board to provide a dashboard for the regulatory body reviews which would move onto a tracker process. Another detailed audit would not be undertaken as good progress had been made towards implementing the agreed actions but they would continue to be monitored. The audits undertaken to date provided the Health Board with a positive indication of the opinion to be arrived at, at the end of year.
- Adjustments to the plan was also provided and explained.
- Due to the level of reduction on specialling within the Medicine Clinical Board they had changed their focus to QSE Governance. The Chief Operating Officer confirmed that he was happy with the change. The Surgery Clinical Board would now look at specialling.
- There were two additions to the plan, namely, Cyber Security follow-up, as the original assurance was limited and Capital Keir Prompt Payments review of compliance with the 'Fair Payment' Charter.

The summary of the appendices attached to the document were presented and it was acknowledged that the Health Board had strengthened its timeliness in reacting to and signing off reports, but further improvements could be made.

**Resolved that:**

a) The Audit Committee considered the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports.
b) The Audit Committee considered and approved updates to the Internal Audit Plan.
c) The Audit Committee agreed to defer five of the reports until January 2020.

**AC: 19/09/009** **WALES AUDIT OFFICE PROGRESS REPORT**

Urvisha Perez, Wales Audit Office provided an overview of the Audit Plan and went through several key points:

- In regards to the Financial Audit Update, the WAO team informed the Committee that they would be onsite to review Charitable Funds.

- In terms of work completed since the last Committee (the Integrated Care Fund), a regional report would come to the December Audit Committee. The report would be available on the WAO website shortly and would cover the local flavour of the key messages. The Wellbeing and Future Generations draft report had been sent to the Health Board. Follow-up of Operating Theatres and Orthopaedics Services work was at fieldwork stage.
- There were delays on the part of Health Boards in the timeliness of responses to the surveys and the dates for on-site visits.
- The IMT follow-up would focus on governance recommendations which had been made previously. The Audit Lead had met with the Director of Digital and Health Intelligence to review the final TORs.
- The Structured Assessment would go forward to the December meeting.
- The Thematic Review of Quality Governance Arrangements was an extension of the Structured Assessment work and was currently being scoped.

**The Committee resolved that:**

a) The Wales Audit Office Progress Report be noted.

**AC: 19/09/010** **AUDIT OF FINANCIAL STATEMENTS REPORT ADDENDUM - RECOMMENDATIONS**

Mike Usher, Wales Audit Office, presented the report that followed up on the financial work where a number of recommendations had been made. Also inspected were recommendations made in the previous year. The following comments were made:

- WAO were pleased with the progress made by management against each of the previous year's proposals.
- In regards to the retire and return arrangements the Health Board's process was reviewed and it was considered that it should strengthen its guidance to ensure that it complied with Department of Health Guidance. This would be completed by February 2020.
- In regard to the Annual Governance Statement, the size of the draft report had increased but this had been reduced to provide a concise document which had been accepted by WAO. There was further learning across Wales that would be shared with the team in relation to the Annual Governance Statement.
- The sensitivity around Related Party Transactions Guidance for Independent Members and Senior Officers needed to be audited for a much tighter level of materiality and to include reputational risk. This had been accepted by management. NF
- The document would be circulated with completed responses.

**The Committee resolved that:**

a) The information provided by WAO in relation to the production Finance Statements and Annual Governance Statement be not

AC: 19/09/011 **WALES AUDIT OFFICE REPORT – CLINICAL CODING**

Urvisha Perez, Wales Audit Office presented the report. The following comments were made:

- In 2014-15 WAO reviewed Clinical Coding arrangements across Wales and highlighted areas of improvement with accuracy of coding, qualitative medical records and engagement between coders, clinicians and medical records staff.
- It highlighted that there was no recognition of specialist staff knowledge and the understanding required. There was no understanding of clinical coding and how this could help with day to day business. The 2014-15 report concluded that while there was a strong focus on clinical coding, there were weaknesses in a number of arrangements and processes which affected timely and robust management of information. At the time, a number of recommendations were made to strengthen the clinical coding team, which included the management of medical records and building of clinical and Board engagement.
- The follow up review examined progress made. It concluded positively that the Health Board was producing good coding data which had been used to support service improvement but more work was needed for these proposals to be fully addressed.
- Since 2017, the Health Board had been consistent in achieving completeness and goals in terms of performance. Furthermore, the Health Board was well above the Wales average against the national performance. The adhoc position had significantly improved since the 2014 report but NWIS had reported the Health Board accuracy rate had decreased slightly over the last 12 months.
- The Health Board understood the value of coding data and used it to support winter and capacity plans.
- Out of the 25 recommendations previously made, seven had been fully implemented, 12 were still in progress, four were overdue and two recommendations had been superseded. One new recommendation within clinical coding had been made to resolve interim management arrangements.
- The follow up review across Wales would pull together key findings from the work into a short paper which would be published around December.

**The Committee resolved that:**

a) The Wales Audit Office Report on Clinical Coding be noted.

AC: 19/09/012 **JOB PLANNING AND CLINICAL AUDIT**

The Medical Director provided a verbal update on the above. The following comments were made:

**JOB PLANNING**

This was currently being re-audited in four areas of the organisation and would provide the Committee with the best indication of the current status. Job Planning had been recorded on ESR in three different ways, (1)in relation to whether someone had a job plan, (2) whether the job plan has been updated in the last year and (3) in the Direct Clinical Care to ATS split.

It was reported that the consultant staff and permanent staff, who were not trainees, numbered 703 and 11% of them did not have a job plan history recorded on ESR and 28% had an update in a year. This varied by Service, Directorate and Board. Secondly, a job planning tracker, was held by each Service and was mixed with some detailed job planning information. In other instances this did not occur. Thirdly, the service would hold job plans locally on their system and provided a good detailed record of what they were like.

In summary, they would await the results of the internal audit report and put together a proposal and take it through the normal business cycle. A significant piece of work needed to be undertaken to develop a comprehensive local job planning process that would integrate a centralised recording system with a bespoke piece of software capable of comparing data.

**CLINICAL AUDIT**

The Medical Director provided a review of the current level of assurance regarding national audit performance. A detailed paper on the local audits would be brought to the December meeting. The following comments were made:

There were 38 nationally mandated audits and some of these were broken down into subdivisions which brought the total to 42. These had been red/amber/green ("RAG") rated and highlighted compliance with 23. These were managed centrally by the Quality and Safety Team. It highlighted exemplars of how national audits were being used to drive through quality improved patient safety. Five had been RAG rated as amber with a partial degree of compliance. These were managed locally within the Health Boards. Three of the mandated audits had been RAG rated red. There had been a systematic analysis of the audits which had been taken back to the Clinical Boards highlighting the amber and red ratings.

There was a need to have a discussion regarding how much of our activity, as an organisation, we wanted to devolve to Clinical Boards and how much we wanted to keep centrally in order to assure ourselves we had the governance processes in place centrally.

The Chair invited comments and questions:

The Chair questioned the lack of timescales regarding the amber and red audit ratings. In response it was stated this was in the Health Board's plans but was dependant on local circumstances within each service. One of the issues with national audits was that, for the vast majority of audits the results were not seen until the report was published and therefore, the Health Board did not have the ability to monitor the outcomes.

There was an issue regarding the process for managing outlying data because the Health Board did not have a systematic approach once it received good quality data informing the Health Board that there was a problem. Therefore there was a need for centralised assurance. It was suggested that this be discussed at a Board Development session regarding the principle of devolvement and for this to be put on the internal audit plan for 2021/22.

The Director of Internal Audit Shared Services said that they had looked at clinical audit across Wales. They commented that the areas of limited assurance and clinical audit were one of the issues highlighted. There was good compliance with national audits but, the local audits identified corporate priorities and how this was being addressed. There was some negative data suggesting this was an area to focus on.

**The Committee resolved that :**

a) The verbal updates on Job Planning and the Clinical Audit be noted.

**AC: 19/09/013** **POST PAYMENT VERIFICATION REPORT**

Scott Lavendar, Post Payment Verification Manager, presented the Post Payment Verification report in the new style format and informed the Committee that feedback from across the whole of Wales had asked for more comparative data and provided the detail on this. The spreadsheet had been RAG rated in order to show where PPV was concerned and when to raise concerns. There would be more input into training, guidance and support measures and Scott Lavendar offered one on one training with the practices. Quarterly meetings had been reinstated with finance, counterfraud, PPV and the Primary Care Team for each discipline. The Report also looked at the schedule performance and what actions should take place. It was pleasing to see that every year the average error rate for each Health Board had decreased.

The Chair invited comments and questions:

Independent Member – Trade Union, questioned how the sample size worked. It was clarified that it was different for each discipline. This has been standardised across the whole of Wales,25% for pharmacies, 103 samples were selected for the ophthalmic sample

and the sample size for the medical discipline was 10% or 22 claims.

Members were informed that where errors were found this was reclaimed. The practices had the opportunity to submit the evidence. If any errors were highlighted the error went through a number of checks and was then deducted from the next imbursement. In terms of visits, each practice was seen on a 3 year cycle but if they triggered a 10% error rate the visit would take place within a year. Visits were now based on trends and themes which allowed the team to be smarter and more effective with their time and resource.

A pilot had been undertaken where a letter was sent to each contractor stating a letter would be sent out to patients to verify the services they had received. A low return was received from five practices and a visit was undertaken on those claims which provided a good deterrent.

**The Committee resolved that:**

a) The Post Payment Verification Report be noted.

**AC: 19/09/014** **WALES AUDIT OFFICE TRACKING REPORT**

The Director of Corporate Governance provided an overview of the above report. The following comments were made:

In 2016 it was identified in the Structured Assessment Review that the trackers needed reworking as they did not track compliance effectively this was picked up again in 2018.

The information provided to the Committee did not provide all the detail but summarised where we were against recommendations on external audits. All of the tracking reports would be followed up on a quarterly basis. The reports would be reported to Management Executive and Health Systems Management Board to provide assurance that this was being undertaken across the Health Board. Data from the Executives would be presented in December, which should display improved figures.

The Chair invited questions and comments:

Independent Member – Trade Union stated that the layout of the report was a helpful platform to judge going forward. It provided an overview of the distribution of the work and would enable the Committee to track performance on the Health Boards improvement, identify what was moving and would be able to display the overall percentages.

Mike Usher, Wales Audit Office suggested that, where recommendations were showing as overdue it would be helpful for the owner of that action to provide the Director of Corporate Governance with a revised completion date whilst keeping the

| | | |
|---|---|---|
| | previous date.<br><br>**The Committee resolved that:**<br>a) the tracking report which was now in place for tracking audit recommendations made by External Audit (WAO) be noted.<br>b) It be noted that progress will be seen over the coming months in the number of recommendations which are completed/closed. | |
| **AC: 19/09/015** | **INTERNAL AUDIT TRACKING REPORT**<br>The Director of Corporate Governance presented the Internal Audit Tracking report. The following comments were made:<br><br>This table was slightly different and provided detail on the assurance rates, whether they were high, low or medium recommendations over the last two financial years. This work was progressing and the expectation was it would lead to improvements. In terms of resource, it was acknowledged there was a huge amount of work to keep the trackers maintained and up to date.<br><br>The Interim Head of Internal Audit asked to see the tracker prior to submission to the next Committee to see if it tied in with their work.<br><br>**The Committee resolved that:**<br>a) the tracking report which was now in place for tracking audit recommendations made by Internal Audit be noted.<br>b) It be noted that progress will be seen over coming months in the number of recommendations which are completed/closed. | NF |
| **AC: 19/09/016** | **REGULATORY BODIES TRACKING REPORT**<br><br>The Director of Corporate Governance presented the Regulatory Bodies Tracking Report informing that it had received a limited assurance rating last year. It was acknowledged there was still a lot of work to be undertaken and that centrally we needed to know what we were being inspected on. This needed to come up through the governance structure as the Board and Executives could potentially not be sighted on some significant reports. All of the Clinical Boards had advised the Corporate Governance Team of the regulatory reviews that they needed to be aware of.<br><br>To ensure that the tracking report went through due process all regulators had been written to and reports received would go into a dedicated inbox. A heat map was shown with an example of the dials highlighting the level of compliance and when an inspection was due. The aim was to complete this for the December meeting. This was a starting point and a policy had been through Management Executives and would be presented at the Health Systems Management Board.<br><br>**The Committee resolved that:**<br><br>a) the development of the Legislative and Regulatory Tracker | |

and 'reasonable' assurance rating provided by internal audit be noted;

b) the next steps required to complete all of the recommendations made within the Internal Audit Report and so provide further assurance to the Audit Committee and the Board on compliance with Legislation and Regulatory Standards be noted.

**AC: 19/09/017** **DECLARATIONS OF INTEREST REPORT**

The Director of Corporate Governance presented the above report. Members were informed that significant progress had been made and the Health Board had achieved a rating of substantial assurance. When the audit was completed last year only a few declarations were disclosed. The tracker now showed those who had declared an interest exceeded 700 plus and this was still growing. The mechanisms were in place for communications and would be followed-up and reported regularly.

The Director of Finance asked to know who had not replied and if the breakdown of disciplines of non-compliance could be provided. NF

**The Committee resolved that:**

- progress made by the Corporate Governance team to date be noted;
- the strengthened governance procedures implemented by the Corporate Governance team be noted;
- they were assured that the new arrangements were sufficient following the recent 'Substantial Assurance' rating for Internal Audit Report.

**AC: 19/09/018** **ITEMS FOR NOTING AND INFORMATION**

**The Committee resolved that:**

**a)** Items for information were noted.

**AC: 19/09/019** **ITEMS TO BRING TO THE ATTENTION OF THE BOARD / COMMITTEE**

There were no items to bring to the attention of the Board / Committee.

**AC: 19/09/020** **REVIEW OF THE MEETING**

- The meeting worked well and it was useful to have the Medical Director present.
- It was good to see how the trackers and tools worked.

| | |
|---|---|
| **AC: 19/09/021** | **DATE OF THE NEXT MEETING OF THE COMMITTEE**<br>Tuesday, 3 December 2019, 9.00am – 12.00pm Coed y Bwl Room, Ground Floor, Woodland House, Heath, Cardiff CF14 4HH |

**Action Log**
**Following Audit & Assurance Committee Meeting**
**30th September 2019**

| REF | SUBJECT | AGREED ACTIONS | LEAD | DATE | \|STATUS/COMMENTS |
|---|---|---|---|---|---|
| **Completed Actions** | | | | | |
| **AC 19/05/018** | Wales Audit Office (WAO) ISA 260 Report | A separate report setting out UHBs actions against last year's recommendations to be provided to the Committee | WAO | | **COMPLETED.** The Audit of Financial Statements Report Addendum – Recommendations: Item on agenda for September meeting. *(Agenda Item 7.4)* |
| **AC 19/05/007** | Internal Audit Progress Report | Three audit reports to come to September meeting | I Virgil | 30.09.19 | **COMPLETED.** Delayed reports to be brought to September meeting *(Agenda Item 7.1 )* |
| **AC 19/05/009** | Items for information | A number of reports to be finalised to be presented at the next Committee meeting | I Virgil | 30.09.19 | **COMPLETED.** See Action AC 19/05/007 *(Agenda Item 9.1)* |
| **AC 19/04/012** | Tracking Report from Recommendations from Regulatory Bodies | A high level dashboard to be presented in September. | N Foreman | 30.09.19 | **COMPLETED.** On agenda for September 2019 meeting. *(Agenda Item 7.12)* |
| **AC 19/04/011** | Declarations of Interest and Gifts of Hospitality | This action was discussed in May meeting and will be subject to re-audit in a few months' time. | I Virgil | | **COMPLETED.** Re-Audit due to be completed in August and report brought to September 2019 meeting *(Agenda Item 9.1)* |
| **AC 19/04/009** | Post Payment Verification Report | To provide an update on error and claim rates. | S Lavendar | 30.09.19 | **COMPLETED.** Item deferred from May to September meeting. *(Agenda Item 7.7)* |
| **AC 19/02/19** | Limited Assurance Reports: Medicine Clinical Board – Internal Medicine Follow up | For the Medical Director to provide an update on Job Planning. | S Walker | 23.04.19<br><br>24.09.19 | **COMPLETED.** This item was deferred from May to the September meeting due to the Interim Medical Director being on annual leave *(Agenda Item* |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | *7.5)* |
| **AC 19/09/010** | Audit of Financial Statements Report Addendum - Recommendations | Final document to be circulated to Members with completed responses | N Foreman | 30.09.19 | **COMPLETED** |
| **Actions in Progress** | | | | | |
| **AC 19/09/005** | Wales Audit Report on Medical Equipment | Investigate how other Health Boards deal with equipment <£5k inventory.<br><br>This was discussed at the May meeting and deferred to September meeting. | F Jenkins | 03/12/2019 | Chair to discuss off line with the Executive Director of Therapies and Health Science and if action completed to bring back to December meeting. |
| **AC 19/09/007** | Brexit Update | Request for update to be brought to a future meeting | A Harris | | |
| **AC 19/09/017** | Declarations of Interest Report | To provide details of those who had not submitted declarations and the breakdown of non-compliance | N Foreman | | |
| **AC 19/05/007** | Internal Audit Progress Report | The review of Performance Reporting Data Quality – RTT would be moved to the 2019/20 plan | I Virgil | 25.02.20 | To be brought to February 2020 meeting |
| **AC 19/05/007** | Internal Audit Progress Report: Cyber Security – Limited Assurance | Follow-up review was on the 2019/20 plan | I Virgil | 25.02.20 | To be brought to a February 2020 meeting |
| **AC 19/09/009** | WAO Progress Report | To bring the Integrated Care Fund and Structured Assessments Reports to the next Committee meeting | WAO | 3.12.19 | Items on agenda for December meeting.<br>*(Agenda Item 7.3 )* |
| **AC 19/09/012** | Clinical Audit | A detailed report on internal audit would be brought to the next meeting. | S Walker | 3.12.19 | Item on agenda for December meeting<br>*(Agenda Item 7.6)* |
| **AC 19/04/012** | Tracking Report from Recommendations from Regulatory Bodies | A project plan on the dashboard would be taken to Management Executives and HSMB for consultation and approval | N Foreman | 30.09.19 | Plan agreed to roll out high level dashboard to Corporate Governance next ……. |
| **Actions referred to other Committees/Board** | | | | | |
| | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **REPORT TITLE:** | Internal Audit Progress Report | | | | | | | |
| **MEETING:** | Audit Committee | | | | | **MEETING DATE:** | 03.12.19 | |
| **STATUS:** | **For Discussion** | | **For Assurance** | **x** | **For Approval** | **x** | **For Information** | |
| **LEAD EXECUTIVE:** | Director of Governance | | | | | | | |
| **REPORT AUTHOR (TITLE):** | Acting Head of Internal Audit | | | | | | | |

**PURPOSE OF REPORT:**

**SITUATION**:

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

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

**REPORT:**

**BACKGROUND:**

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

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

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

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

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

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

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

**RECOMMENDATION:**

The Audit 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 2019/20.

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

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

| | |
|---|---|
| **EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:** | Not Applicable |

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

# Cardiff and Vale University Health Board

## Internal Audit Progress Report

## Audit Committee December 2019

## Private and Confidential

## NHS Wales Shared Services Partnership

## Audit and Assurance Service

## CONTENTS

## 1. INTRODUCTION

**1.1.** This progress report provides the Audit Committee with the current position regarding the work being undertaken by the Audit & Assurance Service as part of the delivery of the approved 2019/20 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 2019/20 was agreed by the Audit Committee in April 2019 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 Decmber Audit Committee but have not met that deadline.

| Audit | Current Position | Draft Rating | Reason |
|---|---|---|---|
| Tentacle IT System | Draft | Limited | Delay in receipt of management responses – Were due by 4/11/19 |
| Consultant Job Planning Follow-up | Draft | Limited | Delay in completion of fieldwork due to waiting for information from management |
| Safeguarding Adults & Children | Draft | Reasonable | Delay in completion of fieldwork due to availability of Internal Audit resources |
| Infection Prevention and Control | WiP | | Delay in completion of fieldwork due to availability of Internal Audit resources |
| Surgery Clinical Board – Enhanced Monitoring of Ward Patients | WiP | | Delay in commencing fieldwork due to availability of Internal Audit resources |
| Medicine Clinical Board – QSE Governance | WiP | | Delay in commencing fieldwork due to availability of Internal Audit resources |
| Control of Contractors | WiP | | Delay in commencing fieldwork due to availability of Internal Audit resources |

## 3. OUTCOMES FROM COMPLETED AUDIT REVIEWS

**3.1.** A number of 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 assignments with Reasonable and Substantial assurance are reported in Section five.

| FINALISED AUDIT REPORTS | ASSURANCE RATING | |
|---|---|---|
| MH CB – Third Sector Contracts | Substantial |  |
| Claims Reimbursement | | |
| Private and Overseas Patients | Reasonable |  |
| Surgery CB – Medical Staff Governance Follow-up | | |
| Deprivation of Liberties Safeguards | | |
| Charitable Funds | | |
| PCIC Business Continuity Planning | | |
| Maelfa: Wellbeing Hub | | |
| PCIC CB - CHC Adults Follow-up | | |
| Children & Women CB – CHC Child Follow-up | | |
| Kier Construction Compliance with the Fair Payment Charter | Not Rated | |

## 4. DELIVERY OF THE 2019/20 INTERNAL AUDIT PLAN

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

In addition, there are a further three audits that have reached draft report stage.

**4.2.** The majority of the audits that have reached reporting stage for the current year have concluded positively with ratings of reasonable or substantial assurance. There are however two audits currently at the draft report stage that have ratings of limited assurance. Management responses are still awaited for The Tentacle IT System and are now significantly outside the required 15 working day deadline. The draft outcome of the Consultants Contract Follow-up illustrates that the previously agreed management actions have not been progressed. The

fact that this follow-up remains Limited will have a more significant impact on the potential year-end opinion.

Since the last Committee meeting a further follow-up has been undertaken for an audit that was given a Limited assurance rating in the previous year. Two separate reports were issued for the Continuing Healthcare follow-up to reflect the separate Adult and Child processes. Both demonstrated sufficient progress towards implementing the agreed actions and the ratings have therefore increased to Reasonable Assurance.

The Health Board will need to be mindful of the impact of the two draft limited assurance reports, especially the Consultants Job Planning Follow-up. However, the Reasonable and Substantial outcomes for the reports that have been finalised to date suggests that Health Board remains on course for a positive overall opinion. However, with the number of audits in the plan still to be delivered, this could obviously change between now and the year-end. Appendix B shows the assurance summary by domain.

The audit assignment schedule at Appendix A gives specific details as to the status of the planned work.

**4.3.** Adjustments to the 19/20 plan.

The following audits has been identified for potential deferral or removal from the plan:

- Brexit Planning – The start of this audit has been delayed to fit in with the availability of management. It is now scheduled to be reported to the March Committee meeting.
- Commercial Outlets - The Director of Estates and Facilities has requested that the audit be removed from the plan due to potential future changes in the strategic direction around these services.

  The request to remove the Audit from the Plan will need to be formally approved by the Audit Committee at its December meeting.

The detail of the allocation of the completed audits across the assurance domains, along with those still to be undertaken and those deferred, is recorded within Appendix B.

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

The current rate of compliance with the KPI for provision of management responses is 79%. Whilst this is below the target of 90%

it does represent an improvement when compared to the overall compliance rate for 2018/19 which was 56%.

## 5. FINAL REPORT SUMMARIES

### 5.1 MH CB - Third Sector Contracts

| 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. |

In summary, Third Sector contracts are being managed effectively and in accordance with the Clinical Board's policies and procedures and the Health Board's Standing Orders and SFIs.

The Clinical Board's framework and guidance in respect of the management and oversight of Third Sector contracts is current, but does require revision to include escalation processes in the event that contractual service delivery issues cannot be resolved at a local level.

Appropriate contract specification documents are produced prior to the completion of competitive tendering and contract awarding processes, both of which are undertaken in compliance with the UHB SFIs.

Testing also identified that bi-annual performance management monitoring and annual governance monitoring is being undertaken on third sector contracts, in accordance with the Clinical Board's procedures and framework.

One additional issue that requires management action was identified relating to an absence of evidence to comprehensively support stakeholder's involvement in the drafting of third sector service specifications.

## 5.2 Claims Reimbursement

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

The audit identified that the Health Board's claims reimbursement process is undertaken in compliance with Assessment Area 23 of the Welsh Risk Pool (WRP) Concerns and Compensation Claims Management Standard and the Organisational Claims Handling Policy and Procedure.

For the sample of reimbursed claims reviewed audit found that the above guidance and procedure had been followed.

## 5.3 Private and Overseas Patients

| 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 sound structures in place that provide effective governance and oversight of the management of private and overseas patients and there are current policies and procedures posted on its intranet and internet sites. The Private and Overseas Patient Office has a formal structure, reporting and lines of accountability and the Finance Department has procedures in place that govern the management and oversight of private patients. The UHB is currently liaising with Welsh Government in preparation for changes in overseas patient's processes arising from the UK withdrawal from the European Union.

Patient fee information and points of contacts for private and overseas patients are also stated on the UHB internet site. Testing undertaken within the sampled departments established that those patients that were charged

for treatment at the point of care were done so in accordance with the appropriate 2019/20 Directorate tariff.

However, the testing of existing processes in place identified a number of areas where controls are inadequate or are not being applied consistently. Two of the four sampled departments did not hold documented procedures/staff guidance in respect of local management of overseas patients, and they also had no awareness of the UHB private and overseas patient's intranet and internet pages or the procedures and fee charges detailed within them.

Additionally, the UHB Private Patient Tariffs posted on the internet site currently state 2018/19 prices and not 2019/20 prices and there has not been a UHB wide review of overseas and private patient costs/tariffs in recent years.

The current processes in place within the Private and Overseas Patients Office for monitoring and following-up on evidence of patient's entitlement to treatment, need to be formalised and built into a regular timetable.

## 5.4 Surgery CB – Medical Finance Governance Follow-up

| 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. |

It is evident that the Clinical Board has made progress towards implementing the agreed management actions from the original review. However, there are still actions that require completion.

There is an appropriate process in place for obtaining staff and Locums now which has been documented in a Standard Operating Procedure for Scrutiny of Posts in General Surgery. In addition, the Directorates are utilising the Health Board Medical Staff Claim forms for Waiting List Initiative.

As detailed within section 5 below, the follow-up has concluded that three of the management responses have been fully actioned (1 high & 2 medium), 2 have been partially actioned (2 High) and 1 has not been actioned (medium).

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Surgery

Clinical Board – Medical Finance Governance has improved to **Reasonable Assurance**.

Management will however need to ensure that the outstanding actions are fully implemented and that job plans are completed for General Surgery and that Colorectal Consultants cover each other's sessions when unavailable.

## 5.5 Deprivation of Liberties Safeguards (DoLS)

| 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 Audit was assessed as reasonable assurance as there have been improvements made since the previous Internal Audit review in early 2018. There has been a decrease overall in the number of DoLS standard and further requests being submitted and it was identified that they were being completed in a timelier manner. In addition, the review highlighted that the DoLS assessments were being authorised on a timely basis as the Health Board have identified additional staff members to undertake signing off the DoLS assessments.

There are still some issues identified as part of the review as there has been a vast increase in the number of urgent DoLS requests and staff are not able to always complete them within the required seven days as documented within the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards. Whilst this is a serious issue that the Health Board will need to seek to address, it is noted that all the sampled urgent DoLS requests have been completed but not in line with the stipulated time limits.

It was evident from our review that there has been a significant increase in awareness of DoLS as identified from our discussions with ward staff and having a specific Nurse managing the process within the Stroke unit. However, there has only been one DoLS training session carried out this year as the others have been cancelled due to the lack of numbers of staff attending.

## 5.6 Charitable Funds

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

Overall the controls in place to manage the risks associated with the systems and processes tested within the review are of a reasonable standard.

Elements of good practice were observed within all the areas covered as documented in section 6 of this report.

The governance arrangements in place for the administration of the charitable funds within the Charitable Funds Committee was good.

However, the review identified some issues, particularly around the management of dormant funds where effective monitoring is not currently in place and the previously agreed management action has not been implemented. It was noted that there has been a 72.7% increase in the level of dormant funds between July 2018 and March 2019.

## 5.7 PCIC CB - Business Continuity Planning

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

The current review has identified that there are generally good processes in place for the management of Business Continuity Planning within the PCIC Clinical Board.

There is overall Health Board Business Continuity Plan (BCP) guidance in place, the template from which has been adopted by the PCIC Business Units and Services Areas in the production of their individual BCPs. It was however observed that some Business Units / Service Areas that required a BCP did not currently have a fully complete and / or formally documented one in place. It is noted that the PCIC Clinical Board has planned steps in place to ensure that all relevant service areas have a formally documented BCP.

In order to test for the robustness of BCPs, the following 4 Service Areas across 4 Business Units were reviewed:

- Urgent Primary Care Out of Office Hours (OOHs);
- Vale of Glamorgan Locality: Day time Services / Communication Hub; and
- North & West Locality: District Nursing:
  - District Nursing Night Visiting team; and
  - North Cardiff District Nursing team.

All areas sampled had a BCP and various processes were in place to ensure their robustness including:

- Consulting with stakeholders;
- Regular review and update of BCPs; and
- Having various groups in place through which information can be shared.

The review also noted that whilst there are effective Committees and Groups in place within the Clinical Board and its Business Units for managing and monitoring Business Continuity, the Terms of Reference (TOR) for a number of these were out of date.

## 5.8 Maelfa Wellbeing Hub

| 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. |

Noting the stage of the project, at the time of our review, general compliance was noted with the established control frameworks in each of the objective areas sampled.

However, certain enhancements have been recommended in respect of:

- Updating the Project Execution Plan, noting the UHB's movement to developing the Full Business Case;
- Attendance of nominated members at both Project Board and Project Team meetings;
- Update to the risk register for the financial risk of affordability against the benchmark base cost;
- Development of resource/ activity plans by work stream leads; and
- Contract documentation being appropriately addressed and executed.

The overall assurance determined is cognisant of these recommendations and the current stage of the project (i.e. awaiting approval of Outline Business Case).

Accordingly, against this context, the level of assurance has been assessed as **reasonable**.

## 5.9 PCIC CB – CHC Adults Follow-up

| 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. |

It is evident that the Clinical Board has made progress towards implementing the outstanding agreed management actions from the original review. However, there is still one action that requires completion.

Work is ongoing between all parties to progress contractual arrangements between providers that will lead to a formalised Heads of Service Agreement (HoSA). All sampled CHC follow up annual reviews were undertaken in 2019 but there is an issue with PARIS management reports not fully capturing the assessments undertaken.

As detailed within section 5 below, the follow-up has concluded that one of the remaining outstanding management responses has been fully actioned and one has been partially actioned.

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with PCIC Clinical

Board Continuing Healthcare: Adults Follow-Up has improved to **Reasonable Assurance**.

## 5.10 Children & Women CB – CHC Child Follow-up

| 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. |

It is evident that the Clinical Board has made progress towards implementing the two outstanding agreed management actions from the original review.

Good practice is noted that a pilot Children's and Young People's Continuing Care Operational Policy has been agreed between Cardiff & Vale UHB, Cardiff Council and the Vale of Glamorgan Council.

KPIs in respect of Children's CHC have been fully introduced but are not currently subject to review and action by the Child Health Directorate.

As detailed within section 5 below, the follow-up has concluded that one of the outstanding management responses have been fully actioned and one has been partially actioned.

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Children & Women's Clinical Board Continuing Healthcare: Children Follow-Up has improved to **Reasonable Assurance**.

## 5.11 Kier Construction Compliance with the Fair Payment Charter

As an examination of processes operating by external entities the assignment was **not** allocated an assurance rating, but compliance or otherwise was reported to the Health Board and the results shared with NWSSP: SES to inform the Designed for Life Strategic Framework Board.

## CARDIFF AND VALE UHB INTERNAL AUDIT ASSIGNMENT STATUS SCHEDULE

| Planned output. | No | CRAF | Exec Director Lead | Plnd Qtr | Current progress | Assurance Rating | Audit Cttee |
|---|---|---|---|---|---|---|---|
| Annual Quality Statement | 18 | | Nursing | Q1 | Final – Issued May 19 | Substantial | Sept |
| MH CB – Sickness Management Follow-up | 36 | | COO/Clinical Board | Q1 | Final – Issued July 19 | Reasonable | Sept |
| Sustainability Reporting | 44 | | Planning | Q1 | Final – Issued August 19 | Reasonable | Sept |
| Carbon Reduction Commitment | 45 | | Planning | Q1 | Final – Issued August 19 | Substantial | Sept |
| Standards of Behaviour (DoI & G&H) Follow-up | 06 | | Governance | Q1 | Final – Issued September 19 | Substantial | Sept |
| Specialist CB – Rosterpro | 34 | | COO | Q1 | Final – Issued September 19 | Reasonable | Sept |
| Legislative / Regulatory Compliance Follow-up | 05 | | Governance | Q1 | Final - Issued September 19 | Reasonable | Sept |
| **Charitable Funds** | **15** | | **Finance** | **Q2** | **Final – Issued October 19** | **Reasonable** | **Dec** |
| **Private and Overseas Patients** | **17** | | **Medical** | **Q1** | **Final – Issued October 19** | **Reasonable** | **Dec** |
| **Maelfa: Wellbeing Hub** | **SSU** | | **Planning** | **Q3** | **Final – Issued October 19** | **Reasonable** | **Dec** |
| **Surgery CB – Medical Staff Governance Follow-up** | **37** | | **COO** | **Q1** | **Final – Issued October 19** | **Reasonable** | **Dec** |

| Planned output. | No | CRAF | Exec Director Lead | Plnd Qtr | Current progress | Assurance Rating | Audit Cttee |
|---|---|---|---|---|---|---|---|
| **MH CB – Third Sector Contracts** | **29** | | **COO** | **Q1** | **Final – Issued October 19** | **Substantial** | **Dec** |
| **Kier Construction Compliance with the Fair Payment Charter** | **SSU** | | **Planning** | **Q3** | **Final – Issued November 19** | **n/a** | **Dec** |
| **PCIC CB – Business Continuity** | **35** | | **COO** | **Q2** | **Final – Issued November 19** | **Reasonable** | **Dec** |
| **Deprivation of Liberties Safeguards (DoLS)** | **19** | | **Medical** | **Q1** | **Final – Issued November 19** | **Reasonable** | **Dec** |
| **PCIC CB – CHC Adult Follow-up** | **07** | | **COO** | **Q2** | **Final – Issued November 19** | **Reasonable** | **Dec** |
| **C&W CB – CHC Child Follow-up** | **07** | | **COO** | **Q2** | **Final – Issued November 19** | **Reasonable** | **Dec** |
| **Claims Reimbursement** | **02** | | **Nursing** | **Q3** | **Final – Issued November 19** | **Substantial** | **Dec** |
| Tentacle IT System | 24 | | Transformation, Improvement & Informatics | Q1 | Draft – Issued October 19 Management responses not received, due by 4/11/19 | Limited | Dec |
| Consultant Job Planning Follow-up | 41 | | Medical | Q2 | Draft – Issued November 19 Completion of fieldwork delayed | Limited | Dec |
| Safeguarding Adults & Children | 22 | | Nursing | Q1 | Draft – Issued November 19 Completion of fieldwork delayed | Reasonable | Dec |
| Infection Prevention and Control | 21 | | Nursing | Q2 | Work in progress | | Dec |
| Surgery CB – Enhanced Monitoring of Ward Patients | 31 | | COO | Q2 | Work in Progress | | Dec |
| Medicine CB – QSE Governance | 32 | | COO | Q2 | Work in Progress | | Dec |

| Planned output. | No | CRAF | Exec Director Lead | Plnd Qtr | Current progress | Assurance Rating | Audit Cttee |
|---|---|---|---|---|---|---|---|
| Control of Contractors | SSU | | Planning | Q2 | Work in Progress | | Dec |
| Brexit Planning | 09 | | Planning | Q2 | Start of fieldwork postponed | | Dec |
| UHB Core Financial Systems | 13 | | Finance | Q3 | Work in Progress | | March |
| Budgetary Control | 14 | | Finance | Q3 | Work in Progress | | March |
| C&W CB – Consultant Leave | 30 | | COO | Q3 | Work in Progress | | March |
| CD&T CB – Laboratory Turnaround Times (TAT) | 33 | | COO | Q3 | Work in Progress | | March |
| Medical Staff Study Leave | 39 | | Workforce | Q3 | Work in Progress | | March |
| Use of Digital Technology | 25 | | Transformation, Improvement & Informatics | Q2 | | | March |
| Strategic Planning / IMTP | 08 | | Planning | Q3 | | | March |
| Strategic Performance Reporting | 11 | | Transformation, Improvement & Informatics | Q3 | | | March |
| Integrated Health Pathways | 20 | | Transformation, Improvement & Informatics | Q3 | | | March |
| Freedom of Information Reviews | 23 | | Transformation, Improvement & Informatics | Q3 | | | March |

| Planned output. | No | CRAF | Exec Director Lead | Plnd Qtr | Current progress | Assurance Rating | Audit Cttee |
|---|---|---|---|---|---|---|---|
| Cyber Security Follow-up | 47 | | Transformation, Improvement & Informatics | Q3 | | | March |
| Medicine CB – Internal Medicine Follow-up | 38 | | COO | Q3 | | | March |
| Service Improvement Team | 42 | | Planning | Q3 | Rescheduled from Q1 to allow appropriate resourcing | | March |
| Commercial Outlets | 43 | | Planning | Q3 | | | March |
| Health & Care Standards | 01 | | Nursing | Q4 | | | April |
| Risk Management / BAF Development / Risk Registers | 03 | | Governance | Q4 | Rescheduled from Q3 to allow cross resourcing with Mamhilad Team | | April |
| Management of Health Board Policies | 04 | | Governance | Q4 | Rescheduled from Q3 at request of Director of Governance | | April |
| Engagement around Service Planning | 10 | | Planning | Q4 | Rescheduled from Q2 to allow appropriate resourcing | | April |
| Data Quality Performance Reporting | 12 | | Transformation, Improvement & Informatics | Q4 | | | April |
| GDPR Follow-up | 27 | | Transformation, Improvement & Informatics | Q4 | | | April |
| IT Service Management (ITIL) | 28 | | Transformation, Improvement & Informatics | Q4 | | | April |
| Pre-Employment Checks | 40 | | Workforce | Q4 | | | April |

| Planned output. | No | CRAF | Exec Director Lead | Plnd Qtr | Current progress | Assurance Rating | Audit Cttee |
|---|---|---|---|---|---|---|---|
| Facilities / Estates Service Board Governance | 46 | | Planning | Q4 | | | April |
| *IM&T Backlog* | *SSU* | | *Transformation, Improvement & Informatics* | *Q4* | | | *April* |
| *Neonatal and Obstetrics Capital Project* | *SSU* | | *Planning* | *Q4* | | | *April* |
| Rookwood Relocation Capital Project | *SSU* | | *Planning* | *Q4* | | | *April* |
| ***Removed / Deferred Audits*** | | | | | | | |
| Management of Long Term Agreements (LTAs) | 16 | | Finance | Q2 | Removed from plan. Agreed by September Audit Committee | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

| C&V UHB AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN 2019/20 (Draft reports highlighted in red italics) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Assurance domain** | **Audits** | | **Final & Draft Audit Assurance Rating** | | | | | **Audits to be completed** | **Removed / Deferred Audits** |
| | | | **Not rated** | **No** | **Limited** | **Reasonable** | **Substantial** | | |
| Corporate Governance, Risk and Regulatory Compliance | 6 | | | | | ● Legislative Comp Follow-up | ● Standards of Behaviour Follow-up<br>● Claims | ● H&CS<br>● Risk Management<br>● Management of HB Policies | |
| Financial Governance and Management | 5 | | | | | ● Private & Overseas Patients (Draft)<br>● Charitable Funds | | ● Core Financials<br>● Budgetary Control | ● Management of LTAs |
| Clinical Governance, Quality and Safety | 5 | | | | | ● DoLS<br>● *Safeguarding Adults & Children (draft)* | ● Annual Quality Statement | ● Integrated Health Pathways<br>● Infection Prevention & Control | |
| Strategic Planning, Performance Management and Reporting | 7 | | | | | ● PCIC CB – Adult CHC Follow-up<br>● C&W CB – Child CHC Follow-up | | ● Strat Plan / IMTP<br>● Brexit Planning<br>● Engagement Around Service Planning<br>● Strategic Performance Reporting<br>● Data Quality Performance Reporting | |

| C&V UHB AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN 2019/20 (Draft reports highlighted in red italics) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Assurance domain** | **Audits** | | **Final & Draft Audit Assurance Rating** | | | | | **Audits to be completed** | **Removed / Deferred Audits** |
| | | | **Not rated** | **No** | **Limited** | **Reasonable** | **Substantial** | | |
| Information Governance and Security | 7 | | | | ● *Tentacle IT System (Draft)* | | | ● Freedom of Information Reviews<br>● Use of Digital Technology<br>● IM&T Backlog<br>● GDPR Follow-up<br>● IT Service Management (ITIL)<br>● Cyber Security Follow-up | |
| Operational Service and Functional Management | 10 | | | | | ● MH CB – Sickness Management Follow-up<br>● Specialist CB - Rosterpro<br>● PCIC CB – Business Continuity<br>● Surgery CB – Medical Staff Governance Follow-up | ● MH CB –Third Sector Contracts | ● C&W CB – Consultant Leave<br>● Surgery CB – Specialing of Ward Patients<br>● Medicine CB – Specialing of Ward Patients<br>● CD&T CB – Laboratory Turnaround Times (TAT)<br>● Medicine CB – Internal Medicine Follow-up | |
| Workforce Management | 3 | | | | ● *Consultant Job* | | | ● Medical Staff Study Leave | |

| C&V UHB AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN 2019/20 (Draft reports highlighted in red italics) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Assurance domain** | **Audits** | | **Final & Draft Audit Assurance Rating** | | | | | **Audits to be completed** | **Removed / Deferred Audits** |
| | | | **Not rated** | **No** | **Limited** | **Reasonable** | **Substantial** | | |
| | | | | | *Planning*<br>*Follow-up*<br>*(Draft)* | | | ● Pre-Employment Checks | |
| Capital and Estates Management | 10 | | ● Kier Construction Compliance with the Fair Payment Charter | | | ● Sustainability Reporting<br>● Maelfa Wellbeing Hub | ● Carbon Reduction Commitment | ● Service Improvement Team<br>● Commercial Outlets<br>● Facilities / Estates Service Board Governance<br>● Neonatal & Obstetrics Project<br>● Rookwood Relocation<br>● Control of Contractors | |

| 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 | 21/05/19 | 12/06/19 | 22/05/19 | 22/05/19 | G | |
| MH CB – Sickness Man Follow-up | Reasonable | Final | 25/06/19 | 16/07/19 | 18/07/19 | 22/07/19 | A | |
| Sustainability Reporting | Reasonable | Final | 12/07/19 | 02/08/19 | 05/08/19 | 16/08/19 | A | |
| Carbon Reduction Commitment | Substantial | Final | 24/07/19 | 12/08/19 | 07/08/19 | 16/08/19 | G | |
| Standards of Behaviour Follow-up | Substantial | Final | 03/09/19 | 24/09/19 | 03/09/19 | 05/09/19 | G | |
| Specialist CB Rosterpro | Reasonable | Final | 15/08/19 | 06/09/19 | 04/09/19 | 12/09/19 | G | |
| Legislative / Regulatory Compliance Follow-up | Reasonable | Final | 20/09/19 | 11/10/19 | 23/09/19 | 23/09/19 | G | |
| Charitable Funds | Reasonable | Final | 30/09/19 | 22/10/19 | 17/10/19 | 17/10/19 | G | |
| Private & Overseas Patients | Reasonable | Final | 24/09/19 | 16/10/19 | 14/10/19 | 21/10/19 | G | |
| Maelfa: Wellbeing Hub | Reasonable | Final | 03/10/19 | 25/10/19 | 21/10/19 | 22/10/19 | G | |
| Surgery CB – Medical Staff Governance Follow-up | Reasonable | Final | 01/10/19 | 23/10/19 | 22/10/19 | 31/10/19 | G | |
| MH CB – Third Sector Contracts | Reasonable | Final | 02/10/19 | 24/10/19 | 22/10/19 | 31/10/19 | G | |
| Kier Construction Compliance with the Fair Payment Charter | n/a | Final | 15/11/19 | 15/11/19 | 15/11/19 | 15/11/19 | G | |
| PCIC CB – Business Continuity | Reasonable | Final | 31/10/19 | 22/11/19 | 20/11/19 | 21/11/19 | G | |
| Deprivation of Liberties Safeguards (DoLS) | Reasonable | Final | 04/10/19 | 28/10/19 | 21/11/19 | 21/11/19 | R | |
| PCIC CB – CHC Adult Follow-up | Reasonable | Final | 20/11/19 | 12/12/19 | 21/11/19 | 21/11/19 | G | |
| C&W CB – CHC Child Follow-up | Reasonable | Final | 21/11/19 | 13/12/19 | 22/11/19 | 25/11/19 | G | |
| Claims Reimbursement | Reasonable | Final | 22/11/19 | 14/12/19 | 24/11/19 | 25/11/19 | G | |
| Tentacle IT System | Limited | Draft | 27/09/19 | 21/10/19 | | | R | |
| Consultants Job Planning Follow-up | Limited | Draft | | | | | | |

| **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 | |
| Safeguarding Adults & Children | Reasonable | Draft | | | | | | |

| AUDIT & ASSURANCE KEY PERFORMANCE INDICATORS | | | | | | |
|---|---|---|---|---|---|---|
| **Indicator Reported to NWSSP Audit Committee** | **Status** | **Actual** | **Target** | **Red** | **Amber** | **Green** |
| Operational Audit Plan agreed for 2019/20 | **G** | April 2019 | By 30 June | Not agreed | Draft plan | Final plan |
| Total assignments reported (to at least draft report stage) against plan to date for 2019/20 | **A** | 83% 21 from 25 | 84% | v>20% | 10%<v< 20% | v<10% |
| Report turnaround: time from fieldwork completion to draft reporting [10 working days] | **G** | 100% 21 from 21 | 80% | v>20% | 10%<v< 20% | v<10% |
| Report turnaround: time taken for management response to draft report [15 working days] | **R** | 79% 15 from 19 | 80% | v>20% | 10%<v< 20% | v<10% |
| Report turnaround: time from management response to issue of final report [10 working days] | **G** | 100% 18 from 18 | 80% | v>20% | 10%<v< 20% | v<10% |

**Audit and Assurance Services**
**Cardiff and Vale / South Central Team**
**First Floor**
**Woodland House**
**Maes y Coed Road**
**Cardiff**
**CF14 4HH**
**Contact details: ian.virgil@wales.nhs.uk**

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

# Integrated Care Fund – **Cardiff and Vale Regional Partnership Board**

Audit year: 2018

Date issued: September 2019

Document reference: 1534A2019-20

This document has been prepared for Cardiff Council, Cardiff and Vale University Health Board and Vale of Glamorgan Council as part of work performed in accordance with statutory 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 the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office 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.

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

The team who delivered the work comprised Anne Beegan, David Wilson and Matthew Brushett under the direction of Matthew Mortlock

# Contents

# Introduction

1 The Integrated Care Fund (the fund) is allocated by the Welsh Government across Wales. The aim of the fund is to drive and enable integrated working between social services, health, housing and the third sector and independent providers to develop sustainable services.

2 Since establishing the fund for 2014-15, the Welsh Government has distributed £270 million across Wales between 2014-15 and 2018-19. In 2019-20, the fund is £115 million.

3 Initially focused on supporting older people, and particularly the frail elderly, the scope of the fund has extended over time to include other population groups and projects as set out in Exhibit 1.

Exhibit 1: the scope of the Integrated Care Fund


Exhibit source: Wales Audit Office

4 The Welsh Government distributes the fund across Wales to the seven Regional Partnership Boards (RPBs). The RPBs are responsible for overseeing and managing the use of the fund in their area.

5 On behalf of the Auditor General for Wales, we have examined whether the fund is being used effectively to deliver sustainable services that achieve better outcomes for service users. We have focused on whether the Welsh Government is effectively managing the fund to deliver against its intentions, and whether RPBs are demonstrating effective use of the fund. We also considered whether the projects supported by the fund are making a clear difference at a local level.

6 In July 2019, we published our national report **Integrated Care Fund**. We concluded that **the fund has had a positive impact, supporting improved partnership working and better integrated health and social care services. However, aspects of the way the fund has been managed at national, regional and project levels have limited its potential to date. There is little evidence of successful projects yet being mainstreamed and funded as part of public bodies' core service delivery.**


7 This supplementary report, which should be read in conjunction with the national report, sets out more detail about our findings for Cardiff and Vale Regional Partnership Board. It builds on feedback that we provided to the Regional Partnership Board following completion of our fieldwork.

8 The RPB brings together the two local authorities across Cardiff and Vale (Cardiff Council, and Vale of Glamorgan Council), Cardiff and Vale University Health Board, and representatives of the third sector and independent providers.

| | |
|---|---|
| | **Part 1** summarises partnership working in relation to the fund |
| | **Part 2** summarises how the fund is used in the region |
| | **Part 3** summarises the regional governance arrangements for the fund |
| | **Part 4** summarises the overall impact of the fund in improving outcomes for service users |

9 In undertaking this work, we have identified a number of areas that we think the Cardiff and Vale RPB could improve upon at a regional level. These are set out throughout this report. We have not made specific recommendations for the RPB; however, the national report contains a number of recommendations which apply to all RPBs.

10 We have also identified examples of practice from across Wales which the Cardiff and Vale RPB can learn from.

11 Finally, we have also identified some key questions that Board members of Health Boards and scrutiny members of local authorities could explore with lead officers responsible for the fund to maintain a close handle on how the fund continues to be used across the region.

# Detailed report

## Partnership working

12 Our national report has identified that **the fund has helped to bring organisations together to plan and provide services.** Health and social care partnerships have been around for some time but integrated working prior to the fund was limited. We found that the fund has provided the impetus for regional partners to develop integrated services and to move to joint funding arrangements in the context of wider policy and legislation.

13 In Cardiff and Vale, members recognised that the RPB has been on an improvement journey since being established in 2016. Partners have been open to using core and other funding such as winter pressure monies to support Integrated Care Fund projects.

14 As part of our survey of RPB members, we asked:

- whether the RPB facilitates good partnership working; and
- whether the partner organisations demonstrate a commitment to partnership working.

15 The responses we received from Cardiff and Vale RPB members were among the most positive responses out of all the regions.

16 As part of our surveys of RPB members and project leads, we also asked about the impact of the fund on partnership working. The responses we received from Cardiff and Vale also gave the most positive views about the impact that the fund has had on strengthening partnership working (Exhibit 2). The full regional responses to the surveys can be found in Appendix 1, along with the response rates.

Exhibit 2: respondents to our surveys across Cardiff and Vale told us that…


Exhibit source: Wales Audit Office surveys of RPB members and project leads

# Detailed report

## Use of the fund

17 Our national report identified that aspects of the way funding has been allocated by the Welsh Government and used by regional partners have limited the potential of the fund to date. The report highlighted that Regional Partnership Boards can find it difficult to balance local population needs with the Welsh Government's indicative allocations for target groups. It also highlights that RPBs use the fund in different ways, not all of which support a regional focus. We found that the approaches to the use of the fund vary between the regions, with limited sharing and learning of the approaches used across Wales.

Exhibit 3: approaches applied to the fund 2014-18

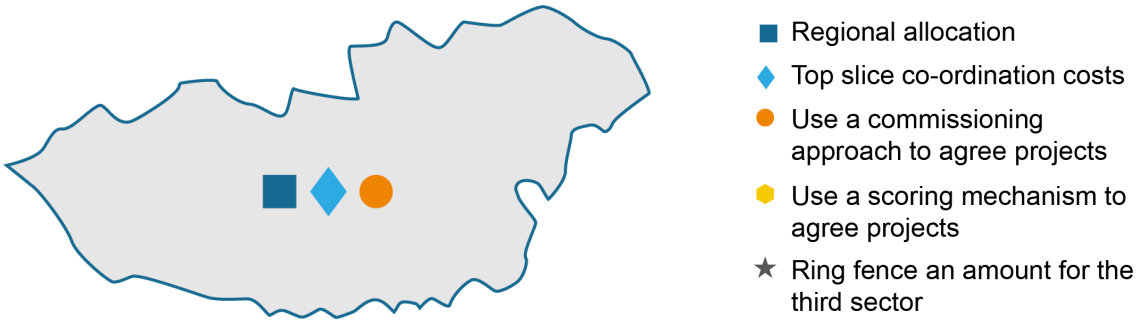



Exhibit source: Wales Audit Office

18 In Cardiff and Vale, a proportion of the allocation is top-sliced to fund co-ordination and project management roles. In contrast to a number of other RPBs, the RPB does not ring-fence a proportion of the fund for the third sector to bid for. Instead the RPB funds the third sector through open access to the funds available. However, third sector representatives told us they felt they have insufficient access to the fund and that they benefit predominantly when spending on other projects slip.

19 Some RPBs recently began allocating the fund by commissioning thematic groups to identify a programme of work that the fund can support, rather than openly seeking bids from member organisations. The Cardiff and Vale RPB follow such an

approach. They do not use a scoring mechanism as some regions do, but we observed good discussion of the fund, and feedback is provided to unsuccessful bids. There is clear evidence that the funding framework requires projects to link to partners' corporate objectives, the strategic objectives of the RPB and local wellbeing objectives to support implementation of the **Wellbeing of Future Generations (Wales) Act 2015**.

20 Our work also highlights that the RPBs have developed varying approaches for managing underspends. The effective management of underspends remains an issue, but the most advanced process is within the West Wales RPB where a reserve list of projects is kept which can be supported if surplus funds become available. Cardiff and Vale RPB encourages project leads to report any likely slippage as soon as possible throughout the year. The RPB also invites short notice small bids which can be delivered in a short timescale.

## Areas for improvement

- Look for ways to improve access to the Integrated Care Fund for the third sector

# Detailed report

## Governance arrangements

21 Our national report has identified that governance arrangements for the fund need to be further developed to strengthen central oversight and ensure greater consistency across the regions. The report highlights that RPBs frequently delegate responsibility for the fund to a sub-group and there is limited scrutiny of the use of the fund by health boards and local authorities. The report also identifies that the rigour of project management varies between RPBs and organisations, and few projects involve services users at the outset.

22 In the Cardiff and Vale RPB, the fund is delegated to the Integrated Care Programme Board, which reports to the Senior Leadership Group who in turn report to the RPB. The Integrated Care Fund Programme Board is responsible for the delivery of the programme. The Programme Board considers the allocation of projects, and closely monitors performance data for all projects, submitting their recommendations to the Senior Leadership Group. Several leads for funded projects are members of both the Integrated Care Fund Programme Board and the Senior Leadership Group which has the potential to create a conflict of interest when allocation and reviewing projects. There is scope to review membership across these groups, to ensure the independence and objectivity of decision makers is not compromised.

23 All the RPBs have representation from the statutory bodies, although representation from housing prior to the 2018 amendment to the Social Services and Well-being (Wales) Act 2014 was variable. We found in Cardiff and Vale, that health and local authority partners have been engaged effectively, due to the establishment of clear communication channels, a culture of trust and a continued focus on achieving outcomes. Members are communicating discussions back to their own organisations and all partners have a good understanding of their roles, although some partners lack capacity to contribute and engage fully.

24 The Cardiff and Vale RPB has taken steps to link its work with local Public Service Boards (PSBs), by:

- having consistent membership across the PSB and RPB; and
- creating strong link between the Area and Wellbeing plans.

25 At a project level, we found both strengths and weaknesses in the management of funded projects (Exhibit 4).

Exhibit 4: strengths and weaknesses in management of projects

| Strengths | Weaknesses |
|---|---|
| ✓ Good communication between the Integrated Care Fund regional leads and project leads<br>✓ Consistent project management methodology applied to all projects<br>✓ A requirement for project leads to work and report against agreed goals targets<br>✓ Project leads want to engage service users when planning projects<br>✓ Risk management of projects<br>✓ Locally there appear to be generally good oversight arrangements for funded projects, with a single performance framework in place for all projects to utilise. | × Not all projects have developed an exit plan.<br>× Access to the fund for third sector organisations is limited. |

Exhibit source: Wales Audit Office fieldwork

26 In contrast with many other regions, Cardiff and Vale RPB is consistently able to collate, scrutinise and sign-off project monitoring information by the tight deadline required by the Welsh Government.

## Areas for improvement

- Building on the work to date, further clarify and improve links between the RPB and PSBs on an ongoing and regular basis.
- Review membership of Integrated Care Fund Programme Board and the Senior Leadership Group to ensure members independence

# Detailed report

## Outcomes for service users

27 Our national report has identified that despite positive examples, the overall impact of the fund in improving outcomes for service users remains unclear, with little evidence of successful projects yet being mainstreamed. The report highlights that RPBs identify a range of positive case studies, but there is little evidence that successful projects have yet been mainstreamed and funded as part of public bodies' core service delivery.

28 Cardiff and Vale RPB members felt strongly that the fund is used to fund the right projects, and that the focus is on outcomes when overseeing the use of the fund. The Cardiff and Vale regional partners are getting better at capturing performance data for the projects, but acknowledge that capturing consistent and comparable outcomes, rather than output data remains a challenge.

29 The Cardiff and Vale RPB have developed a quarterly dashboard which include project key performance indicators (KPIs), information on outcomes and risks. The dashboard provides an overview of project performance for the RPB members and allows them to quickly identify strengths and weaknesses in project performance.

30 In common with other RPBs, in Cardiff and Vale there are few examples of projects being mainstreamed due to financial and savings pressures. Members reported that there is a reluctance to mainstream projects, as the fund is a relatively secure funding stream. They identified that some projects would struggle to compete for mainstream funding if they were subject to challenge as part of annual budget setting processes. A number of projects do not have a clear exit strategy should the funding cease. Routine evaluation of projects is not in place although some evaluation does take place at a local level on an ad hoc basis. The Integrated Care Fund Programme Board has however ceased funding projects that have not demonstrated tangible outcomes, but in most cases, project leads will have already raised this with the Board, prior to intervention

31 Many projects are continuously rolled forward from previous years, limiting opportunities to use the fund to develop new and innovative projects. While still reliant on the fund, several of the projects are now considered as part of core services.

Exhibit 5: challenges identified with mainstreaming projects through our project lead survey across Cardiff and Vale

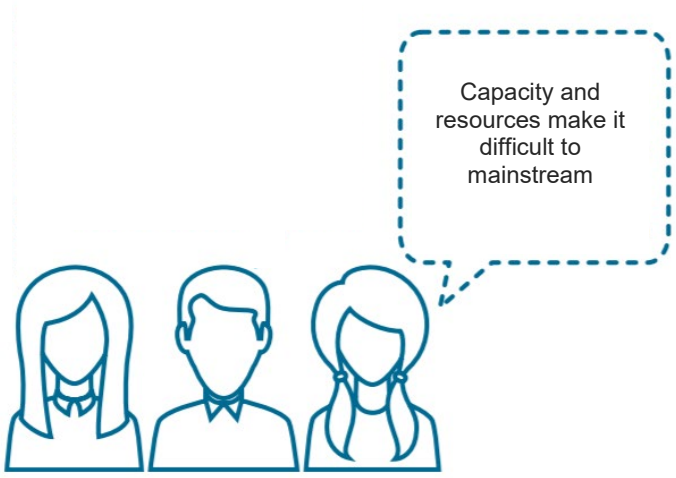



Exhibit source: Wales Audit Office survey of project leads

32 The Cardiff and Vale RPB has developed ways to share learning within the region which enables opportunities to improve projects and deliver them more efficiently. It has also made efforts to share learning with other regions but acknowledges it could do more in terms of sharing learning and good practice.

## Areas for improvement

- Develop exit strategies for all Integrated Care Fund projects
- Building on the mechanisms for sharing good practice within the region already in place, increase the involvement and communication with project leads to enable the embedding of learning into the project planning stages
- Learn from good practice in other regions

# Appendix 1

## Key findings from our surveys of RPB members and project leads

Our survey of Cardiff and Vale RPB members[1][2] identified that

| | | Across Wales... |
|---|---|---|
|  | 9 out of 9 agreed that partner organisations demonstrate a commitment to partnership working | 84% |
|  | 6 out of 9 agreed that there were appropriate links with other regional groups and forums, such as Public Service Boards, to ensure that there were no overlaps or gaps in responding to legislative requirements | 56% |
|  | 4 out of 8 agreed that the ring fencing of the fund for the national initiatives was helpful. | 53% |
|  | 4 out of 9 agreed that the templates provided by the Welsh Government for quarterly reporting captures the right information. | 34% |
|  | 6 out of 7 agreed that there was helpful ongoing communication between the RPBs and the Welsh Government to understand any changes to the fund | 63% |
|  | 8 out of 9 agreed that proposals put forward for the RPB to approve are generally good quality | 80% |
|  | 7 out of 9 agreed that the RPB sets enough time aside for effective scrutiny of the delivery of the projects supported by the fund | 57% |
|  | 8 out of 9 agreed that there is a clear process for monitoring and managing project underspends and overspends within the RPB structure | 72% |
|  | 8 out of 8 agreed that the RPB and its sub-group focusses on outcomes when scrutinising the projects | 69% |
|  | 8 out of 9 agreed that the fund is funding the right projects | 64% |
|  | 9 out of 9 agreed that the projects funded were making a difference to service users | 87% |

[1] Nine of the 13 (69%) RPB members invited to take part in our RPB member survey responded.

[2] Not all members responding answered every question

Our survey of project leads[3] across Cardiff and Vale identified that

| | | Across Wales... |
|---|---|---|
|  | 4 out of 8 identified that their project(s) had received funding in previous years | 71% |
|  | 3 out of 8 identified that their project(s) received additional funding as well as the Integrated Care Fund | 48% |
|  | 8 out of 8 identified that their project(s) clearly linked to national strategic priorities, including the Well-Being of Future Generations (Wales) Act. | 92% |
|  | 4 out of 7 identified that there was a risk management framework for their project(s). | 58% |
|  | 6 out of 7 identified that they had received appropriate guidance from managers to support them in delivering the project(s). | 89% |
|  | 2 out of 7 identified that they were required to include an exit strategy as part of their project plans. | 40% |
|  | 5 out of 7 identified that there was a single point of accountability for delivery of the project(s). | 78% |
|  | 5 out of 7 identified that their project(s) started on time | 32% |
|  | 4 out of 8 identified that there was a mechanism to measure the financial benefits of the project(s). | 40% |
|  | 5 out of 7 identified that they had been able to demonstrate the impact of the project(s). | 60% |
|  | 7 out of 8 identified that the fund is helping to provide sustainable and improved services in their region. | 66% |
|  | 3 out of 7 identified that there were challenges in mainstreaming the project(s). | 75% |
|  | 8 out of 8 identified that the project(s) was making a difference to service users. | 91% |

[3] Eight of the 16 (50%) project leads invited to take part in our project lead survey responded.

# Appendix 2

## Examples of notable practice

In undertaking our work, we have identified a number of areas of practice which other RPB areas could learn from.

Across the **Cwm Taf Morgannwg** regional footprint, development work has been undertaken between the Regional Partnership Board and the Cwm Taf Public Service Board to identify areas of crossover between the partnerships, and to agree the responsibility of each. To strengthen these arrangements, a representative from the RPB sits on the PSB as a non-voting member and vice versa, ensuring communication between the partnerships.

The **West Wales** Regional Partnership Board has developed a strategic approach to using underspend. When allocating money to new projects at the beginning of the financial year, the unsuccessful projects are ranked using the same scoring mechanism as the successful projects. The highest scoring projects are identified and agreed as to be delivered via any underspend that occurs. This approach means that the regional partnership board is not trying to use up underspend at the end of the year on short term interventions.

Following an internal review, the **Cardiff and Vale** Regional Partnership Board has developed a performance dashboard to monitor the Integrated Care Fund. The dashboard supports quarterly reporting of planned and actual levels of activity, impact and outcomes being achieved by the fund using a RAG rated system to visually identify projects that are off track.

In the **Greater Gwent** Regional Partnership Board, roles and responsibilities of the RPB and its subgroups are set out in a memorandum of understanding. Signed by all partners, the document sets out their shared intention to work together in a spirit of cooperation for the benefit of residents living with Gwent. The memorandum includes a conflict resolution process which has supported open and honest discussions between partners should conflict arise.

These examples are not exhaustive. Further examples can be found in the materials produced following our recent Good Practice Exchange webinars **Key Issues for Regional Partnership Boards**

# Appendix 3

## Key questions for Board and scrutiny members

To enable Board members of Health Boards and scrutiny members of local authorities to maintain a close handle on how the fund is used across the region, we have identified some examples of questions that could be used with lead officers responsible for the fund and lead officers who are members on the RPB.

### Partnership working

- Is the organisation challenging existing working practices and actively seeking new opportunities through the fund to work in partnership with its regional partners?
- Is the organisation considering options to utilise funding more effectively, for example by combining various funding streams, where appropriate, to support services to achieve greater impact?

### Use of the fund

- Is the organisation through its representatives on the RPB effectively engaging with relevant stakeholders, including the public, to inform its plans for the use of the fund?
- Is the organisation through its representatives on the RPB ensuring third sector organisations are equal partners and have fair access to the Integrated Care Fund at the beginning of the financial year and in-year?
- Is the organisation through its representatives on the RPB ensuring the approach to assessing, prioritising and approving services in receipt of the Integrated Care Fund is robust?
- Is the organisation through its representative on the RPB ensuring that the fund is used in a way that maximises value for money (for example, by reducing administrative costs)?
- Is there an effective approach to managing fund underspends in-year?

### Governance arrangements

- Is there a mechanism in place to ensure the organisation is regularly kept up-to-date about the work of the RPB and its sub-groups in relation to the fund?
- Is there a robust risk management framework in place for the services funded through the Integrated Care Fund, and who would be responsible for any unforeseen issues with projects?
- How does the organisation and the RPB get assurance that the approved Integrated Care Fund projects are managed effectively and that the reporting of approved projects is accurate?

## Outcomes for service users

- Is the organisation working with its RPB partners to evaluate what difference funded initiatives have made in terms of outcomes for the regional population?
- Is the organisation working in partnership with its RPB partners to demonstrate outcomes from a multi-agency view?
- Are there services continually funded through the Integrated Care Fund which would significantly impact on the organisation if they were to cease i.e. those now considered core services?
- Is the organisation mainstreaming Integrated Care Fund projects that have demonstrated a positive impact?
- Is the organisation supporting the RPB to facilitate shared learning within the region to enable continuous improvement of project development and management, and the roll-out of successful localised projects?
- Is the organisation supporting the RPB to engage with other regions to share information and learn lessons from other examples and experiences of the Integrated Care Fund?

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

# Audit Committee Update – **Cardiff and Vale University Health Board**

Date issued: December 2019

Document reference: CVACU2019

# Contents

Summary report

# About this document

1 This document updates the Audit Committee on current and planned Wales Audit Office work. It covers financial audit, performance audit and the Auditor General's programme of national value-for-money examinations.

# Financial audit update

Exhibit 1: Financial audit update

| Annual Accounts and other financial-audit work |
| --- |
| 1. In October we audited and certified the Health Board's 2018-19 Substance Misuse Action Fund grant claim.<br>2. We are currently auditing the 2018-19 Funds Held on Trust Account. The Trustee Members are due to consider our audit report on 19 December 2019, and if content approve and sign the Account. The Auditor General is scheduled to certify the Account on 15 January 2020. The Charity Commission's deadline for the receipt of 2018-19 charitable accounts is 31 January 2020.<br>3. We have recently commenced our planning of the audit of the Health Board's 2019-20 Accountability Report and Financial Statements. |

# Performance audit update

## Work completed since the last Audit Committee update

Exhibit 2: Work completed since last Audit Committee update

| Topic | Conclusions | Status | Executive lead | Considered by Audit Committee | Management response status |
|---|---|---|---|---|---|
| Integrated Care Fund (thematic review) | The fund has had a positive impact, supporting improved partnership working and better integrated health and social care services. However, aspects of the way the fund has been managed at national, regional and project levels have limited its potential to date. There is little evidence of successful projects yet being mainstreamed and funded as part of public bodies' core service delivery. | National report published July 2019<br><br>Regional report published September 2019 | Abi Harris | December 2019 | N/a |
| Examination under the Well-being of Future Generations Act 2015 (thematic review) | The Health Board has a good understanding of the sustainable development principle which it clearly considered when developing corporate arrangements and embodying the social model of care in the development of health and well-being centres and well-being hubs but recognises there is more to do. | Final report | Fiona Kinghorn | December 2019 | Completed |

| Topic | Conclusions | Status | Executive lead | Considered by Audit Committee | Management response status |
|---|---|---|---|---|---|
| Structured Assessment 2019 (thematic review) | The Health Board is strengthening processes that support board business, risk management and arrangements for tracking recommendations. It now has an approved IMTP, forecasts a breakeven position and is making progress in tackling workforce issues. But there are opportunities for improvement, these include; Board level performance reporting and scrutiny of IMTP delivery, flows of information between the senior management teams and the Board and addressing a large volume of outstanding audit recommendations. | Final report | Nicola Foreman | December 2019 | Completed |

## Work underway

### Exhibit 3: Work currently underway

| Topic | Focus of the work | Status | Executive Lead | For Audit Committee |
|---|---|---|---|---|
| Follow-up of operating theatres (local) | Between 2011 and 2013, the Wales Audit Office reviewed operating theatres across Wales. In 2015 we carried out work to assess the health board's progress. We concluded that the Health Board had improved theatre utilisation by focussing on processes and performance management. But there wasn't the same focus on improving service quality and addressing problems with staff engagement. At that time, we made some additional recommendations. In 2019 we will follow up progress against these recommendations. | Fieldwork – additional fieldwork is being considered in light of issues being raised | Steve Curry | February 2020 |
| Orthopaedic Services follow-up (thematic review) | This work will examine the progress made in orthopaedic services since our 2015 all Wales review. The work will assess whether recommendations and areas we identified for improvement have been effectively responded to and to determine whether health boards are developing arrangements to help manage the demand on, and supply of, orthopaedic services. | Fieldwork – delays experienced in receiving relevant documentation | Steve Curry | February 2020 |
| Follow-up of previous IM&T recommendations (local) | 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. In 2019 we will follow up progress against these recommendations. | Fieldwork | David Thomas | To be confirmed |
| Counter Fraud Phase 2 (national) | Earlier in 2019, we set out the counter fraud landscape for the public sector. This work will inform Phase 2 of that review which aims to examine how effective counter-fraud arrangements are in practice across the public sector and to make recommendations for improvement. | Briefing to be issued | Bob Chadwick | February 2020 |

## Work planned

Exhibit 4: Work currently planned

| Topic | Focus of the work | Status | Executive Lead | For Audit Committee |
|---|---|---|---|---|
| Quality Governance arrangements (thematic review) | As an extension of our structured assessment work, we plan to undertake a specific thematic review of quality governance arrangements and how these underpin the work of quality and safety committees. In recent years our structured assessment work across Wales has pointed to various challenges with such governance arrangements. We therefore intend to undertake a review that will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows and reporting. | Scoping | Ruth Walker and Stuart Walker | To be confirmed |

# Responses to queries

Exhibit 5: Further information about queries raised at previous audit committees

| Raised | Query |
|---|---|
| | No queries raised. |

# Other Auditor General studies

Since the last Audit Committee, we have published the following reports, which are of relevance to the NHS.

Exhibit 6: Auditor General Reports published since last audit committee

| Output | Summary |
|---|---|
| A review of quality governance arrangements at Cwm Taf University Health Board | This review has highlighted a number of fundamental weaknesses in the Health Board's governance arrangements in respect of the quality of care and patient safety. |
| Primary Care Services in Wales | This report focuses on the main issues and areas of progress found in primary care services in Wales on national level. It draws from the findings of our local work reported in May 2019. |
| Review of Public Services Boards | This report examines how Public Service Boards are operating, looking at their membership, terms of reference, frequency and focus of meetings, alignment with other partnerships, resources and scrutiny arrangements. |
| Public Spending Trends in Wales 1999-00 to 2017-18 | This briefing reflects on what has happened to public spending in Wales over the last 20 years. An interactive data tool is available to support the report. |
| The Well-Being of Young People | This report focuses on 16-24-year olds and seeks to understand how well the Welsh Government is joining up across its policy areas and what impact its approach to strategic planning is having on young people themselves. The work has focussed on five topics, the findings of each are set out in individual reports:<br>• Youth homelessness<br>• Young adult carers<br>• Young parents<br>• Mental health<br>• Skills and employability<br>An interactive data tool is available to support the report. |
| The 'front door' to adult social care | This report focuses on the effectiveness of the new 'front door' to social care, looking specifically at services for adults.<br>An interactive data tool is available to support the report. |

# Good Practice Exchange

The Good Practice Exchange (GPX) helps public services improve by sharing knowledge and practices that work. We run events where people can exchange knowledge face to face and share resources online.

Details of past and forthcoming events, shared learning seminars and webinars can be found on the GPX page on the Wales Audit Office's website. The table in Exhibit 7 lists recent and forthcoming events.

Exhibit 7: Good Practice Exchange

| Recent and forthcoming events |
|---|
| **Recent events** |
| Making an Equal Wales a reality<br>September<br>This seminar looked at what public services are doing to contribute to a More Equal Wales. It was the starting point of knowledge sharing and knowledge gathering around this topic over the next two years for the Wales Audit Office. An all Wales study, the focus of which is yet to be determined, will follow in early spring, reporting in 2021 with a follow up event. |
| How technology is enabling collaborative working across public services<br>October<br>The possibilities that digital technologies can provide are endless. This seminar provided better understanding of tools available and how they can improve collaboration and help deliver smarter and higher quality services.<br>This seminar also shared examples of organisations that are maximising the use of digital technology, enabling them to deliver services that promote independence (including through housing services), combat social isolation, promote carbon reduction and community wellbeing. |
| **Upcoming** |
| Accountability and governance in partnership services<br>13 February 2020<br>27 February 2020 |
| Adverse Childhood Experiences – alternative delivery models<br>19 March 2020<br>26 March 2020 |

Diary markers and details of new events are circulated in advance to the Health Board, together with information on booking delegate places. Further information on any of our past or planned GPX events can be obtained by contacting the local audit team or emailing good.practice@audit.wales.

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

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

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

# Structured Assessment 2019 – **Cardiff and Vale University Health Board**

Audit year: 2019

Date issued: November 2019

Document reference: 1527A2019-20

The team who delivered the work comprised Anne Beegan, John Llewellyn and Urvisha Perez, under the direction of Dave Thomas.

# Contents

# Summary report

## About this report

1 This report sets out the findings from the Auditor General's 2019 structured assessment work at Cardiff and Vale University Health Board (the Health Board). The work has been undertaken to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2014, to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources.

2 Our 2019 structured assessment work has included interviews with officers and Independent Members (IM), observations at board and committee meetings, and reviews of relevant documents, performance and financial data.

3 The key focus of structured assessment is on the corporate arrangements for ensuring that resources are used efficiently, effectively and economically. This year, auditors paid critical attention to the progress made to address recommendations and opportunities for improvement identified in 2018 and previous years[1]. The report groups our findings under four themes – the Health Board's governance arrangements, strategic planning, managing financial resources and managing the workforce.

## Background

4 Our 2018 Structured Assessment concluded that the Health Board's strategic planning arrangements were generally sound, and while it had made some progress, significant improvements were still needed in governance, risk management and performance monitoring arrangements.

5 This year, the Health Board has improved its status under the NHS Wales Escalation and Intervention Framework. After spending three years under targeted intervention, in March 2019, Welsh Government de-escalated the Health Board to enhanced monitoring and then further de-escalated it to routine arrangements in September 2019. This was in recognition of the Health Board's improved financial position and improving performance, which contributed to the approval of its integrated medium-term plan (IMTP) in March 2019.

6 For 2018-19, the Health Board reported a financial deficit of £9.9 million, which was within the control deficit target agreed with Welsh Government. However, this position still contributed to a cumulative rolling 3-year deficit totalling £65.9 million at March 2019.

[1] In early 2020, we will be undertaking a review of the Health Board's quality governance arrangements, therefore we have not commented on this area of work. We have also not commented on information governance as we are conducting a separate follow-up review of previous recommendations.

7 For the same period, the Health Board delivered against its scheduled and unscheduled care profiles, which is an area the Health Board has continued to strengthen over the past few years by moving from quarterly to monthly profiling of Referral to Treatment Time targets (RTT). However, there are some areas of performance that need to be improved, such as urgent suspected cancer and outpatient follow-up backlogs.

8 The way in which the Health Board organises its clinical and corporate services is largely unchanged. However, there has been some turnover amongst board members. In April 2019, the Medical Director retired. Interim arrangements were put in place until the new Medical Director joined in July 2019. In June 2019, the Director of Transformation and Informatics (also the Deputy Chief Executive) took up post as the interim Chief Executive at Cwm Taf Morgannwg University Health Board. Interim arrangements are being put in place to cover her portfolio of responsibilities. In November 2019, the Director of Workforce and Organisational Development took on the role of interim Deputy Chief Executive. In August 2019, the Chair of the Health Board stood down and the Vice-Chair took over as interim Chair until a new Chair is appointed. An interim Vice-Chair was appointed in October 2019.

9 As this report provides a commentary on key aspects of progress and issues arising since our last structured assessment, it should be read with consideration to our 2018 review.

# Main conclusions

10 The overall conclusion from our 2019 structured assessment work is **the Health Board is strengthening processes that support board business, risk management and arrangements for tracking recommendations. It now has an approved IMTP, forecasts a breakeven position and is making progress in tackling workforce issues. But there are opportunities for improvement, these include; Board level performance reporting and scrutiny of IMTP delivery, flows of information between the senior management teams and the Board and addressing a large volume of outstanding audit recommendations.**

11 The Board is maturing and processes that support it are improving but there are issues with independent member capacity. We identified opportunities to improve the flows of information between Board and senior management team structures. There have been significant improvements to risk management, with the Board Assurance Framework now an integral part of the Health Board's risk management process.

12 The Health Board has strengthened its system for tracking recommendations and regulatory compliance. But this has highlighted an unacceptably high number of outstanding recommendations, which need to be addressed. The Health Board has started to review its performance management arrangements. But further work is

needed to ensure the Strategy and Delivery Committee has the right level of performance information to provide assurance to the Board.

13 For the first time in three years, the Health Board's IMTP received ministerial approval. But we found there is little scrutiny of its delivery at Board and committee level. The Health Board is nearly five years into delivering its long-term strategy to shape future population wellbeing, but progress in delivering it is slow.

14 The Health Board continues to improve its revenue financial position and is projecting to breakeven at the end of 2019-20 and meet its 3-year rolling revenue resource target by 2021-22. Arrangements for managing and monitoring budgets, cost improvement plans, and single tender actions are sound and there is good Board and committee oversight. But some policies are out of date and National Fraud Initiative data matches which could help detect undisclosed staff interests and procurement fraud are yet to be reviewed.

15 Workforce challenges remain, such as consultant job planning compliance, recruiting to some consultant posts and low appraisal rates. But the Health Board is progressing plans to tackle its issues, and this years has had success in recruiting nurses and delivering its culture and leadership programme.

16 We consider our findings in more detail in the following sections.

# Recommendations

17 Exhibit 1 details recommendations arising from this audit. The Health Board's management response to these recommendations and our final report will be available on our website once considered by the relevant committee. The Health Board will also need to address the outstanding recommendations made in previous years.

Exhibit 1: 2019 recommendations

| Recommendations |
|---|
| **Committee meeting frequency and timing** |
| R1 We found scope to review the timings and frequency of some committee meetings to support members to scrutinise current information more often. Reviewing timings will also allow maximum attendance at meetings. The Health Board should:<br>a) review the frequency of Audit Committee meetings to close the gap between the May and September meeting; and<br>b) review independent member's capacity and timings of committee meetings where there is infrequent independent member attendance. |
| **Performance Management Framework** |
| R2 We found that performance monitoring at an operational level is sound, but some information received by the Board and its committees need to be |

| Recommendations |
| --- |
| improved. When the Health Board restarts its performance framework review it should be extended to include:<br>• monitoring IMTP delivery on a quarterly basis and reporting the wholescale position to the Strategy and Delivery Committee and Board. We have previously suggested presenting the committee with a summarised version of the IMTP progress reports available at clinical board performance reviews.<br>• ensuring that the Strategy and Delivery Committee receives, the same or more, detailed performance information than that received by the Board.<br>• review the format and legibility of the performance dashboard currently reported to Board. |

# Detailed report

## Governance arrangements

18 As in previous years, our structured assessment work has examined the Health Board's governance arrangements. We looked at the way in which the Board and its committees conduct their business, and the extent to which organisational structures are supporting good governance and clear accountabilities. We considered the information that the Board and its committees receive to help it oversee and challenge performance and monitor the achievement of organisational objectives. We also reviewed the progress made in addressing our recommendations.

19 In 2019, we found that **the Health Board is strengthening processes that support board business and risk management. Arrangements for tracking recommendations have improved significantly but highlighted an unacceptably high number of outstanding audit recommendations. There is scope to improve performance reporting at Board and committee level and the flows of information between the senior management teams and the Board.** Findings are set out below.

### Conducting business effectively

The Board is maturing and processes that support it are improving but there are issues with independent member capacity. There are opportunities to improve the flows of information between Board and senior management teams

20 Our 2018 Structured Assessment found that the Health Board was taking steps to improve how the Board and its committees conducted business, but it had not yet achieved consistent good practice. This year the Health Board has developed a Corporate Governance Improvement Programme, which aims to re-establish basic governance processes and procedures that support the Board. The programme includes ensuring Standing Orders, Standing Financial Instructions, committee terms of reference and committee work programmes are up to date and the Health Board has appropriate systems for maintaining probity and propriety. The Health Board is making good progress on the improvement programme, but it is taking longer than intended. This is both because of capacity issues within the corporate governance team and because the team is ensuring existing systems are thoroughly reviewed and new processes implemented properly.

21 Our work in 2018 found that committee terms of reference and workplans were out of date. These have since been reviewed and in March 2019, the Board approved the appointment of nine committees for 2019-20, their terms of reference and work programmes. In May 2019, the Board approved its plan of business for 2019-20. Committee structures remain largely the same as last year, except for one new committee. The former Information, Technology and Governance Sub-Committee, is now a committee of the Board and has been renamed the Digital Health Intelligence Committee. It met for the first time in August 2019. Audit Committee

has also been renamed the Audit and Assurance Committee to better reflect its remit. When the terms of reference are next reviewed, the Health Board should minimise any overlap or duplication. It should also review arrangements for cross referring issues between committees.

22 The past two years has been a period of settling in for the Board, with new independent and executive members. During 2019, we have observed a growing maturity in the conduct, scrutiny and challenge at the Board and meetings of several committees[2]. The Health Board continues to work towards improving the quality of scrutiny by lifting the conversation from operational detail to strategic matters. This can be attributed to a more settled Board and committee structure, IMs growing in confidence and improving arrangements that support scrutiny.

23 However, through our observations we have also picked up some issues. The Quality, Safety and Experience Committee[3] has a sizeable agenda and papers. This raises the risk of the committee not focusing on the right areas. The membership of Audit and Assurance Committee was refreshed, and we have seen an improvement in the quality of discussion and scrutiny. But we are concerned about the irregular frequency of these meetings, with no meeting held between May and September each year. Overall, the Strategy and Delivery (S&D) Committee continues to bed in, its remit is clearer and there is a good level of scrutiny. Although we still have concerns about the limited information to enable scrutiny of performance and IMTP delivery.

24 In May 2019, the Board approved some changes in committee membership and Board champions. Most committees have three IMs including the chair. But we have found that the attendance of some IMs is variable which leaves meeting quoracy and therefore decision making at risk. For example, at the June 2019 S&D Committee meeting, only the chair was present. The interim Chair is aware of this issue and is looking to review committee membership. We would also suggest reviewing independent member's capacity and the timing of meetings to allow greater attendance. There are also vulnerabilities in terms of IM turnover. There has been one less IM since the chair left in August 2019, the chair of the Finance Committee is standing down as an IM in October 2019, and two IMs are waiting to be reconfirmed.a

25 The Health Board has recognised that its operational governance arrangements are not working optimally, so it is reviewing them. The intention is that the Health Service Management Board, which includes executive and clinical board leaders, will be the decision-making body. While the Management Executive Team, which includes the executive leaders, will act as a sounding board. The terms of

[2] As part of our structured assessment work, we observed several Board and committee meetings, in particular the Finance Committee, Strategy and Delivery Committee, Audit and Assurance Committee and Quality, Safety and Experience Committee (QSE).

[3] We will be observing more QSE Committee meetings as part of our upcoming audit of the quality governance arrangements.

reference for both groups are under review. However, the Health Board should extend this review to clarify what information should flow between these groups and the Board and its committees.

26 The Health Board's Standing Orders require committees to undertake an annual review of their effectiveness. The reviews were conducted for the first time in 2019 using an electronic survey. All committees, except for the Audit and Assurance Committee, have received feedback. Improvement plans were developed where answers to survey questions resulted in an 'adequate', 'needs improvement' or 'no response' response. A common issue highlighted through the review was timeliness of minutes. In response, the Corporate Governance Team has introduced a one-week deadline to prepare minutes and send them to respective committee chairs for ratification. Those we interviewed told us that the quality of the papers is improving and that the Health Board is committed to reducing the size of meeting papers. The cover template for Board and committee papers was updated last year and is working well, but further improvements are planned. Moving forward, cover papers, which are usually written by assistant directors, will be signed off by executive directors to ensure they highlight key messages.

27 Board development sessions take place bi-monthly. In July 2019, the Board received its 2019-20 development programme. Members had an opportunity to contribute to the draft plan. The board development plan is a live document that can be amended as needed. In future, the intention is to present the development plan to the Board at the end of the financial year. The Corporate Governance Team is also working to develop an induction programme for new IMs and members new to a committee.

28 Our Structured Assessment work in 2018 highlighted several weaknesses in systems of internal control that support board assurance. The Health Board has addressed these issues through its Corporate Governance Improvement Programme (paragraph 20). Specifically, it has reviewed its Standing Orders, which had not been reviewed since May 2015. In addition, an action plan addressing area of non-compliance with the Standing Orders was presented to the Board in March 2019. The Welsh Government issued its reviewed model standing orders in September 2019, with a directive to implement it by no later than 30 November 2019. The Scheme of Reservation and Delegation forms part of the Standing Orders, it was last reviewed in May 2015. This is listed as an area of non-compliance; an updated version was intended to be received by the Board in July 2019. This is still pending. The Heath Board also plans on updating its detailed scheme of delegation, which was last reviewed in February 2018.

29 The Health Board has not reviewed its Standing Financial Instructions since May 2015. However, the model Standing Financial Instructions are being reviewed and updated at an all Wales level with publication expected for the start of 2020-21. In the meantime, we would expect the Health Board to review annually documents that support the Standing Financial Instructions, such as the scheme of delegation, in line with the recommendation included in our 2018 structured assessment report.

30 Last year, we reported that internal audit had issued a limited assurance report on standards of business conduct, specifically focusing on arrangements for declarations of interest and gifts, hospitality and sponsorship. The Health Board has addressed internal audit's recommendations and was given substantial assurance in September 2019. The Health Board's policy on policies has been updated and is next due to be reviewed in 2020. The Health Board has identified that the current policy register, which lists over 400 documents, shows several out-of-date polices and a lack of consistency in the use of the terms policy, guidance, protocol and procedure. To address these issues the Health Board has developed a policy improvement programme. Progress is reported quarterly to Health Services Management Board and will also report to Management Executive.

31 In 2017 and 2018 we made several recommendations to improve governance arrangements. Exhibit 2 describes the progress made.

Exhibit 2: progress on 2017 and 2018 governance recommendations

| 2018 recommendations | Description of Progress |
|---|---|
| **Governance**<br>R3. The Health Board should:<br>a) Update the Scheme of Delegation to reflect the delegated responsibility for calculating nurse staffing levels for designated acute medical and surgical inpatient wards;<br>b) Review and update the Standing Orders and Standing Financial Instructions, ensuring these documents are reviewed and approved on an annual basis;<br>c) Improve the format of the registers for declarations of interest and gifts, hospitality and sponsorship and clarify the frequency with which the registers are presented to the Audit Committee;<br>d) Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date;<br>e) Review all committee terms of reference to make sure they are up to date, do not overlap, and are reviewed annually; and<br>f) Ensure all committees have an up-to-date work programme, which is linked to the cycle of Board meetings and reviewed annually. | **On track but not yet complete**<br>The Health Board is making good progress against our governance recommendations. The bullet points below detail progress:<br>a) **Pending** – the scheme of delegation does not yet reflect the delegated responsibility under the Nurse Staffing Levels (Wales) Act.<br>b) **Part complete** – the updated Standing Orders were approved by the Board in March 2019. The Standing Financial Instructions are yet to be reviewed.<br>c) **Complete** – standards of business conduct received substantial assurance in September 2019.<br>d) **Complete** – the policy on policies has been updated and a policy improvement programme is in place.<br>e) **Complete** – in March 2019, the Board approved the revised committee terms of reference.<br>f) **Complete** – all committee work programmes and Board plan of business approved in March and May 2019 respectively. |

| 2017 recommendations | Description of Progress |
|---|---|
| **Board/Committee papers**<br>R3. To enable effective scrutiny, the Health Board needs to improve the quality of its papers to Board and Committees by ensuring that the length and content of the papers presented is appropriate and manageable. | **Complete**<br>The Health Board has improved and is continuing to improve the quality of Board and committee papers. |
| **Finance Committee papers**<br>R4. To improve transparency, the Health Board needs to ensure that the Finance Committee papers are made available on its website in a timely manner. | **Complete**<br>Finance Committee papers are now consistently available on the Health Board's website prior to the meeting. |

## Managing risks to achieving strategic priorities

### The Health Board has made significant improvements to risk management, with the Board Assurance Framework now an integral part of its risk management process

32 Our 2018 Structured Assessment found that there were delays in revising the corporate risk and assurance framework, which meant the Board had insufficient oversight of strategic risks for almost one year. In November 2018, the Board approved its Board Assurance Framework (BAF), which replaced the corporate risk and assurance framework that we had been critical about in the past.

33 This year, we found the BAF is an integral part of the Health Board's risk management process. The BAF is now a standard Board agenda item and improvements have been made over the year. For example, the document now highlights changes such as to the risk score or actions to mitigate risks. Before the BAF is presented to the Board it is reviewed by the executive leadership team and updated by the risk owning executive and the Director of Corporate Governance. To provide assurance to the Board, individual risks are assigned to and reviewed by the relevant committees.

34 Development, maintenance and scrutiny of the BAF is part of the Health Board's risk management improvement programme, which was approved by the Board in November 2018. This work has good Board oversight and the changes to risk management processes is helping to ensure better scrutiny. The Health Board has made good progress against the improvement programme.

35 At its Board development day in April 2019, the Health Board assessed its current risk appetite[4] as 'cautious'. The Risk Management and Board Assurance Framework Strategy, which was approved by the Board in July 2019, states that

[4] The Board assessed its risk appetite using the Good Governance Institute Matrix for NHS Organisations.

the Board's risk appetite will be reviewed on an annual basis. To support the strategy, a risk management procedure has been developed. The Director of Corporate Governance, who is responsible for risk management, is rolling out training on the procedure to Corporate Directorates and Clinical Boards.

36 The Corporate Governance Team has been reviewing the risk registers for the corporate directorates and clinical boards to understand how risk is managed and to introduce a more consistent approach. This work is an integral part of developing the Health Board's corporate risk register, which will include operational risks with a risk score of 20 and above. On occasion, clinical boards and corporate directorates may have risks scoring less than 20 which they feel they cannot mitigate. The Health Board should ensure it has a system to escalate and manage such risks. Currently, there are concerns that some clinical boards are over scoring risks, which would overburden the corporate risk register. However, training on the risk management procedure should, over time, help reduce this risk as risk owners learn to score appropriately.

37 The Health Board is taking a phased approach to developing its corporate risk register. The first draft will be presented to the Board at its meeting in November 2019. This version will not be perfect but will improve over the year, and as operational risk registers strengthen. In the interim, clinical boards and corporate directorates will be asked to provide their top three to five risks to the Director of Corporate Governance using the new risk management procedure. The corporate risk register will be reported to the Health Services Management Board prior to the Board. Currently, the Health Board's risk management systems are paper based. It plans to implement the DATIX web-based risk system by April 2020.

38 In 2017, we made one recommendation in relation to risk management. Exhibit 3 describes the progress made.

Exhibit 3: progress on 2017 risk management recommendation

| 2017 recommendations | Description of Progress |
|---|---|
| **Risk management**<br>R5. The Health Board needs to strengthen its corporate risk assurance framework (CRAF) by:<br>• mapping risks to the Health Board's strategic objectives;<br>• reviewing the required assurances;<br>• improving clarity of risk descriptors; and<br>• clarifying to the reader the date when risks are updated and/or added. | **Complete**<br>The corporate risk assurance framework has been replaced by the BAF which is now an integral part of the Health Board's risk management process and is reviewed at Board and executive level. |

## Embedding a sound system of assurance

### The Health Board has strengthened its system for tracking recommendations and regulatory compliance, but this has identified an unacceptably high number of outstanding recommendations

39 Our 2018 Structured Assessment highlighted ongoing weaknesses in the Health Board's system for tracking internal and external recommendations. Echoing some of our concerns, internal audit issued a limited assurance report on legislative compliance, in February 2019. This highlighted issues such as the poor format of the tracking report, not having a comprehensive list of required regulators and completed actions not being supported by evidence. The Health Board has acted on internal audit's recommendations and as a result a follow-up review in September 2019 gave reasonable assurance.

40 In response to our recommendations and those of internal audit, the Corporate Governance Team has updated systems to track internal and external recommendations and regulatory compliance. As recommended in last year's Structured Assessment, the Health Board reviewed all outstanding internal and external recommendations and reported the findings to Audit and Assurance Committee in September 2019. This exercise revealed that the Health Board has an unacceptably large volume of outstanding recommendations, 201 in total[5]. To improve this position the Corporate Governance Team has started to follow-up recommendations with executive leads on a quarterly basis. Executive and clinical board leads will discuss future audit reports. The trackers are 'work in progress', but the Audit and Assurance Committee will be able to take greater assurance from the tracking system as it improves and becomes established. However, the Health Board should consider using the clinical board performance reviews to hold services to account on outstanding recommendations. In addition, future iterations of the trackers should highlight common weaknesses and themes highlighted by inspectorates. The trackers are live documents and the Health Board should ensure there is adequate capacity within the corporate governance team to maintain this system.

41 The legislative and regulatory compliance tracker lists all regulatory bodies that inspect the Health Board and the regulatory standard being inspected. Each standard and/or body has a lead executive and assurance committee where inspection reports and action plans will be presented. The tracker also lists, where information is available, inspection cycles, current and future inspection dates, where inspections were undertaken 10 or more years ago and the outcome of inspections. The Health Board intends on simplifying this tracker by developing a

[5] There are 49 outstanding Wales Audit Office recommendations made between 2017-18 and 2019-20. 152 internal audit recommendations made in 2017-18 and 2018-19 are outstanding. The main tracker goes back to 2013-14.

visual dashboard, like one used by the Clinical Diagnostics and Therapies Clinical Board.

42 Exhibit 4 describes the progress made in addressing our 2017 Structured Assessment recommendations and our 2018 recommendation on recommendations tracking.

Exhibit 4: progress on 2017 Structured Assessment recommendations and 2018 recommendation on recommendations tracking

| 2018 recommendations | Description of Progress |
|---|---|
| **Progressing 2017 recommendations**<br>R1. The Health Board should complete our 2017 structured assessment recommendations by the end of 2019. Recommendations related to planning savings targets, quality of information, committee administration, risk management and performance reporting. | **On track but not yet complete**<br>The Health Board is making progress against our 2017 recommendations[6]. The recommendations are detailed in our 2017 Structured Assessment report. |
| **Audit recommendation tracking**<br>R2. The Health Board should improve its recommendation tracking by:<br>a) addressing our outstanding 2016 structured assessment recommendation to strengthen tracking arrangements for external audit recommendations;<br>b) including the tracking of internal audit recommendations; and<br>c) completing a review of all outstanding internal and external audit recommendations and reporting the findings to the Audit Committee. | **Complete**<br>The Health Board now has trackers in place for internal and external audit recommendations and for legislative and regulatory compliance. The Health Board has reviewed all outstanding internal and external recommendations and reported these findings to the Audit and Assurance Committee in September 2019. |

[6] We cannot comment on recommendations related to information governance until we have completed our separate follow-up review of previous recommendations.

## Performance management arrangements

The Health Board has started to review its performance management arrangements. Further work is needed to ensure the Strategy and Delivery Committee has the right level of performance information to provide assurance to the Board

43 Last year we found the Health Board's performance management framework had not been reviewed since 2013. It therefore did not reflect current organisational structures and performance arrangements. The Health Board had started to review its performance management arrangements by reviewing and mapping how and where performance is scrutinised. An initial paper was presented to the S&D Committee in April 2019, but progress stalled because of a sudden gap in capacity within the executive team. The Health Board intends on restarting this work but it should extend this work to take account of the issues highlighted below and to improve scrutiny of IMTP delivery (see paragraph 52).In previous years, we found that performance management arrangements were sound at an operational level but there were weaknesses at a strategic level because performance information reported at committees was less detailed than that reported to the Board. Since April 2019, the S&D Committee receives a cover report with a high-level summary narrative to accompany the tier 1 target performance data. Whilst this is an improvement on previous years it is still less detailed than that received by the Board. The Finance Committee scrutinises financial performance in detail and the Board receives assurance through a summary report of the financial position. A similar system should be in place for providing assurance on key performance measures. The performance dashboard is presented at each Board meeting with accompanying narrative on areas of performance that have been prioritised by the Board. The format of the performance dashboard is not easy to read, the font is too small and becomes blurry when the page is expanded. The Health Board should review the content and format of performance reporting at Board and committee level.

44 As reported in previous Structured Assessments, the Health Board has performance review and escalation arrangements for the clinical boards. As at September 2019, three clinical boards - Specialist, Medicine and Surgery - have been escalated because of concerns around financial performance and activity.

45 The performance dashboard, which shows national and local measures, was presented to Board in September 2019. As at August 2019, out of the 70 performance indicators presented, 23 were rated green, 21 were rated amber and 26 rated red. The Annual Plan for 2018-19 includes Welsh Government's summary of the Health Board's performance against the outcome's delivery framework measures. It shows that the Health Board's performance had improved against 35 measures, was sustained against 2 and performance declined against 30 measures. Particular areas for improvement include performance against urgent suspected cancer targets and outpatient follow-up backlogs.

46 In 2017 and 2018 we made recommendations in relation to performance management. Exhibit 5 describes the progress made.

Exhibit 5: progress on 2017 and 2018 performance management recommendations

| 2018 recommendations | Description of Progress |
|---|---|
| **Performance management**<br>R4. The Health Board should update its performance management framework to reflect the organisational changes that have taken place since 2013. | **On track but not yet complete**<br>The Health Board has started to review its performance management arrangement, but progress stalled because of capacity issues in summer 2019. |
| **2017 recommendations** | **Description of Progress** |
| **Performance reporting**<br>R7. The Health Board needs to ensure that the level of information reported to the Resource and Delivery Committee on performance is sufficient to enable the Committee to scrutinise effectively. This should include:<br>a) 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;<br>b) See Exhibit 9 for recommendation on workforce metrics. | **Superseded by 2019 recommendation**<br>The S&D Committee now receives summary narrative to accompany performance data. But the detail provided is still less than that received by the Board. The Health should review performance reporting as part of its review of performance management arrangements (see Exhibit 1; and Recommendation 4 above). |

# Strategic planning

47 Our work considers how the Board sets strategic objectives for the organisation and how well the Health Board plans to achieve these, using the resources that it has, or can, make available. We also examine the Health Board arrangements for monitoring progress against its objectives and the difference it is making.

48 In 2019, we found that **the Health Board has an approved IMTP for the first time in three years, but there is little scrutiny of its delivery by the Board or its committees. The Health Board is nearly five years into delivering its long-term strategy to shape future population wellbeing, but progress is slow.**

49 This year the Health Board has taken steps to streamline its IMTP planning process and progress plans that underpin its long-term strategy to shape future population wellbeing (10-year strategy), but it needs to increase the pace of

delivery. We also found that the Health Board needed to improve scrutiny of IMTP delivery at Board and committee level.

50 As reported in previous years, the Shaping our Future Wellbeing Strategy (10-year strategy) sets out the Health Board's vision and strategic objectives, these were developed in 2015. The Health Board is nearly five years into the life of the strategy, but we have concerns about the pace of delivery. In April 2019, the S&D Committee received a mid-way progress report on delivery against strategic objectives. Whilst a helpful summary, IMs commented that the summary did not show what was left to do and milestones for delivery. In addition to the 10-year strategy and to support the next phase of its implementation, the Health Board is currently further developing its Clinical Services Plan. The Shaping Our Future Wellbeing in the Community programme, which is aligned to the emerging Clinical Services Plan, sets out proposals for developing the infrastructure plans to support the model of care already described in Shaping Our Future Wellbeing. It will be important to ensure that the Clinical Services Plan and the infrastructure plan includes the next phases of Shaping Our Future Wellbeing in the Community. The plan for community services is further ahead with business cases in place for three wellbeing hubs and one centre. The plan for hospital services is still in draft, with plans to engage staff and stakeholders during November and December 2019. We note that the hospital service plan is for 2019-29, which covers a different timeframe than the main strategy.

51 The IMTP is the main delivery vehicle for the 10-year strategy. In January 2019, the Board approved the Health Board's IMTP prior to submission to Welsh Government and in April 2019, the IMTP received ministerial approval for the first time in three years. Approval of the IMTP contributed to the de-escalation from Welsh Government's targeted intervention to routine arrangements in September 2019. The Health Board has streamlined its IMTP to focus on six core priority areas, one of which is achieving financial balance. The IMTP is also underpinned by several plans, including the estates strategy, workforce plan and some clinical board plans.

52 In July 2019, the Board received an update setting out the process for refreshing the IMTP, which also provided a set of initial priorities for 2020-21. The Health Board is working towards a January 2020 Welsh Government submission date. In order to develop a collective IMTP, the Health Board held a joint workshop session with clinical boards and executive leaders. In general, the Health Board reported that there is less silo working. This is largely attributed to the challenge posed by executives at clinical board performance reviews. Silo working should reduce further once all corporate services and executives have moved to the new headquarters at Woodland House. Those we interviewed reported that there is good IM engagement in the IMTP planning process.

53 We have previously raised the need for better scrutiny of annual plan delivery. This is still the case for this year's IMTP. The S&D committee receives progress reports on individual IMTP projects and programmes. It does not receive an overall or collated progress summary against all IMTP deliverables. The purpose of the BAF

is to highlight and mitigate keys risks to achieving the Health Board's strategic objectives. The IMTP is the key plan for delivering the strategic objectives. If the S&D committee and the Board are unable to scrutinise overall delivery this leaves a gap in assurance. We have previously suggested presenting the committee with a summarised version of the IMTP progress reports available at clinical board performance reviews.

54 In 2018, we reported that the Health Board had developed a transformation programme to support the implementation of its 10-year strategy. There are five workstreams[7], each with an executive lead and at different stages of progress. The culture and leadership workstream, branded Amplify 2025, is visible and ambitious. The Health Board has a learning alliance with Canterbury Health Board in New Zealand and is employing similar methods of engagement. In July 2019, the Health Board held its first Amplify 2025 event. The event aimed to get the 80 participating staff to think differently about delivering healthcare. The Health Board is planning the next phase of Amplify 2025, which is a showcase experience inviting up to five thousand people including staff, partners and patients to attend. The showcase will be a two-hour experiential walk through the Health Board's system, incorporating both current and future models of delivering care.

55 Aspects of other workstreams are also starting to deliver. For example, the Health Board is rolling out a system which allow decisions to be made on real-time patient flow data (Lightfoot Solutions). The Health Board has introduced a healthcare pathways website, rolling out pathways for services under the greatest pressure first. It is also in the early stages of developing the Patient Knows Best portal, which aims to help patients avoid unnecessary follow-up appointments by supporting their recovery.

# Managing financial resources

56 We considered the action that the Health Board is taking to achieve financial balance and create longer-term financial sustainability. We have assessed the financial position of the organisation, the approach to financial planning, financial controls and stewardship, and the arrangements for financial monitoring and reporting. We also reviewed the progress made in addressing our recommendations

57 We found that **the Health Board continues to improve its revenue financial position and is projecting to breakeven at the end of 2019-20 and meet its 3-year rolling revenue resource target by 2021-22. Financial management, monitoring and Board and committee oversight are sound. But some policies are out of date and National Fraud Initiative data matches related to potential procurement fraud are yet to be reviewed**. Our findings are set out below.

[7] The five transformation workstreams are: health pathways, alliancing, culture and leadership, digitally enabled organisation and accessible information.

## Financial performance and planning

The Health Board continues to improve its revenue financial position and cost improvement plans. It is projecting that it will achieve a breakeven financial position at the end of 2019-20 and anticipates meeting its 3-year rolling revenue resource target by 2021-22

58 The Health Board has consistently met its capital resource limit both for the annual limit and three-year limit. The Health Board expects to meet the capital resource limit for 2019-20. In terms of revenue funding, for 2018-19 the Health Board exceeded its annual and three-yearly expenditure limits for net revenue. Consequently, the Auditor General qualified his regularity opinion in the Health Board's annual financial statements. The Health Board did, however, achieve the £9.9 million control total revenue position that had been agreed with Welsh Government. This was achieved with additional funding totalling £10 million provided by the Welsh Government.

59 For 2019-20, the Health Board expects to operate within its annual revenue resource limit. However, given the deficit position of the previous two years (£26.9 million in 2017-18 and £9.9 million in 2018-19) it will not meet its statutory financial duty to break even over the three-year rolling period up to 2019-20. The rolling three-year deficit up to 2018-19 is £65.9 million. In addition, the Health Board's cumulative deficit since the introduction of the 3-year rolling resource limit in 2014-15 is £87.2 million.

60 The Health Board's financial returns to Welsh Government for month five show that achieving an
in-year breakeven position at the end of 2019-20 will be a challenge. The Health Board's net revenue expenditure at the end of August 2019 exceeded the profiled position by £2.8 million. This is an increase in the profiled deficit position of £1.8 million at the end of June 2019.

61 We reported last year that the Health Board had effective arrangements for identifying savings and developing savings plans. The savings target for 2018-19 was £33.8 million, which the Health Board exceeded by £0.8 million. In order to breakeven at the end of 2019-20, the Health Board has set a savings targets of £31.2 million. The target is broken down as:

- 2% (£16.4 million) recurrent savings target devolved to the clinical boards; and
- 1.8% (£14.9 million) recurrent savings target, which are managed corporately and mainly delivering via high value opportunities.

62 As at month five, the Health Board revised its savings target downwards from £31.2 million to £26.1 million to reflect the release of £2.1 million relating to the

Health Board's remaining investment reserve and a further £2.8 million to reflect an operational underspend on Weqas[8].

63 The Health Board has addressed our 2017 recommendation by changing the basis of its cost improvement (CIP) targets from 2019-20 by:

- eliminating non-recurrent savings targets;
- all clinical boards having a 2% recurrent target, centred on core efficiencies, but with the expectation of finding further savings opportunities beyond their delegated target; and
- including an extra cost improvement target of no more than 2%, based on benchmarking data and significant service changes.

64 Our review of the cost improvement plan target for 2019-20 confirms that the Health Board has incorporated the above changes into its plan and that as at August 2019 (month five) has identified savings, and is on track, to fully achieve its savings target of £26.1 million.

65 The Health Board has a robust system for monitoring its cost improvement plans, which includes: oversight by the Cost Improvement Board, Finance Committee and at clinical board performance reviews. In addition, monthly and weekly monitoring reports are produced for each clinical board. Where cost improvement plans are not being achieved, clinical boards are subject to the Health Board's escalation process, which was updated in early 2018. In December 2018, internal audit gave the Health Board's cost improvement programme substantial assurance.

66 The Health Board is improving its understanding and reporting of activity and associated cost drivers. It has implemented the All Wales Costing System 'PCG monitoring', which replaces the previous 'Synergy' system. The Health Board has already seen benefits from the implementation of the new system, for example significant time savings when producing the 2017-18 Welsh Costing Returns. In April 2019, the Finance Committee received a progress update on the system as per our 2018 recommendation.

67 In 2017 and 2018 we made the following recommendations in relation to financial planning. Exhibit 6 describes the progress made.

Exhibit 6: progress on 2017 and 2018 financial planning recommendations

| 2018 recommendation | Description of Progress |
|---|---|
| **Financial planning**<br>R5. The Health Board should provide the Finance Committee, or Board, with an update on progress with its testing and | **Complete**<br>An update was provided to Finance committee in April 2019. In addition, the Health Board has now fully implemented the All Wales Costing System. |

[8] Weqas is a quality assessment provider for laboratory medicine. It is an independent organisation that is hosted by the Health Board.

| | |
|---|---|
| delivery of the All Wales Costing System Implementation Project. | |
| **2017 recommendation** | **Description of Progress** |
| **Saving targets**<br>R1. For 2018-19, the Health Board needs to use intelligence such as benchmarking data to identify stretch targets on a case-by-case basis in areas where greater levels of savings could be made. | **On track but not yet complete**<br>Whilst the Health Board has improved the basis of its cost improvement targets, it is still in the processes of making further improvements. |

## Financial management and controls

The Health Board has a clear framework for managing and monitoring its budgets and has a new system which is reducing the number of single tender actions. However, some policies are out of date and National Fraud Initiative data matches related to potential procurement fraud are yet to be reviewed

68 Our 2018 Structured Assessment identified some weaknesses in the documentation that supports the systems of internal control. As outlined above, the Health Board is taking steps to address weaknesses in governance and systems of control, in particular updating the Standing Financial Instructions and detailed Scheme of Delegation, both of which need review (see Paragraph 28). We also found that the counter fraud policy[9] and the capital management procedure are out-of-date (review dates June 2014 and February 2019 respectively). These documents should be updated in line with the Health Board's recently reviewed policy on polices.

69 The Health Board has a clear framework in place for managing and monitoring its revenue and capital budgets. Revenue budgets together with savings targets are devolved to clinical boards who have responsibility for setting and monitoring their budget areas. Each clinical board's budget is further allocated to individual budget holders, who are responsible for monitoring their budgets on a monthly basis. Clinical boards are supported by senior business partnering teams who provide support and assistance in the monthly monitoring process together with scrutiny and challenge on the monthly budget position. Capital budget monitoring is delegated to the Assistant Director of Planning (Capital and Estates) who has the responsibility for ensuring that the Health Board stays within its Capital Resource Limit on an annual basis. At an operational level, the Assistant Director of Planning delegates monitoring of individual capital budgets to nominated budget holders.

[9] The Auditor General is undertaking further work to examine the effectiveness of counter fraud arrangements across the public sector in Wales, with a view to publishing his findings in summer 2020. His work will be informed by local fieldwork commencing in late 2019.

70 Our 2018 structured assessment found that the Health Board has effective arrangements for monitoring procurement activity and spend. In February 2019, the Audit and Assurance Committee received an internal audit report giving contract compliance reasonable assurance. Internal audit found that whilst processes and procedures were in place, testing found several instances where staff could not provide evidence that they had obtained quotations prior to raising purchase orders and one instance where a full tender exercise should have been undertaken.

71 In terms of single tender actions, we found the Health Board has processes in place for identifying non-compliance and to manage and reduce the number of single tender actions. Approved single tender actions are reported at each Audit and Assurance Committee together with details of non-compliance with tender procedures. To help reduce the number of single tender actions, in April 2019 the Health Board introduced a new system called 'MultiQuote', which is a sourcing service that enables buyers to investigate the market and find suppliers quickly and easily. The new system is making a difference. In the six months between April and August 2019, 35 single tender actions were reported to Audit and Assurance Committee compared with 66 in the four-month period between December and March 2019.

72 The NFI is a biennial data-matching exercise that helps detect fraud and overpayments by matching data across organisations and systems to help public bodies identify potentially fraudulent or erroneous claims and transactions. It is a highly effective tool in detecting and preventing fraud and overpayments and in helping organisations to strengthen their anti-fraud and corruption arrangements. Participating bodies submitted data to the current NFI data matching exercise in October 2018.

73 In January 2019, the Health Board received 6,983 data-matches through the NFI web application. Whilst we would not expect organisations to review all data-matches, some of the matches are categorised as 'recommended matches. These are matches considered to be of high risk and therefore recommended for early review. The Health Board's matches included 823 recommended matches. The NFI web-application, which records the findings of the Health Board's review of its data-matches, shows that as at 15 October 2019, the Health Board had concluded or was in the process of reviewing most of the high-risk matches. The Health Board has generally made good progress in addressing the NFI matches. However, we note that Health Board does not appear to have reviewed matches between payroll, creditor payment and Companies House data. These are important matches because they can help to identify undisclosed staff interests and procurement fraud. We therefore recommend that the Health Board review these data-matches as a matter of urgency.

74 In 2018 we made the following recommendations in relation to NFI matches. Exhibit 7 describes the progress made.

Exhibit 7: progress on 2018 National Fraud Initiative matches recommendation

| 2018 recommendation | Description of Progress |
|---|---|
| **National Fraud Initiative matches**<br>R6. The Health Board should ensure that all recommended matches from the next NFI exercise in January 2019 are reviewed and where necessary investigated in a timely manner. | **On track but not yet complete**<br>Whilst the Health Board has generally made good progress in addressing the NFI matches, it should review matches between payroll, creditor payment and Companies House data as a matter of urgency. |

## Oversight and scrutiny of financial performance

### Oversight and scrutiny of financial performance at Board and committee level is strong

75 The Health Board has a clear process in place for monitoring monthly budgets, which ensures that all relevant information is captured, analysed and reported to Finance Committee, the Board and to Welsh Government. The Health Board has clearly defined roles for monitoring and reporting of financial performance, providing sufficient scrutiny and challenge. The Finance Committee, which meets on a monthly basis receives in depth financial reports that are generally well structured and informative. The level of detail included is sufficient and appropriate to allow committee members to adequately scrutinise the financial position. Sufficient time is given to members to allow them to scrutinise and challenge the financial position before and during meetings. Financial reports set out data along a traditional format of income, pay and non-pay expenditure, cash flows and important capital schemes. This aligns with monthly reporting to Welsh Government. The Board receives assurance through a summary report of the financial position. The report is an integral part of the performance report.

# Managing workforce productivity and efficiency

76 We considered the action that the Health Board is taking to ensure that its workforce is well managed and productive. We also assessed arrangements for addressing training and development needs and action to engage and listen to staff and address wellbeing needs. We reviewed the progress made in addressing our recommendations.

77 We found that **workforce challenges remain, such as consultant job planning compliance, recruiting to some consultant posts and low appraisal rates. But the Health Board is progressing plans to tackle its issues, with success in recruiting nurses and delivering its culture and leadership programme.**

78 Our 2018 Structured Assessment found that the Health Board was developing plans to tackle its workforce challenges but had failed to address consultant job planning. This year, whilst workforce challenges remain the Health Board is making

progress to tackle them. The Health Board has had success in recruiting nurses and delivering culture and leadership transformation workstream (branded Amplify 2025).

79 Last year we reported that compared with the Wales average, the Health Board's performance against some key workforce measures was mixed. Exhibit 6 shows performance as at July 2018 and 2019, and the Wales average at July 2019.

Exhibit 8: performance against key workforce measures, July 2018 and 2019

| | Health Board July 2018 | Health Board July 2019 | Health Board July 2018 compared to 2019 | Wales average July 2019 |
|---|---|---|---|---|
| Sickness average | 5.1% | 5.2% | ↑ | 5.4% |
| Turnover | 9.8% | 10.4% | ↑ | 7.1% |
| Vacancy | 3.2% | 2.3% | ↓ | 2.9% |
| Appraisal | 61% | 56% | ↓ | 70% |
| Statutory and mandatory training | 75% | 77% | ↑ | 80% |

Source: NHS Wales Workforce Dashboard, Health Education and Improvement Wales, July 2018 and 2019

80 Exhibit 8 shows that sickness rates have risen slightly (by 0.1%) since last year, but the Health Board's performance is better than the Wales average (by 0.2%). In April 2019, the S&D Committee received a deep dive on sickness absence along with the 'maximising attendance plan' to address issues. The deep dive revealed that anxiety and stress is the biggest reason for sickness absence. In response to this, in September 2019, the Board of Trustees agreed to fund the employee wellbeing service through the Cardiff and Vale Health Charity.

81 The Health Board reported that a lot of work has gone into nurse recruitment this year, using a range of social media and open days to attract staff. As a result, the Health Board has appointed several overseas candidates and there are potential candidates through other recruitment initiatives. Exhibit 8 shows that the Health Board has reduced its vacancy rate by 0.9% since last year and its performance is 0.6% better than the Wales average. This equates to 105 fewer vacancies than last year, with over half (54% or 57 staff) attributed to a rise in nursing and midwifery staff. The Health Board is also working with the Apprenticeship Academy and its

local authority partners to offer apprenticeships to 16-19-year olds, an age group that is currently underrepresented. The Health Board is playing its part in promoting value-based healthcare and increasing staff skill mix. For example, it is leading on an endoscopy curriculum to train nurses for Wales. However, some consultant posts remain challenging to fill. For example, interventional radiologists and specialists in operating theatres.

82 Since last year, the Health Board's appraisal rate has fallen by 5% and is 14% below the Wales average (Exhibit 8). The Health Board has revised the Personal Appraisal Development Review (PADR) process and in June 2019 introduced the Values Based Appraisal (VBA). The focus of the PADR is performance, what staff are doing and pay progression. Whilst these elements remain, the annual VBA is a discussion about expected values and behaviours, development needs and aspirations. This new approach hopes to promote the organisation's culture, manage talent and help with succession planning. Training on VBA is being rolled out to senior managers and includes encouraging managers to using a coaching style to encourage positive discussions with staff.

83 Job planning compliance at the Health Board is still a challenge. In September 2019, the S&D Committee received the workforce performance dashboard for June 2019. It shows that 89% of consultants had job plans recorded of which only 27% had been reviewed within 12 months[10]. At the September 2019 Audit and Assurance Committee, the new Medical Director gave a verbal update on his ambitions for job planning. He aims to standardise job planning and introduce a centralised system for recording them, but no timeframe was specified.

84 In 2017, we recommended the Health Board expand the range of performance metrics reported to S&D Committee to include a broader range of workforce KPIs. In June 2019, the Health Board introduced a new format for its key workforce indicators. The report, which shows 18 KPIs, is clearly presented and was well received by the committee. Since April 2019, the committee receives the workforce performance dashboard at each of its meetings. Whilst there is no narrative accompanying the dashboard, the committee receives regular deep dives on underperforming workforce areas.

85 In 2018, the Health Board told us it would be running 180-degree reviews for its top leaders (band 8 and above). The reviews aim to understand current leadership styles with a view to introducing a coaching, high-trust less bureaucratic style. The Health Board told us that to date, 40 leaders have had their review. The 180-degree review was conducted by an external company called Korn Ferry. Each leader received an individual report. Korn Ferry presented high-level results to the 40 leaders collectively to show the organisation's current leadership style. The Health Board is about to run the review with another 40 leaders. The Health Board plans on training a pool of staff to conduct 180-degree reviews internally.

[10] As part of next year's programme of local work, we will be following up recommendations made through our NHS consultant contract reviews.

86 Since 2018, the Health Board has improved its statutory and mandatory training by 2%, but it is 3% below the Wales average of 80%. The Health Board is continuing to review statutory and mandatory training requirements for different roles. To date, training at level one and two is role appropriate but further work is needed to review level three and four training.

87 In response to last year's NHS staff survey the Health Board established an employee stakeholder group, chaired by the Executive Director of Workforce and Organisational Development, to consider the results of the survey and develop an action plan. The working group was made up of around 50 staff volunteers from across the organisation. In April 2019, the action plan was presented to the S&D Committee. The action plan centres around four main themes: engagement, leadership, culture and behaviour and involvement. A staff survey steering group has been set up to drive the action plan forward, but as yet it has not reported back to the S&D Committee.

88 In 2017 we made the following recommendation in relation to the workforce performance report. Exhibit 9 describes the progress made.

Exhibit 9: progress on 2017 workforce performance report recommendation.

| 2017 recommendation | Description of progress |
|---|---|
| **Performance reporting**<br>R7. 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:<br>a) See Exhibit 5 for recommendation on Strategy and Delivery Committee performance reports.<br>b) 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 (this was superseded by the Strategy and Delivery Committee). | **Complete**<br>The Health Board has introduced a new, clear dashboard for its key workforce indicators, which is supported by regular deep dives presented to the S&D Committee. |

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

# Structured Assessment 2019 – management response to audit recommendations

## Cardiff and Vale University Health Board

Audit year: 2019

Date issued: November 2019

Document reference: 1604A2019-20

# Introduction

1. We have concluded our 2019 Structured Assessment of Cardiff and Vale University Health Board. As part of this work, we made a number of audit recommendations to the Health Board. These are set out with our findings and conclusions, in our full report which will be uploaded to our website once considered by the appropriate committee.

2. This document sets out the Health Board's management response and the actions it intends to take to address our 2019 structured assessment recommendations.

3. Any enquiries regarding re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

# Cardiff and Vale University Health Board: management response

The following table sets out the Health Board's management response to our 2019 structured assessment audit recommendations

| Recommendation | Management response | Completion date | Responsible officer |
|---|---|---|---|
| **Committee meeting frequency and timing** | | | |
| R1 We found scope to review the timings and frequency of some committee meetings to support members to scrutinise current information more often. Reviewing timings will also allow maximum attendance at meetings. The Health Board should: | | | |
| a) Review the frequency of Audit Committee meetings to close the gap between the May and September meeting. | Agree this can be achieved an additional meeting will be added in for July which will also coincide with other meetings taking place in July 2020. | December 2019 | Director of Corporate Governance |
| b) Review independent member's capacity and timings of committee meetings where there is infrequent independent member attendance. | This is already under review with the change in Chair and Vice Chair. Current proposals include increasing the membership of each Committee to ensure the meetings are quorate. | December 2019 | Director of Corporate Governance / Interim Chair of the Board |

| Recommendation | Management response | Completion date | Responsible officer |
|---|---|---|---|
| **Performance Management Framework** | | | |
| R2 We found that performance monitoring at an operational level is sound, but some information received by the Board and its committees need to be improved. When the Health Board restarts its performance framework review it should be extended to include: | | | |
| • Monitoring IMTP delivery on a quarterly basis and reporting the wholescale position to the Strategy and Delivery Committee and Board. We have previously suggested presenting the committee with a summarised version of the IMTP progress reports available at clinical board performance reviews. | Agree to recommendation. The flash report which is used for Performance Reviews will be sent to Strategy and Delivery of a quarterly basis. | December 2019 we will start from the beginning of the New year and send to the S&D Committee in January 2020. | Executive Director of Strategic Planning |
| • Ensuring that the Strategy and Delivery Committee receives, the same or more, detailed performance information than that received by the Board. | Agree to the recommendation. The performance information is currently under review alongside other performance information to the Committees to ensure a consistent approach and that assurance can then be appropriately provided to the Board from each Committee. | January 2020 | Director of Digital and Health Intelligence |

| Recommendation | Management response | Completion date | Responsible officer |
|---|---|---|---|
| • Review the format and legibility of the performance dashboard currently reported to Board. | Agree with recommendation. The Committees of the Board will all be considering their respective KPIs and they will then provide assurance to the Board. The dashboard will be presented in a format which is legible and clearly identifies the areas for concern and what is happening with them. | March 2020 | Director of Digital and Health Intelligence |

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

# Implementing the Well-Being of Future Generations Act – **Cardiff & Vale University Health Board**

Audit year: 2019

Date issued: November 2019

Document reference: 1509A219-20

This document has been prepared as part of work performed in accordance with statutory functions, including s15 of the Well-being of Future Generations (Wales) Act 2015.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, the Wales Audit Office and relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at info.officer@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.

The team who delivered the work comprised Emily Howell and Urvisha Perez.

# Contents

The Health Board has a good understanding of the sustainable development principle which it clearly considered when developing corporate arrangements and embodying the social model of care in the development of health and well-being centres and well-being hubs, but recognises there is more to do.

## Appendices

# Summary report

## Background

1 In accordance with the Well-being of Future Generations (Wales) Act 2015 (the Act) the Auditor General for Wales (the Auditor General) is statutorily required to examine public bodies to assess the extent to which they have acted in accordance with the sustainable development principle when:

a. setting their well-being objectives; and

b. taking steps to meet them.

2 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.'

3 The Auditor General must provide a report on his examinations to the National Assembly for Wales at least a year before each Assembly election. The first such report must be published by 2020, before the 2021 Assembly election.

4 In May 2018, the Auditor General published a preliminary report, **Reflecting on Year One – How have public bodies responded to the Well-being of Future Generations Act (2015)**. He concluded that public bodies support the principles of the Act and are taking steps to change how they work.

5 During 2018 and 2019, the Auditor General is undertaking examinations across the 44 bodies covered by the Act to inform his 2020 report to the National Assembly. In developing our approach to undertaking the examinations, we engaged with a range of stakeholders and carried out pilot work during 2017-18. We have also worked closely with the Future Generations Commissioner.

6 The preliminary work we undertook in 2017 included a consideration of how public bodies had set their well-being objectives. The principal focus of our 2019 work is the way in which public bodies are taking steps to meet their well-being objectives.

7 We undertook our fieldwork at Cardiff and Vale University Health Board (the Health Board) between June and July 2019.

## Focus of the work

8 We reviewed the extent to which the Health Board is:

- applying the SD principle and the five ways of working in order to do things differently;
- embedding the SD principle in core arrangements and processes; and
- involving and working with citizens and stakeholders to deliver its well-being duty.

9 We carried out a high-level review of how the Health Board has continued to develop its corporate arrangements since our baseline work in 2017 to inform the Auditor General's one-year commentary in 2018. We also examined the extent to which the Health Board is acting in accordance with the SD principle and applying

the five ways of working through a step being taken to meet a well-being objective. Specifically, we reviewed the development of the proposals and business cases for health and well-being centres and well-being hubs (centres and hubs) described in Appendix 1.

10 Exhibit 1 summarises the five ways of working as defined in the Welsh Government's **Well-being of Future Generations (Wales) Act 2015: The Essentials** document. Appendix 2 outlines positive indicators for each of the five ways of working that we have identified and used as part of our examination.

Exhibit 1: the 'five ways of working' as defined by the Welsh Government

| The Five Ways of Working |
| --- |
| **Long term –** The importance of balancing short-term needs with the need to safeguard the ability to also meet long-term needs. |
| **Prevention –** How acting to prevent problems occurring or getting worse may help public bodies meet their objectives. |
| **Integration –** Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their other objectives, or on the objectives of other public bodies. |
| **Collaboration –** Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives. |
| **Involvement –** The importance of involving people with an interest in achieving the well-being goals and ensuring that those people reflect the diversity of the area which the body serves. |

11 This report sets out our findings on the Health Board's corporate approach to embedding the sustainable development principle and how the five ways of working have been applied through its work on **embodying the social model of care in the development of health and well-being centres and well-being hubs** (the step).

## Main findings

12 Our examination found that **the Health Board has a good understanding of the sustainable development principle which it clearly considered when developing corporate arrangements and embodying the social model of care in the development of health and well-being centres and well-being hubs, but recognises there is more to do**.

13 We reached this conclusion because:

- there has been progress in embedding the sustainable development principle and evidence shows the Health Board is doing things differently, but it recognises there are still challenges to overcome.

- the five ways of working have been central to planning the health and well-being centres and well-being hubs but there is scope for the Health Board and its partners to build upon successes over the next phases of the programme.

14 Our findings are discussed in detail in the following sections of this report.

## Opportunities for improvement

15 As the main provision of the Act came into force in 2016, it is inevitable that public bodies will need time to fully effect that change. We recognise that this is a transition period and that all public bodies are on a learning path. We presented our findings at a workshop of key representatives involved in 'embodying the social model of care in the development of health and well-being centres and well-being hubs' in July 2019. At this workshop the Health Board considered our findings, identified opportunities for improvement in relation to the step and began to consider a more detailed response.

16 Exhibit 2 sets out the Health Board's opportunities for improvement (I), which are intended to support continued development and embedding of the SD principles and five ways of working.

Exhibit 2: Opportunities for improvement

| Opportunities for improvement |
|---|
| **Long term** |
| I1 Further enhance the profile of primary care by building upon the successes of existing promotional campaigns. |
| I2 Develop a campaign to educate the public about what types of services will be available at each of the centres and hubs. |
| I3 Use examples of successfully moving services from secondary to community and primary care to promote and sustain a shift in resources from other services that could be provided closer to home. |
| I4 Develop a model to monitor and review the impact and benefits of the centres and hubs. Use a blended approach that includes outcome measures, data, exemplar projects and patient stories to show not only cost effectiveness but also the positive impact on patient experience. |
| **Prevention** |
| I5 Undertake needs assessments on an ongoing basis and continually review services to ensure that centres and hubs remain current and fit for purpose. |
| I6 Develop a clear plan to agree finances prior to centre and hub services commencing to prevent duplication of resources. |
| **Integration** |
| I7 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. |

| Opportunities for improvement |
| --- |
| **Collaboration** |
| I8 Develop some overarching principles for the centres and hubs operating model which allow for some local variation based on community need. |
| **Involvement** |
| I9 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. |
| I10 Include a question in the IMTP template which asks how clinical boards will reach marginalised groups. |

17 The Health Board's management response will be inserted as Appendix 3 once developed and agreed. The final report will be published on the Wales Audit Office website after consideration by the Board or a relevant board committee.

# Detailed report

## Part 1 – Corporate arrangements

## The Health Board has taken steps to embed the sustainable development principle and is able to provide examples of working differently, but recognises there are still challenges to overcome

18 Prior to examining the step (embodying the social model of care in the development of health and well-being centres and well-being hubs) we wanted to understand how the Health Board's corporate arrangements support delivery of that work.

19 The Health Board is making steady progress in using the principles of the Act to ensure that the long-term impact of decisions is seriously considered before decisions are made. The Health Board developed its 10 year strategy, Shaping Our Future Well-being (SOFW) 2015-25 as the WFG Act was going through the Assembly and incorporated the SD principles directly into the strategy. The Health Board's well-being objectives are the same as their strategic objectives.

20 There is a clear action plan to progress WFG across the organisation, for example through the WFG Steering Group. Working with Public Services Boards (PSB)s is seen as an organisational priority and the Health Board said it has good working relationships with officers in partner organisations. As the Health Board continues to implement its strategy and develop its vision, it aims to reflect and apply learning to influence the setting of future well-being objectives.

21 However, the Health Board recognises there are some challenges to progressing its well-being objectives and is aware that it needs to transform the way services are delivered and encourage people to adopt healthy behaviours.

22 The Health Board also recognises the need to continue to engage and raise awareness of the Act amongst senior leaders, clinical board managers and staff. It understands the importance of demonstrating the Act's relevance and use in practice.

23 We wanted to understand how the Health Board is responding to the SD principle and the five ways of working by:

- doing things differently to deliver change;
- developing core arrangements and processes; and
- involving citizens and stakeholders.

24 Our findings are set out in Exhibit 3.

Exhibit 3: embedding the SD principle and the five ways of working

| Doing things differently to deliver change |
| --- |
| The Health Board provided positive examples that show how it is seeking to use the sustainable development principle to underpin culture and delivery of key work programmes<br><br>• The Health Board says that the Act has provided a good basis for partnership working through PSBs and there is now a broader recognition of the value of work contributing to wider well-being goals in addition to health.<br>• The Health Board promotes the SD principle in workshops, training sessions and inductions.<br>• The Health Board has also developed a directory of WFG demonstrator projects within the UHB. |
| **Developing core arrangements and processes** |
| A number of examples show that the sustainable development principle and five ways of working are successfully being woven into core arrangements and processes<br><br>• The Health Board has a WFG Steering Group which is chaired by the Executive Director of Public Health. The Steering Group reports to the Strategy and Delivery Committee, which is a committee of the Board. The Vice Chair, who is the Health Board's WFG champion, also sits on the Steering Group.<br>• The five ways of working and SD principle are embedded throughout the Health Board's 10 year strategy.<br>• The Board is considering how it can apply the 5 ways of working in decision-making. Board and committee template reports direct officers to identify which ways of working their projects and updates are contributing to. |
| **Involving citizens and stakeholders** |
| The Health Board has shown commitment to involving and collaborating with its citizens and stakeholders through different methods<br><br>• Citizens and stakeholders have been engaged during the development of service plans and have contributed to service developments such as the Major Trauma Network and Thoracic Surgery Services.<br>• The Health Board and local third sector organisations have signed a memorandum of understanding to demonstrate commitment to adopt the SD principle in the way they work together.<br>• The Health Board has collaborated with Cardiff and Vale College, the National Welsh Language Learning Centre and a regional partnership called More than Just Words Forum (comprised of Cardiff Council, Vale of Glamorgan Council and Velindre University NHS Trust) to help improve collaboration when developing Welsh language in health and social care. |

# Part 2 – Examination of 'embodying the social model of care in the development of health and well-being centres and well-being hubs'

## The five ways of working have been central to planning the health and well-being centres and well-being hubs but there is scope for the Health Board and its partners to build upon successes for the next phases of the programme

25 We looked at the Health Board's approach to the development of the proposals and business cases for the projects in tranche one of the Shaping Our Future Well-being: In Our Community programme. The projects in tranche one are the well-being hubs at Maelfa, Penarth, Parkview and a health and well-being centre at Cardiff Royal Infirmary. Further information on this step is set out in Appendix 1.

### The health and well-being centres and wellbeing hubs are designed to be part of the wider long-term vision to create a more sustainable health care model but achieving a shift in resources remains a challenge

26 We looked for evidence of:

- a thorough understanding of current and long-term needs and the associated challenges and opportunities;
- planning over an appropriate timescale;
- resources allocated to ensure long-term benefits; and
- appropriate monitoring and review.

27 We identified the following strengths:

- development of the centres and hubs are key components of the Health Board's 'Shaping Our Future Well-being: In Our Community Programme'. This aims to develop and reconfigure community infrastructure over the period to 2025 and beyond to support the transformation of services.
- the business cases are based on an understanding of current and future population need, specific to different clusters. For example, rapid population growth, ageing population, degree of unhealthy lifestyle behaviours and acknowledged, persistent health inequalities across Cardiff and Vale. The proposed hubs considered the key population needs identified in the Cardiff and Vale of Glamorgan Area Plan for Care and Support Needs 2018-2023 when deciding where they should be placed.
- the Health Board and its partners have taken an evidence-based approach to developing the business cases by undertaking options appraisals and benefits realisation exercises.

- the Health Board has identified that its current primary care model is not sustainable and is designing a new model that will meet long term needs and use resources more efficiently.
- environmental sustainability has been built into the design of the infrastructure.
- the proposals aim to future proof the community facilities, so the buildings are workable for present and future needs.
- the Health Board and its partners have identified a set of measures to monitor the Shaping Our Future Well-being: In Our Community programme and recognises the need to continuously review this.

28 We identified the following learning points:

- the Health Board is starting to raise the profile of community-based services working together such as primary care, community health, local authority and third sector services but more could be done to raise the profile of the concept of the centres and hubs and the benefits of collaborative working.
- investment is being made in primary care, through transformation funding and a developing process of resource allocation from secondary care. For example, recent investment in Mental Health and Musculoskeletal services in primary care has been made through an allocative resource shift, but there is more work to do to continue to develop this process. Wellbeing coordinators will play a significant role in the operating of hubs and centres providing a role in connecting communities to services. Currently these roles are funded through short term programmes and the health board along with partners will need to explore sustainable support for these roles**.** The Health Board and its partners need to consider how it will monitor the short- and medium-term successes of new models of service delivery to inform plans for future tranches of the programme as well as longer term outcomes including patient experience.
- the Health Board and its partners need to be clear about the aims of the well-being centres and hubs. Ongoing cluster and population needs assessments should be conducted to feed into future planning and ensure appropriate services are delivered.

There is a strong focus on educating and empowering communities to take control of their own health by promoting a shift of thinking from illness to wellness, but the Health Board needs to continue to develop a process to monitor the effectiveness of new models of care to deliver preventative benefits

29 We looked for evidence of:

- a thorough understanding of the nature and type of problem the step could help prevent from occurring or getting worse;

- resources allocated to ensure preventative benefits will be delivered; and
- monitoring and review of how effectively the step is preventing problems from occurring or getting worse.

30 We identified the following strengths:

- the Health Board understands the root cause of ill health and as a result has designed the centres and hubs with its partners to bring together a range of primary care, community health and well-being services. They will aim to support the physical, mental and social well-being of residents in the community and will focus on prevention and wellness rather than illness.
- the Health Board and its partners are seeking to empower people to choose healthy behaviours and manage their own health. Long term this will reduce demand and reliance on health services and will change mindsets about healthy behaviours.
- the buildings themselves are designed to be "future-proofed" so that they do not become a barrier to future development.

31 We identified the following learning points:

- before a centres or hub opens, there should be a clear plan for services and finances to avoid duplication; this should not be limited to health services.
- the Health Board and its partners recognise the need to monitor the effectiveness of the new model of care on an ongoing basis to ensure preventative benefits are delivered. For example, through working as a member of the Regional Partnership Board to develop an outcomes framework and learn from the development in the South West Cardiff Cluster.

There is a clear vision for how the centres and hubs will support each of the well-being goals but there are opportunities to work with other organisations to maximise the impacts across all well-being goals

32 We looked for evidence of consideration of:

- how this step could contribute to the seven national well-being goals;
- how delivery of this step will impact on the Health Board's well-being objectives and wider priorities; and
- how delivery of this step will impact on other public bodies' well-being objectives.

33 We identified the following strengths:

- the business cases for the centres and hubs outline how they will support each of the well-being goals.
- there has been integration at all levels of the project from project planning to RPB level with all partners working towards common objectives.

- there was a focus on joining-up resources with partners to meet objectives and avoid duplication of funding. For example, investment in the third sector to support GP sustainability with mental health services.
- the Health Board and partners are starting to think about how they can use the centres and hubs to deliver on different aspects of well-being. For example, community classes and meetings, such as computer classes, gardening club, peer support and health improvement.

34 We identified the following learning points:

- there is potential for further integration through partnerships. For example, working with community ownership foundations to provide arts and culture options in centres and hubs and working with the councils and RPB to create more accessible bus routes to them.

The Health Board has collaborated well with its partners to develop the health and well-being centres and well-being hubs resulting in strengthened relationships but there is further work to complete on the overarching operating principles of the centres and hubs

35 We looked for evidence that the Health Board:

- has considered how it could work with others to deliver the step (to meet its well-being objectives, or assist another body to meet its well-being objectives);
- is collaborating effectively to deliver the step; and
- is monitoring and reviewing whether the collaboration is helping it, or its stakeholders meet well-being objectives.

36 We identified the following strengths:

- the centres and hubs have been designed for collaborative working as they will be multi-functional spaces with co-located services and multi-disciplinary, multi-agency team working.
- proposals for the centres and hubs have been developed in partnership with local GPs, the local authority and third sector organisations.
- partners feel that developing proposals for the centres and hubs collaboratively has strengthened relationships and there is now greater trust, awareness and more mature conversations between organisations.

37 We identified the following learning points:

- there are opportunities to apply the successes of joint working to the future planning and development of the centres and hubs.
- the overarching principles for the centres and hubs operating model and policies are yet to be decided by the Delivery Group.

## The Health Board and its partners have involved a wide variety of groups and updated its engagement plan to include lessons learned from engagement events

38 We looked for evidence that the Health Board has:

- identified who it needs to involve in designing and delivering the step;
- effectively involved key stakeholders in designing and delivering the step;
- used the results of involvement to shape the development and delivery of the step; and
- sought to learn lessons and improve its approach to involvement.

39 We identified the following strengths:

- the fundamental rationale behind the Shaping Our Future Well-being Strategy is the focus on the health and well-being needs of the local population through the delivery of a social model of health and delivering services collaboratively with partners.
- the Health Board has an Engagement and Communication Plan for the development of the centres and hubs which is updated throughout the project.
- the Health Board held engagement sessions about the centres and hubs with a wide variety of stakeholders including members of the public, third sector, board members, councillors and contractors. Seldom heard groups such as young people and religious groups were also involved. The Health Board engaged with young people through arts projects at schools asking what they would like to see in the hubs. The engagement events were successful and provided quality outputs which were fed back to the design and delivery team.
- the Health Board worked in partnership with Cardiff and Vale Community Health Council and third sector organisations to engage local communities and co-produce the plans for the community-based facilities. For example, Action in Caerau and Ely (ACE) at Parkview and church groups at Maelfa.
- the Health Board and its partners felt that the project has fostered a culture of listening and partners felt they are learning from each other, from citizens and from similar successful projects. For example, the Health Board visited the Bromley by Bow Centre.
- the Health Board has applied lessons learned from engagement events to future engagement sessions.

40 We identified the following learning points:

- the Health Board and its partners recognise the potential to support behaviour change and encourage people to make healthy choices by creating the right environment to make better choices.

- the Health Board and its partners recognised the potential of finding community leaders to help roll out key messages to ensure communication is ongoing.

# Appendix 1

## The Step

### Information provided by the Health Board on the step: Embodying the social model of care in the development of health and well-being centres and well-being hubs

The step examined was the approach the Health Board has taken in the development of the proposals and business cases for the projects in tranche one of the Shaping Our Future Well-being in Our Community programme (Well-being Hubs in Maelfa, Penarth and Parkview and a Health and Well-being Centre at Cardiff Royal Infirmary)

The Shaping Our Future Well-being: In Our Community Programme sets out the rationale for developing and reconfiguring community infrastructure over the period to 2025 to support the implementation of the Shaping Our Future Well-being Strategy.

- the buildings will have shared facilities with councils and spaces for community groups to use, to enable and support community groups as assets in the community for well-being. The strategy sets out the constituent capital projects they plan to facilitate with a focus on:-
  - The health and well-being needs of the local population through the delivery of a social model of care;
  - The promotion of healthy lifestyles;
  - The reduction of health inequality;
  - The planning and delivery of healthcare close to people's homes; and
  - Delivering services collaboratively with our partners and supporting economic growth.
- the Programme was established with the aim of developing the major physical infrastructure required to support sustainable and prudent, collaborative health and well-being services provided closer to home, which improve health outcomes and reduce health inequalities. This will see the development of a sustainable network of facilities across Cardiff and Vale, designed to create flexible spaces to enable change. These include:
  - a Health and Well-being Centre in each Locality (CRI, Cardiff North and West, Barry Hospital);
  - a Well-being Hub in each Cluster, co-located with Council facilities where possible;
  - fit for purpose primary care premises; and
  - community facilities rationalised where appropriate.
- a formal programme structure is in place with the Regional Partnership Board acting as the Programme Board to drive collaborative working through the programme.

- in developing the proposals, the Health Board used the five case model to develop the business cases which involved determining strategic fit, agreeing local (Cluster) objectives, scoping service requirements, an options appraisal, risks and benefits appraisal, selecting preferred options, testing affordability and funding requirements, and community engagement. The Health Board also explored social model excellence from elsewhere (Bromley by Bow).
- the programme is underpinned by the Health Board's vision that a person's chance of leading a healthy life is the same wherever they live and whoever they are. At its heart, the Strategy (co-produced with staff, partner organisations and community representatives) has the desire to achieve joined up care based on home first, avoiding harm, waste and variation, empowering people and delivering outcomes that matter to them.
- in considering how to shape future well-being, the focus has been on the health and care needs of the local population, working collaboratively with partners to provide sustainable services.
- the Health Board engaged local people about what was important to them in terms of how the health and well-being centre / well-being hub would work for local people.

# Appendix 2

## The Five Ways of Working

The table sets out 'positive indicators' for each of the five ways of working that we have identified and used to help inform our assessments of the extent to which bodies may be applying the SD Principle. We do not intend the indicators to be used as a 'checklist'. We have used them as 'indicators' to help us to form conclusions, rather than 'determinants' of the extent to which a body is acting in accordance with the SD Principle in taking steps to meet its well-being objectives.

Exhibit 4: the five ways of working

| What would show a body is fully applying the long-term way of working? |
|---|
| • There is a clear understanding of what 'long term' means in the context of the Act.<br>• They have designed the step to deliver the well-being objective/s and contribute to their long-term vision.<br>• They have designed the step to deliver short or medium-term benefits, which are balanced with the impact over the long-term (within the project context).<br>• They have designed the step based on a sophisticated understanding of current and future need and pressures, including analysis of future trends.<br>• Consequently, there is a comprehensive understanding of current and future risks and opportunities.<br>• Resources have been allocated to ensure long-term as well as short-term benefits are delivered.<br>• There is a focus on delivering outcomes, with milestones/progression steps identified where outcomes will be delivered over the long term.<br>• They are open to new ways of doing things which could help deliver benefits over the longer term.<br>• They value intelligence and pursue evidence-based approaches. |
| **What would show a body is fully applying the preventative way of working?** |
| • The body seeks to understand the root causes of problems so that negative cycles and intergenerational challenges can be tackled.<br>• The body sees challenges from a system-wide perspective, recognising and valuing the long-term benefits that they can deliver for people and places.<br>• The body allocates resources to preventative action that is likely to contribute to better outcomes and use of resources over the longer term, even where this may limit the ability to meet some short-term needs.<br>• There are decision-making and accountability arrangements that recognise the value of preventative action and accept short-term reductions in performance and resources in the pursuit of anticipated improvements in outcomes and use of resources. |

| What would show a body is taking an 'integrated' approach? |
| --- |
| • Individuals at all levels understand their contribution to the delivery of the vision and well-being objectives.<br>• Individuals at all levels understand what different parts of the organisation do and proactively seek opportunities to work across organisational boundaries. This is replicated in their work with other public bodies.<br>• Individuals at all levels recognise the cross-organisation dependencies of achieving the ambition and objectives.<br>• There is an open culture where information is shared.<br>• There is a well-developed understanding of how the well-being objectives and steps to meet them impact on other public sector bodies.<br>• Individuals proactively work across organisational boundaries to maximise their contribution across the well-being goals and minimise negative impacts.<br>• Governance, structures and processes support this, as do behaviours. |
| **What would show a body is collaborating effectively?** |
| • The body is focused on place, community and outcomes rather than organisational boundaries.<br>• The body has a good understanding of partners' objectives and their responsibilities, which helps to drive collaborative activity.<br>• The body has positive and mature relationships with stakeholders, where information is shared in an open and transparent way.<br>• The body recognises and values the contributions that all partners can make.<br>• The body seeks to establish shared processes and ways of working, where appropriate. |
| **What would show a body is involving people effectively?** |
| • Having an understanding of who needs to be involved and why.<br>• Reflecting on how well the needs and challenges facing those people are currently understood.<br>• Working co-productively, working with stakeholders to design and deliver.<br>• Seeing the views of stakeholders as a vital source of information that will help deliver better outcomes.<br>• Ensuring that the full diversity of stakeholders is represented, and they are able to take part.<br>• Having mature and trusting relationships with its stakeholders where there is ongoing dialogue and information is shared in an open and transparent way.<br>• Ensure stakeholders understand the impact of their contribution.<br>• Seek feedback from key stakeholders which is used to help learn and improve. |

# Appendix 3

## The Health Board's management response to improvement opportunities

The Health Board's management response will be inserted here. This appendix will form part of the final report to be published on the Wales Audit Office website once the report has been considered by the Board or a relevant board committee.

The Health Board considered our findings at the workshop held in July 2019 and agreed a number of improvement opportunities regarding embodying the social model of care in the development of health and well-being centres and well-being hubs. The following table presents the actions that the Health Board has identified in response.

Exhibit 5: management response to improvement opportunities

| Improvement opportunities | Management response | Completion date | Responsible officer |
|---|---|---|---|
| **Long-term** | | | |
| I1 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. | Ongoing | Lisa Dunsford Director of Operations, Primary, Community and Intermediate Care |

| Improvement opportunities | Management response | Completion date | Responsible officer |
|---|---|---|---|
| I2 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. | December 2021 | Abigail Harris Executive Director Strategic Planning |
| I3 Use examples of successfully moving services from secondary to community and primary care to promote and sustain a shift in resources from other services that could be provided closer to home. | Supporting services to move to community delivery is a core element of the Health Board's Integrated Medium Term plan. Through this process we are celebrating and promoting examples of good practice. | Ongoing | Abigail Harris Executive Director Strategic Planning |
| I4 Develop a model to monitor and review the impact and benefits of the centres and hubs. Use a blended approach that includes outcome measures, data, exemplar projects and patient stories to show not only cost effectiveness but also the positive impact on patient experience. | The Regional Partnership Board is developing an Outcomes Framework which will provide a tool to support the evaluation of the impact of Health and Wellbeing Centres and Wellbeing Hubs. | July 2020 | Abigail Harris Executive Director Strategic Planning |
| **Prevention** | | | |
| I5 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 | Annually | Lisa Dunsford Director of Operations, Primary, Community and Intermediate Care |

| Improvement opportunities | Management response | Completion date | Responsible officer |
|---|---|---|---|
| I6 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. | November 2021 | Fiona Kinghorm Executive Director of Public Health |
| **Integration** | | | |
| I7 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. | October 2021 | Abigail Harris Executive Director Strategic Planning |
| **Collaboration** | | | |
| I8 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. | October 2021 | Abigail Harris Executive Director Strategic Planning |
| **Involvement** | | | |
| I9 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. | October 2021 | Abigail Harris Executive Director Strategic Planning |

| Improvement opportunities | Management response | Completion date | Responsible officer |
|---|---|---|---|
| I10 Include a question in the IMTP template which asks how clinical boards will reach marginalised groups. | Considerations of service developments and engagement with marginalised groups already form part of the development of IMTPs. | January 2020 | Abigail Harris Executive Director Strategic Planning |

We will monitor the Health Board's progress in implementing these actions, and the extent to which they address the issues we have identified in our findings, through our future programmes of work.

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **REPORT TITLE:** | **CLINICAL AUDIT** | | | | | | | | |
| **MEETING:** | Audit and Assurance Committee | | | | | | **MEETING DATE:** | **03.12.19** | |
| **STATUS:** | **For Discussion** | | **For Assurance** | **x** | **For Approval** | | **For Information** | | |
| **LEAD EXECUTIVE:** | Executive Medical Director | | | | | | | | |
| **REPORT AUTHOR (TITLE):** | **Head of Patient Safety and Quality Assurance** | | | | | | | | |

**PURPOSE OF REPORT:**

**SITUATION**:
The purpose of the paper is to provide the Audit Committee with assurance that the Health Board is facilitating an effective programme of clinical audit that provides assurance around the quality of care delivery and informs quality improvement.

**REPORT:**

**BACKGROUND:**

The UHB procedures around clinical audit have previously been subject to an Internal Audit review and in January 2017 were awarded reasonable assurance.

Audit activity in the UHB comprises national clinical audit, as mandated by Welsh Government and local clinical audit activity instigated within Directorates and Clinical Boards. Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes. A targeted and considered clinical audit programme is an invaluable tool in the provision of assurance around the quality of the services the UHB provides.

In 2017 the UHB clinical Audit Strategy was presented to the Quality Safety and Experience Committee with the purpose of supporting Clinical Audit Plans that reflected the Clinical priorities of each of the Clinical Boards. These priorities included:

- Clinical effectiveness
- Reducing unwarranted variation
- Management of clinical risk
- Management of complaints and clinical negligence claims
- Ensuring the fundamental standards laid out in the Health and Care Standards.

In 2018 in a drive to ensure a prudent programme of audit, three categories of clinical audit were defined

- **Tier 1** National clinical audit.

- **Tier 2** Local clinical audit undertaken to address the patient safety and quality agenda,
- **Tier 3** Local clinical undertaken for any other reason including revalidation and CPD purposes.

**ASSESSMENT:**

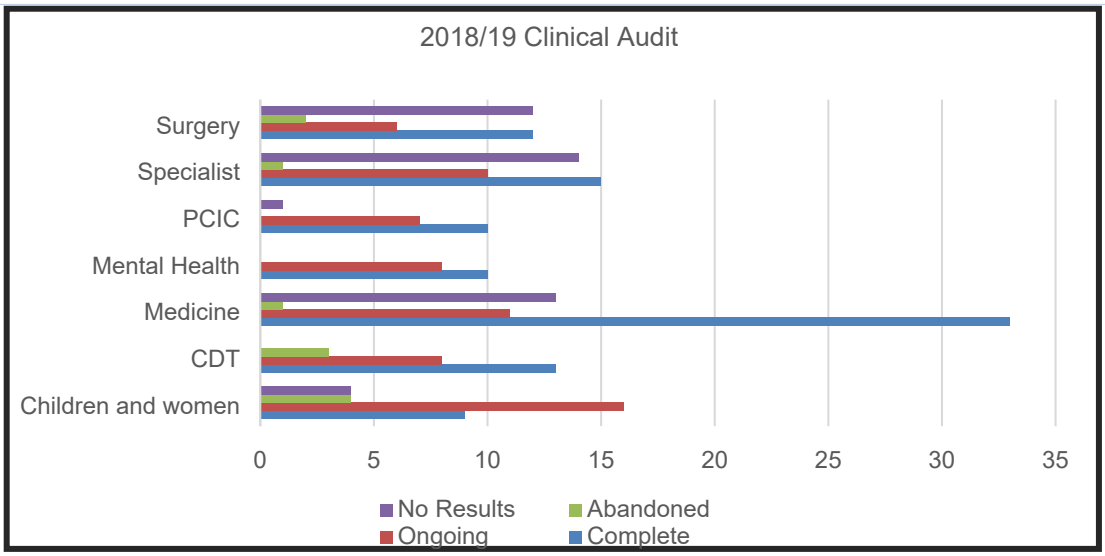
**Audit Activity**

Currently the UHB is mandated to participate in 38 national audits some of which have several components. The majority of these are facilitated within clinical teams with the burden of data collection falling to the clinicians, generally Consultants and Clinical Nurse Specialists. Adequate case ascertainment (the number of patients captured) and data completeness is dependent on audit administration being balanced with Clinical priorities. In the case of several of the national audits including the National Emergency Laparotomy Audit (NELA) and the National Joint Registry, the Clinical Boards have recruited into dedicated administration roles to undertake data collection and entry.

Variation in the processes around the facilitation and availability of data and reporting arrangements of the National Audits means that the health board cannot gain full assurance that the appropriate governance processes are in place around the entire national clinical audit programme.

The National Vascular registry report was published in January 2019 and at this point it became apparent that no carotid endarterectomy cases had been submitted and case ascertainment around lower limb bypass was very low (data on less than a quarter of cases had been submitted). This has been escalated to the network and a business case is being developed to appoint a data clerk. In addition the UHB is not currently participating in the National Paediatric Epilepsy Audit (Epilepsy 12) despite it being a mandated audit, as no resource has been identified to facilitate this project this was escalated to the Health Service Management Board in August 2019.

Since 2017 Clinical Boards have been required to develop clinical audit plans that reflect their quality and safety priorities. The annual audit plans and a six month update are reported through the Quality Safety and Experience Committee. In 2018/19 over 220 clinical audits were registered, 45% of audits were completed within the year and the results reported and a further 30% remained ongoing. In addition 25% of clinical audits that were registered are recorded as either being abandoned or there was no formal records of the results being reported as of March 31st 2019. The failure to complete or present the results of an audit can pose a risk if the performance around that element of care is not understood, at the very least it reflects waste and a system that is not prudent.




## Reporting Arrangements and Governance

The reporting and escalation of audit results is vital in ensuring appropriate governance around a clinical audit programme. Clinicians are required to identify a forum in which to present the results of their audit at the point of registering the project. The UHB set aside 9 half days each calendar year to allow directorates to facilitate Quality and Safety sessions. These are multi professional sessions that incorporate all members of the multi-disciplinary team. Agenda items include clinical audit presentations and progress updates on previous improvement programmes.

## Quality Assurance and Information Governance of Clinical Audits

All proposed audits are quality assured by the clinical audit team prior to final approval to ensure that the projects are criterion based audits and are not research projects. Information Governance declarations are completed for each proposed audit.

- The project data must be anonymised and not be re-attributed or used in conjunction with other data that could result in any patient being identified.
- No contact will be made with any individuals identified from the data processed for the project.
- Any reports, papers or statistical tables that are published or released to other organisations will fully protect the identity of individuals.
- All information supplied by Cardiff and Vale University Health Board and any copies will be destroyed when it is no longer required for the purpose for which it was supplied.
- PID must not be stored on the hard drive of a non-UHB PC, laptop or PDA, or e-mailed to an address that is not on the Digital All Wales Network (must end with .wales.nhs.uk).
- Non UHB staff are not allowed to access any PID unless they have Honorary Contracts or Confidentiality Agreements which allow access to the UHB's patient identifiable resources via an approved UHB network/system account.
- The information will be held within a secure environment where access can be traced. Cardiff and Vale University Health Board will have the right to audit the security arrangements put in place.
- All project information will be processed in accordance with the principles and conditions as stipulated in the Data Protection Act 1998 and with proper safeguards to ensure confidentiality.

**Clinician Support and Training**
As well as quality assuring all audit proposals, the UHB Clinical Audit Team support in the development of audit projects as required. In addition, they provide half day workshops several times a year to provide staff with basic understanding of clinical audit processes and methodologies as well as ad hoc sessions delivered to departments on request.

**RECOMMENDATION:**

The Audit Committee is to **Consider** arrangements in place to deliver and effective programme of clinical audit.

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

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Sustainable development principle: 5 ways of working | Prevention | x | Long term | x | Integration | | Collaboration | x | Involvement | | |

| | |
|---|---|
| **EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:** | Not Applicable<br>If "yes" please provide copy of the assessment. This will be linked to the report when published. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Report Title:** | **Declarations of Interest, Gifts, Hospitality & Sponsorship Register** | | | | | | | | |
| **Meeting:** | **Audit & Assurance Committee** | | | | | | **Meeting Date:** | **03.12.2019** | |
| **Status:** | **For Discussion** | | **For Assurance** | **X** | **For Approval** | | **For Information** | **X** | |
| **Lead Executive:** | **Director of Corporate Governance** | | | | | | | | |
| **Report Author (Title):** | **Corporate Governance Officer** | | | | | | | | |

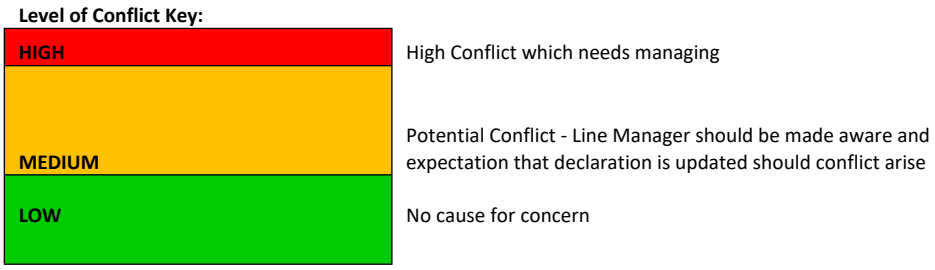
## SITUATION

As agreed by Audit & Assurance Committee the Declarations of Interest, Gifts, Hospitality & Sponsorship Register would be brought to each meeting for information.

## ASSESSMENT

The following number of Declarations have been received and included on the register at the time of writing this report (26/11/2019)

- 812 Declarations of Interests, Gifts, Hospitality & Sponsorship Forms
- Cardiff & Vale UHB has 648 staff members banded 8a and above, out of these 25.93% of staff have returned their declaration forms. At the time of writing the report an additional 318 declarations received from staff band 8A + are waiting to be added to the register, this is a back log from a recent targeted chase email.
- The Declarations of Interests G, H&S received are RAG rated by the Corporate Governance Officer to ensure appropriate action and monitoring. The RAG rating system is as follows:




To date (26/11/2019), 84.73% of Declarations received are rated **Green**.

To date (26/11/2019), 15.02% of Declarations received are rated **Orange**.

To date (26/11/2019), 0.24% of Declarations are rated **Red.**

In addition, at the time of writing the report a further 148 declarations are awaiting RAG rating

and adding to the register. With this in mind, including the declarations received from Band 8A +, a total of 466 declarations are waiting to be added to the register making the overall number of declarations received to date as 1,278. These will be included on the register at the next meeting in February 2020.

**ASSURANCE** is provided by:

Strong governance arrangements.

**RECOMMENDATION**

The Audit & Assurance Committee is asked to:

- **NOTE** the Declarations of Interest, Gifts, Hospitality & Sponsorship Register.

| **Shaping our Future Wellbeing Strategic Objectives**<br>*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**<br>*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<br>If "yes" please provide copy of the assessment. This will be linked to the report when published. |

Level of Conflict Key:

HIGH — High Conflict which needs managing

MEDIUM — Potential Conflict - Line Manager should be made aware and expectation that declaration is updated should conflict arise

LOW — No cause for concern

**Declarations of Interest**
**Interests Declared**

| Level of Conflict | Name | Position held in UHB | Clinical Board / Corporate Dept | Third Party Declaration eg Spouse/Partner (Yes/No) | a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies | 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 | d) Sponsorship or funding from a known NHS supplier or associated company/subsidiary | e) A position of authority in a charity or voluntary body in the field of health and social care | f) Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests |
|---|---|---|---|---|---|---|---|---|---|
| | Craig Greenstock | Counter Fraud Manager | Executives | Yes | N/A | Wife works as a Procurement Supervisor for the NHS Wales Shared Partnership and is based in the Lakeside Stores at UHW in Cardiff. | N/A | N/A | N/A |
| | Aron White | Senior Nurse - Standards & Professional Regulation | Corporate Nursing | No | N/A | N/A | N/A | N/A | Associate Counsellor/Psychotherapist- Voices From Care Cymru |
| | Aled Roberts | Interim Clinical Board Director | Medicine | Yes | • Director of PLC - SAGE Roberts PLC.<br>• Wife is also a Director | N/A | N/A | N/A | N/A |
| | Richard Hurton | Head of Financial Accounting & Services | Corporate Department | Yes | N/A | N/A | N/A | N/A | Partner is a Financial Manager with WHSCC |
| | Sridhar Kamath | Consultant Radiologist | | No | • Director of Kamath Medical Services, Sahika Investments Limited<br>• Archana Kamath, Director of Kamath Medical Services | I occasionally teach at courses sponsored by 'SI Bone' | N/A | N/A | N/A |
| | Rhys Morris | Principal Clincal Scientis | CD&T | No | N/A | Department of Medical Physics & Clinical Engineering paid equivalent of half my salary by Arjo for scientific sevices. | N/A | N/A | N/A |
| | Eileen Brandeth | Independent Membembe of the Board | | No | N/A | N/A | N/A | N/A | N/A |
| | John Michael Imperato | Independent Membembe of the Board | | Yes | • Director Association of Personal Injury Lawyers<br>• Director Bevan Foundation Charity<br>• Director Swansea University Childrens Legal Centre | N/A | N/A | N/A | N/A |
| | John Union | Independent Membembe of the Board | N/A | No | • John Union Limited<br>• Swansea Building Society<br>• Cardiff Business Club Director | N/A | N/A | N/A | Vice Chair, Cadwyn Housing Limited |
| | Gary Baxtor | Independent Membembe of the Board | Cardiff University | No | N/A | N/A | N/A | N/A | N/A |
| | Nicola Foreman | Director of Corporate Governance | | No | Company Secretary of Husbands Business Safe Ventures (UK) LTD | N/A | N/A | N/A | N/A |
| | Lance Carver | Associate Member | | No | N/A | N/A | N/A | N/A | Director of Social Services |
| | Mandy Sara Collins | Interim Head of Governance | Corporate Governance | Yes | N/A | N/A | N/A | N/A | N/A |
| | Sara Moseley | Independent Member of the Board - Third Sector | | No | • WCVA Elected Board Member<br>• Executive Director, MIND | N/A | N/A | • Director, MIND Cymru<br>• Non Executive Director, MIND<br>• WCVA Board | N/A |
| | Richard Thomas | Chair of Strategic Reference Group | N/A | No | • Care & Repair Home Improvement Services Ltd | N/A | N/A | N/A | N/A |
| | Sharon Hopkins | Director of Transformation, Improvement and Informatics / Dep CEO | Executive | No | N/A | N/A | N/A | N/A | Chair of a Public Health Advisory Committee for NICE |
| | Lee Davies | Operational Planning Director | Chief Operating Officer | Yes | N/A | N/A | N/A | N/A | N/A |
| | Maria Battle | Chair | | No | N/A | N/A | N/A | Member of Social Care Wales Board | Child Protection Safeguarding Officer for St Teilos Parish Tenby |
| | Abigail Harris | Executive Director of Strategic Planning | | Yes | N/A | N/A | N/A | • Husband - Board Member of Wales Council for Voluntary Action (And Chair of Audit Committee)<br>• Uncle - Trustee of Teenage Cancer Trust | • Non Executive Director of Social Care Wales (A Ministerial Public Appointment)<br>• Husband - Employee of Competition and Markets Authority |
| | Christopher Howrad Lewis | Deputy Director of Finance | Finance | Yes | N/A | N/A | N/A | President of Wales Branch of the Healthcare Financial Management Association (HFMA). HFMA is a registered charity. | Wife is Samantha Lewis, Assistant Director of Finance, Abertawe Bro Morgannwg University Health Board |
| | Charles Janczewski | Vice Chair | | No | N/A | N/A | N/A | N/A | • WHSSC - Chair of Quality & Patient Safety Committee<br>Swansea University<br>• Chair of Governance Board for Health & Wellbeing Academy |
| | Fiona Kinghorn | Executive Director of Public Health | Public Health | Yes | N/A | N/A | N/A | N/A | Husband is Non-Executive Director of Trivallis Community Mutual Housing Association |
| | Fiona Jenkins | Executive Director of Therapies and Health Science | | No | Director JJ Consulting Healthcare Ltd | N/A | N/A | N/A | N/A |
| | Len Richards | Chief Executive | Executive Team | No | Advisor to the Life Sciences Hub Board | N/A | N/A | Chairman of Improving Chances | Council Member, Cardiff University |
| | Ruth Walker | Executive Nurse Director | Corporate | No | N/A | N/A | N/A | N/A | N/A |
| | CLLR Susan Elsmore | Independent Member of the Board - Local Authority | | No | N/A | N/A | N/A | N/A | Welsh Local Government Association Health & Social Care Spokesperson |
| | Paula Martyn | Chair of Stakeholder Ref Group (until Dec 2018) | N/A | No | N/A | N/A | N/A | N/A | Advisor to Care Forum Wales |
| | Mary Lawrence | Associate Specialist in Psychiatry | Mental Health | No | N/A | N/A | N/A | N/A | N/A |
| | Julie Gittings | Counsellor | Mental Health | No | N/A | N/A | N/A | N/A | N/A |
| | Rebecca Williamson | Counsellor | Mental Health | | N/A | N/A | N/A | Trustee of Bridgend Community Bereavement Service | Ty Elis. Couselling Services, Bridgend Community Bereavement Service, Place 2 Be. |
| | Jan Melichar | Counsultant in Substance Misuse Psychiatry (Long-Term Locum) | Medicine | No | 100% Owner /Director of Limited Company used for any Private Work | N/A | N/A | Medical Director of DHI - A Charity in the Substance Misuse and Homelessness Sector in the Avon Region of England | N/A |
| | Emily Harrington | Consultant Psychiatrist | Adult Mental Health | No | N/A | N/A | N/A | N/A | N/A |
| | Hannah Brayford | Head of Programme Management Office | Transformation | Yes | • I'm a director of Longford Pugh Properties, a limited company<br>• Wife is also a Director of Longford Pugh Properties | N/A | N/A | N/A | N/A |
| | Ruth Jordan | Head of Continuous Service Improvement | Executives | Yes | Spouse is Director of the Plaza Cardiff Bay (Phase 1) Management Company Limited | N/A | N/A | N/A | N/A |
| | Mark Thomas | Senior Service Improvement Programme Manager | Executive | Yes | N/A | N/A | N/A | Spouse: Helen Docloo, Trustee for Diversity Cymru | N/A |
| | Emma Cooke | Head of Physiotherapy | CD&T | Yes | N/A | N/A | N/A | N/A | N/A |
| | Claire Ganderton | Senior Appraisal Pharmacist | CD&T | Yes | Director and Spouse is Director too | N/A | N/A | N/A | N/A |
| | Nia Jones | Specialist Podiadrist | CD&T | No | N/A | Wound Care Consultant | N/A | N/A | N/A |
| | Rhodri Willment | Physiotherapist | Therapies | No | N/A | N/A | N/A | N/A | N/A |
| | Joanne Moon | Dietitcian | CD&T | No | N/A | N/A | N/A | N/A | GLL (LTD) Fitness Instructor |
| | Annie Gover | Weight Management CNS | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Alexandra Saunders | Physiotherapy Team Lead North and West Community Resource Team (Secondment) | PCIC | Yes | N/A | N/A | N/A | N/A | N/A |
| | Claire Bruce | Community Physiotherapist CRT | PCIC | No | N/A | N/A | N/A | N/A | N/A |
| | Lisa Small | Occupational Therapist | | No | N/A | N/A | N/A | N/A | N/A |

| Level of Conflict | Name | Position held in UHB | Clinical Board / Corporate Dept | Third Party Declaration eg Spouse/Partner (Yes/No) | a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies | 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 | d) Sponsorship or funding from a known NHS supplier or associated company/subsidiary | e) A position of authority in a charity or voluntary body in the field of health and social care | f) Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests |
|---|---|---|---|---|---|---|---|---|---|
| | Alsling Pigott - Jones | Lead Paediatric Diabetes Dietitian | | No | N/A | N/A | N/A | N/A | Media Spokesperson for Professional Organisation - British Dietetic Association. Important voluntary role of CPD. Occasional expenses paid from BBC between £20 - £50. Undestand that I cannot receive money during working hours. Occasionally asked to comment on behalf of HB regarding Health Matters. Understands to communicate with communications team appropriatly. To date, not rajiresented the HB in media capacity. |
| | Melanie Wilkey | Head of Outcomes Based Commissioning | Executives | Yes | N/A | N/A | N/A | N/A | N/A |
| | Jamie Hayes | Director - Welsh Medicines Resource Centre & All Wales Therapeutics & Toxicology Centre | CD&T | No | Director, JMH Collaborations LTD | N/A | N/A | N/A | Wife is Medical Director at the Marie Curie Cardiff & Vale Hospice (her terms & conditions are with Velindre NHS Trust) |
| | Jane Maddison | Community Peadatric Physiotherapy Lead | Children & Women | No | N/A | N/A | N/A | N/A | Chartered Society Physiotherapy Welsh Board Member |
| | Annette Mclean | Dietitian | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Natalie Robertson | Principal Physiotherapist in Mental Health | CD&T | Yes | N/A | My husband is the Director of Operations and Delivery for CD&T clinical board and therefore there is a conflict of interest | N/A | N/A | N/A |
| | Robert Bleehen | Consultant Radiologist | CD&T | Yes | Both Directors of Cardiff Medical Consulting Ltd | N/A | N/A | N/A | N/A |
| | Sarah Congreve | Vale Assistant Locality Manager | PCIC | Yes | N/A | N/A | N/A | N/A | Partner is the Business Manager of West Quay Medical Centre, Barry |
| | Vanessa Adams | Cluster Pharmacist | Primary, Community & Intermediate Care | No | N/A | Spouse: Merck - Serono Advisory Role | N/A | Executive Board South Wales - Sierra Leone Cancer Care. Husband isExpert Advisor Bowel Cancer UK, Cancer Research, Exec Board South Wales Sierra Leone Cancer Care | Spouse - Bowel Cancer UK |
| | Farzana Mohammed | Cluster Pharmacist | PCIC | No | N/A | N/A | N/A | N/A | N/A |
| | Sarah Clements | Clinical Lead SLT | CD&T | No | N/A | N/A | N/A | N/A | MacMillan Adoption |
| | Lorna Bennett | Consultant - Public Health | | No | N/A | N/A | N/A | N/A | Parent Governor at Victoria Primary School |
| | Michelle Smalley | LATCH Clinical Psychologist | Acute Child Health / Child Phychology | No | N/A | N/A | N/A | N/A | N/A |
| | Nicholas Grape | Occupational Therapist | Therapies | No | N/A | N/A | N/A | N/A | N/A |
| | Dr Kathrin Hammer | Consultant | | No | Director MSK Radiology ltd | N/A | N/A | N/A | N/A |
| | Christopher Ronald Ellis | Contact Lens Specialist - Opthamology | | No | R. N. Roberts (North Road) Ltd | N/A | N/A | N/A | N/A |
| | Deborah Keoghane | Lead Colorectal / Soma CNS | Surgery | No | N/A | N/A | Department is funded by Coloplast Ltd | N/A | N/A |
| | Sharon Ivins | Senior Nurse | Surgery | No | N/A | Just offered a position with Health Inspectortae Wales (HIW) as a nurse peer reviewer. | N/A | N/A | Leaves Of Hope charity for a Belarusian children's Orphanage. |
| | Andrew Jones | Lead Nurse | Surgery, Urology, Opthalmology, ENT | No | N/A | N/A | N/A | Trustee / Deacon in Heath Evangelical Church (Registered Charity) Providing Spiritual, Social Care and Youth Work | N/A |
| | Roger Maggs | Laboratory Manager | Surgery | Yes | Directorship<br>Wife also has Directorship | N/A | N/A | N/A | N/A |
| | Catherine Marshall | Physio Clinical Lead | CD&T | Yes | Husband works in CMHT (Mental Health)<br>Son working in Public Health (Dietetics) | N/A | N/A | N/A | N/A |
| | Denise Hayes Davies | Clinical Specialist Physiotherapist | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | George Oliver | Performance and Service Improvement Lead, Outpatient Physiotherapy | CD&T | Yes | N/A | N/A | N/A | N/A | Spouse employed as Senior Broadcast Journalist at BBC Wales. Potential to cover Health Related Stories |
| | Claire Butterworth | Clinical Specialist Physiotherapist | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Jacqueline Sharp | Clinical Service Lead - Physiotherapy (Neurosciences) | CD&T | Yes | N/A | N/A | N/A | N/A | N/A |
| | Ruth Walford | Specialist Speech and Language Therapist | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Emily Morris | Speciality Doctor | Child Health | No | N/A | N/A | N/A | N/A | Trustee Charity of ACE Cardiff |
| | Ellen Long | Specialist Physiotherapist | Therapies | No | N/A | N/A | N/A | N/A | N/A |
| | Alison Millard | Urology Clinic Sister | Surgery | No | N/A | N/A | N/A | N/A | N/A |
| | Paul Rogers | Directorate Manager | Specialist Services | Yes | N/A | N/A | N/A | N/A | N/A |
| | Maurice Wentworth | Posture & Mobility Centre Business Manager | Specialist Services | No | N/A | N/A | N/A | N/A | N/A |
| | Shahad Latif | Specialist Information Pharmacist | Pharmacy | No | N/A | N/A | N/A | N/A | N/A |
| | Andrew Sully | Principal Pharmacist Quality Control | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | | Pharmacist | | | | | | | |
| | Peter Meades | Manager | Mental Health | No | N/A | N/A | N/A | N/A | N/A |
| | Scott Gable | Cellular Pathology Service Manager | CD&T | No | Executive Director - LabXcell Ltd | N/A | N/A | N/A | N/A |
| | Ann Birch | Speech and Language Therapist - Cochlear Implant | Surgical Services | No | N/A | N/A | N/A | N/A | N/A |
| | Richard Cuddihy | Consultant Clinical Psychologist/Head of Specialty/Lead Psychologist SpSCB | Specialist Services | No | N/A | N/A | N/A | N/A | N/A |
| | Lucy Wheeler | Pharmacist | CD&T | Yes | N/A | N/A | N/A | N/A | N/A |
| | Aarti Sharma | Consultant | | Yes | Yes<br>Spouse - Ram Misra | N/A | N/A | N/A | N/A |
| | Abigail Holmes | Consultant Midwife | Maternity | No | N/A | N/A | N/A | N/A | N/A |
| | Annapurna Darbhamulla | Consultant | Women & Children | | Darbhamulla Consultancy Limited (10018781) | N/A | N/A | N/A | N/A |
| | Robert Brian Beattie | Consultant | Women & Children | No | Founding Director of Innermost Secrets Limited | N/A | N/A | Founding Chairman of Innermost Learning Registered Charity<br>Spouse - Trustee of Innermost Learning | Shareholder in Time for Medicine |
| | Preetkiron Bhal | Consultant | Children & Women | No | Director - Infiniti Healthcare Ltd<br>Spouse - Nadia Bhal Director - Infiniti Healthcare Ltd | N/A | N/A | N/A | N/A |
| | Richard Panketh | Consultant O & G | | Yes | Director - RPSF Ltd<br>Spouse - Director, RPSF Ltd | N/A | N/A | Trustee - Welsh Institute for Womens Health<br>Spouse - Trustee, Welsh Institue for Womens Health | N/A |
| | Marc Williams | Clinical Psychologist | Gastroenterology | No | N/A | N/A | N/A | N/A | Work at Cardiff University as Senior Academic Tutor |
| | Ruth Cann | Senior Nurse | Medicine | Yes | N/A | N/A | N/A | N/A | N/A |
| | Holly Davies | Clinical Psychologist | MHSOP | No | N/A | N/A | N/A | N/A | N/A |
| | Aimee Stimpson | Clinical Psychologist | Directorate of Psychology and Psychological Therapies / Internal Medicine | No | N/A | N/A | N/A | N/A | N/A |
| | Bethan Phillips | Clinical Psychologist | Paediatric Psychology | No | N/A | N/A | N/A | N/A | N/A |

| Level of Conflict | Name | Position held in UHB | Clinical Board / Corporate Dept | Third Party Declaration eg Spouse/Partner (Yes/No) | a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies | 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 | d) Sponsorship or funding from a known NHS supplier or associated company/subsidiary | e) A position of authority in a charity or voluntary body in the field of health and social care | f) Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests |
|---|---|---|---|---|---|---|---|---|---|
| | Kerry-Ann Holder | Consultant Clinical Psychologist | | No | Bridgeman Psychological Consultancy - I am Director of this company, but all of my private practice is operated out of Talis Consulting Ltd | N/A | N/A | N/A | I have asked to become a Trustee of St Davids Children's Society (Adoption Agency) from Nov/Dec 2018. I have accepted the post and was recently asked to be on the interview panel for the CEO of said society (Oct 2018) |
| | Kathryn Bond | Peadiatric Neuropsychologist | | No | N/A | N/A | N/A | N/A | N/A |
| | Andrew Vidgen | Consultant Psychologist | Mental Health | No | N/A | N/A | N/A | N/A | N/A |
| | Rona Aldridge | Clinical Psychologist | Mental Health | No | N/A | N/A | N/A | N/A | N/A |
| | Menna Mayfanwy Jones | Clinical Lead | Mental Health | No | N/A | N/A | N/A | Chair of Trustees of the Vegan Society | N/A |
| | Shibendra Datta | Consultant | Surgery | No | Director of 'Urology Solution Cardiff Limited'<br>Wife is Co - Director of 'Urology Solution Cardiff Limited' | N/A | N/A | N/A | N/A |
| | Owen Hughes | Consultant | Surgery | No | N/A | N/A | N/A | SPR Education Lead | N/A |
| | Howard Kynaston | Consultant | Surgery | Yes | Company Director - Bay Tree Wine Company<br>Wife, Amanda Kynaston - Company Director Bay Tree Wine Company | N/A | N/A | N/A | N/A |
| | Alun Rhys Bonello | Physiotherapist | CD&T | Yes | N/A | N/A | N/A | N/A | N/A |
| | James Smith | Advanced MSK Physiotherapist | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Sarah Alexander | Physiotherapist | Therapies | No | N/A | N/A | N/A | N/A | N/A |
| | Hayley Dalls | Physiotherapist | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Leanne Matthews | Physio Technician | CD&T | No | N/A | N/A | N/A | N/A | Working at Private Clinic |
| | Kath Singleton | Dietitian | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Elizabeth Wilding | Dietician | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Gary Howell | Macmillan AHP Cancer Lead | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Marzena Zyd | Dietetic Support Worker | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Victoria Chapman | Dietetic Support Worker | CD&T | Yes | Father is Director of Nodor international | N/A | N/A | N/A | N/A |
| | Julia Lisa Williams | All Wales Nutrition Training Facilitator | CD&T | No | Director British Dietetic Association | N/A | N/A | N/A | N/A |
| | Gemma Purcell-Jones | Community Dietitian - Chronic Conditions Management Team | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Fiona Moore | Community Dietitian | CD&T | Yes | Director GRJM Consultancy Limited<br>Spouse - Director GRJM Consultancy Limited | N/A | N/A | Spouse - Trustee and Treasurer for Cancer Research Wales | N/A |
| | Melanie Gray | Community Dietitian | CD&T | No | N/A | N/A | N/A | Representative on the All Wales Diabetes Patient Reference Group, BDA South Wales Branch PR and Social Media Manager, Founder | Novo Nordisk Patient Reference Group Representative, Abbott Diabetes Patient Blogger, International Diabetes Federation Young |
| | Sally Shand | Counsellor | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Conor Dunleavy | Physiotherapy | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Garwyn Bridges | Physiotherapy, Cystic Fibrosis | CD&T | No | N/A | N/A | Advisory Board - CLIESI Ltd - Honararia | N/A | N/A |
| | Georgina Hooper | Physiotherapy Team Lead | CD&T | No | N/A | N/A | N/A | N/A | Chair of South Wales (ATOCP) Professional Network Group |
| | Ann Jones | Patient Safety Manager | Corporate Nursing | No | N/A | N/A | Annual participation in conference sponsored by Fresenius Medical Care Middle East | N/A | N/A |
| | Rachael Barlow | Clinical Lead | Surgery | No | N/A | N/A | N/A | N/A | N/A |
| | Pippa Mundy | Clinical Psychologist | Women & Children | No | N/A | N/A | N/A | N/A | N/A |
| | Kathryn Louise Allen | Community Pharmacy Advisor | PCIC | No | Davies Homes Ltd | N/A | N/A | N/A | N/A |
| | Andy Jones | Lead Nurse: Surgery, urology, ophthalmology ent, dental wound healing and breast | Surgery | No | N/A | N/A | N/A | Trustee of Heath Evangelical church (registered charity) | N/a |
| | James Coulson | Honorary Consultant Physician, Clinical Pharmacologist & Toxicologist | Medicine & CD&T | Yes | Both Director of Medical, Scientific & Toxicology Consultancy Ltd | Consultancy for Simbec-Orion Plc, a CRO involved in early phase clinical trials. | N/A | N/A | N/A |
| | Jessica Quirke | Consultant Clinical Neuropsychologist | Specialist Services | No | N/A | N/A | N/A | N/A | N/A |
| | Christopher Howrad Lewis | Deputy Director of Finance | Executives | Yes | N/A | N/A | N/A | President of Wales Branch of the Healthcare Financial Management Association(HFMA). HFMA is a registered charity. | My wife is Samantha Lewis, Assistant Director of Finance, Abertawe Bro Morgannwg University Health Board |
| | Christopher Anderson | Clinical Scientist | All Wales Genomics Service | Yes | N/A | My spouse also works for AWMGS (Sarah Anderson) | N/A | N/A | N/A |
| | Louise Evans | Clinical Psychologist | Mental Health | No | N/A | N/A | N/A | N/A | N/A |
| | Miranda Barber | Consultant Clinical Psychologist | Mental Health | No | Director Limited company (not traded on it since April 2018) - end client was not in the business of providing any form of health care | N/A | N/A | N/A | N/A |
| | Rhys Morris | Clinical Scientist | CD&T | No | N/A | Provision of scientific advice and teaching to Eezcare Medical Corp | N/A | N/A | N/A |
| | Helen Ludlow | CNS | Medicine | No | N/A | N/A | N/A | N/A | N/A |
| | Catherine Bryant | Consultant Clinical Scientist, Head of Non-Ionising Radiation | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Clare Quinn | Consultant Clinical Psychologist | MHCB | No | N/A | N/A | N/A | N/A | N/A |
| | Kim Atkinson | Strategic Lead Occupational Therapist | CD&T | No | Director of the Royal College of Occupational Therapists | N/A | N/A | Royal College of Occupational Therapists (Council Member) | N/A |
| | Julie Highfield | Consultant Clinical Psychologist Critical Care / Asscoaite Director Critical Care | Specialist Services | Yes | N/A | N/A | N/A | N/A | N/A |
| | Lee Davies | Operational Planning Director | Chief Operating Officer | Yes | N/A | N/A | N/A | N/A | N/A |
| | Declan Coleman | Clinical Scientist | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Emyr Stephens | Prescribing Advisor | PCIC | no | N/A | N/A | N/A | N/A | I have taken part in an Advisory Board for various products over the last 10 years or so. These were all for 1 day only. |
| | Judy Gaunt | Service Manager | CD&T | Yes | N/A | N/A | N/A | N/A | N/A |
| | Gary Howell | Macmillan AHP Cancer Lead | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Annette Mclean | Dietitcian | CD&T | No | N/A | N/A | N/A | N/A | N/A |
| | Matthew Thomas | Consultant | Dental | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Report Title:** | **Legislative and Regulatory Tracker Report** | | | | | | |
| **Meeting:** | Audit Committee | | | | **Meeting Date:** | 03.12.19 | |
| **Status:** | **For Discussion** | | **For Assurance** | | **For Approval** | | **For Information** |
| **Lead Executive:** | **Director of Corporate Governance** | | | | | | |
| **Report Author (Title):** | **Director of Corporate Governance** | | | | | | |

**SITUATION**

This report provides Members of the Audit Committee with information on Legislation and Regulatory Compliance at Cardiff and Vale Local University Health Board by means of a Regulatory Tracking Report (attached at Appendix 1).

**BACKGROUND**

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

**ASSESSMENT**

Good progress has been made on the development of a Legislative and Regulatory Tracker and the follow up internal audit report now gives 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. The tracker now provides the following details:

- All Regulatory Bodies which inspect Cardiff and Vale UHB are listed
- The Regulatory Standard which is being inspected is listed
- The Lead Executive in each case is detailed
- The Assurance Committee where any inspection reports will be presented along with any action plans as a result of inspection is detailed
- The accountable individual is detailed and where there is a gap this will be the lead Executive
- Where we have been informed what the inspection cycle is we have detailed it where we have not been informed or simply don't know we have put 'ad hoc'.
- The last inspection date is detailed and also detailed is where Cardiff and Vale have not been inspected in the last 10 years.
- Where we know the inspection date it is detailed. Where we know the inspection cycle and the last time it was inspected we have put in a predicted date so we don't completely lose sight of it. Where the cycle time is ad hoc we have stated that no inspection has been notified and when we are notified via the central inbox, which has been set up, this will be added to the tracker. Hence we have called this column 'expected date of inspection'. Where there is an * it means an inspection was expected but never took place.

- Where we know the outcome of the inspection we have included it. Where there were no issues picked up we have put this column to 'action complete' this links to the final column which is a binary complete or not complete. The reason for this is that it will link to the dials in due course.

Clearly the Legislative and Regulatory tracker will continue to develop and improve through the quarterly follow up process which has been put in place. The next steps in the development of the tracker will be the completion of the dials which show the level of compliance and predicted next inspection date which then gives an indication and assurance on whether the area being inspected is likely to be compliant or not.

A new policy has been developed and approved by the Management Executives it is also due to be approved by HSMB at the beginning of October.

The tracker will now be updated on a quarterly basis throughout the organisation and also reported to the Audit Committee on a quarterly basis after been presented to HSMB.
Based on the information currently contained within the tracker there are six inspections due in relation to Regulatory Compliance for the remainder for 2019. These are as follows:

1. An inspection by the **All Wales Quality Assurance Pharmacist** is due in October 2019 on **Pharmacy SMPU**. This is currently classed as high risk and not yet compliant due to the fact the there is an issue resourcing an accountable pharmacist. This is an annual inspection. The outcome will be reported to the QSE Committee and then at a higher level to the Audit Committee.

**Outcome:** Inspection was undertaken on 1st November 2019. The outcome of the inspection was 'high risk' with the requirement to resource and accountable pharmacist.

2. An inspections by the **Health and Safety Executive** on **Violence and Aggression** is due in November 2019. The inspection is ad hoc and there is no data on previous inspections in this area. The outcome will be reported to Health and Safety Committee and then at a higher level to the Audit Committee.

**Outcome:** No inspection undertaken as of 26th November 2019

3. An inspection by the **Medicines and Healthcare products Regulatory Agency** (MRHA) on **Blood Transfusion** is due in December 2019. They last inspected 12 months ago in December 2018 and found 2 major issues and 1 other issue. These issues are on track for compliance by the next inspection. The outcome will be reported to the QSE Committee and then at a higher level to the Audit Committee.

**Outcome:** No inspection undertaken as of 26th November 2019

4. An inspection by **Natural Resources Wales** is due to take place on **Medical Physics** at the University Hospital Llandough. It was last inspected in January 2018 and due for another inspection in November 2019. This is an annual inspection. From the last inspection there was 1 action and 1 recommendation and these issues are on track for compliance by the next inspection. The outcome will be reported to Health and Safety

Committee and then at a higher level to the Audit Committee.

**Outcome:** Inspection was undertaken on 1st November 2019. The outcome of the inspection was 1 action and 1 recommendation.

5. An inspection by **Quality in Primary Immunodeficiency Services (QPIDS)** is due in October 2019 on **Immunology**. There is currently no further detail on this inspection but the outcome will be reported to QSE Committee and then at a higher level to the Audit Committee.

**Outcome:** Inspection took place on 1st October. The outcome of the inspection was accreditation declined.

6. An inspection by **SGS/UKAS** is due to take place in September 2019 in SSSU on M**edical Devices**. It is an annual inspection and was last inspected in January 2019 where three minor issues were highlighted. These issues are on track for compliance. The outcome will be reported to the QSE Committee and then at a higher level to the Audit Committee.

**Outcome:** No inspection undertaken as of 26th November 2019

In addition to the above the following inspections have been undertaken since the last meeting of the Audit Committee :

1. An inspection by **Cardiff and Vale of Glamorgan Food Hygiene Rating** at **Teddy Bear Nursery**

**Outcome**: Inspection took place on 4th September. The outcome of the inspection was a Food Rating 4

2. An inspection by **Cardiff and Vale of Glamorgan Food Hygiene Rating** at **Llandough Hospital**

**Outcome:** Inspection took place on 19th September. The outcome of the inspection was a Food Rating 5

3. An inspection by **Cardiff and Vale of Glamorgan Food Hygiene Rating** at **Hafan y Coed**

**Outcome:** Inspection took place on 19th September. The outcome of the inspection was a Food Rating 5

4. **Fire and Rescue Service** at **Cerys Ward ICU**

**Outcome:** Inspection took place on 19th September. The outcome was failed to comply with the requirements of safety order. Schedule of works required 1 x estates, 1 x compliance.

5. **Fire and Rescue Services** at **Ward 5**

**Outcome:** Inspection took place on 19th September. The outcome was failed to comply with the requirements of safety order. Schedule of works required 1 x estates.

6. **Fire and Rescue Service** at **Ward B5**

**Outcome:** Inspection took place on 19th September. The outcome was failed to comply with the requirements of safety order. Schedule of works required 1 x estates, 1 x compliance, 1 x management.

7. **Fire and Rescue Services** at **Operating Theatre**

**Outcome:** Inspection took place on 19th September. The outcome was failed to comply with the requirements of safety order. Schedule of works required 1 x estates, 2 x compliance.

8. **HIW** at **Rookwood Hospital**

**Outcome:** Unannounced inspection took place on 1st October 2019. Awaiting further information

9. **HIW** at **Stroke Rehabilitation**

**Outcome:** Unannounced inspection took place on 17th and 18th September 2019. Immediate assurance was required in relation to appropriate checks on resuscitation trolleys. Action plan completed.

10. **HIW** Bupa **Dental Care Canton**

**Outcome:** Inspection took place on 2nd September 2019. Non compliance notice issued regarding hazardous storage of healthcare waste and inaccurate dental records. Improvement plan was required by 11th September.

11. **SGS/UKAS Haematology**

**Outcome:** Inspection took place on 6th November 2019. Accreditation extra visit which had 2 x mandatory actions requiring evidence to UKAS and 1 x action recommended**.**

12. **SGS/UKAS Medical Genetics**

**Outcome:** Inspection took place on 2nd and 5th November 2019. 14 x mandatory actions requiring evidence to UKAS and 5 x recommended actions.

13. **West Midlands QRS Haematology Red Cell Service**

**Outcome:** Inspection took place on 24th September 2019. Was that the Radio pharmacy Laboratory was approved until 31st December 2019.

**RECOMMENDATION**

For Members of the Audit Committee to:

(a) Note the inspections which have taken place since the last meeting of the Audit Committee in September 2019 and their respective outcomes.

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

| **Shaping our Future Wellbeing Strategic Objectives**<br>*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**<br>*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<br>*If "yes" please provide copy of the assessment. This will be linked to the report when published.* |

**REGULATORY BODY REVIEW TRACKER - September 2019**

| Clinical Board | Directorate | Regulatory body/inspector | Service area | Regulation/Standards | Lead Executive | Assurance Committee | Accountable individual | Inspection cycle time | last inspection date | Next inspection date | Inspection outcome | inspection closure due by | inspection closure complete/ontrack? 1=Y 2=N |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Pharmacy | All Wales Quality Assurance Pharmacist | Pharmacy SMPU | Medicines Act 1968 (c.67) specific review of section 10 | Stuart Walker | | Darrell Baker | annual | 11/1/2018 | Oct-19 | High Risk - resourcing of an accountable pharmacist | 11/1/2019 | 2 |
| | Pharmacy | All Wales Quality Assurance Pharmacist | Pharmacy UHL | Medicines Act 1968 (c.67) specific review of section 10 | Stuart Walker | | Darrell Baker | annual | 7/16/2019 | | High Risk - estate and PQS defciencies - link to MHRA inspection | 1/1/2019 | 1 |
| | | **British Standards Institute** | | | | | | | | | | | |
| | | Cardiff and Vale of Glamorgan Food Hygiene Ratings | Teddy Bear Nursery | Food Safety Act 1990 (the Act), | Abigail Harris | Health and Safety | | | 9/4/2019 | | Food rating 4 | 9/30/2019 | |
| | | Cardiff and Vale of Glamorgan Food Hygiene Ratings | Llandough Hospital | Food Safety Act 1990 (the Act), | Abigail Harris | Health and Safety | | | 9/19/2019 | | Food rating 5 | | |
| | | Cardiff and Vale of Glamorgan Food Hygiene Ratings | Hafan y Coed | Food Safety Act 1990 (the Act), | Abigail Harris | Health and Safety | | | 9/19/2019 | | Food rating 5 | | |
| | Pharmacy | | | Falsifying Medicines Directive | Stuart Walker | QSE Committee | Darrell Baker | n/a | n/a | n/a | no inspection data as yet | | |
| | | Fire and Rescue Services | C5 UHW | Health and Safety at Work Act 1974 | Abigail Harris | Health and Safety | | | 6/17/2019 | | Failed to comply with requirements of safety order. Schedule of works required included:<br>3 x management<br>1 x estates | | |
| | | Fire and Rescue Services | B7 UHW | Health and Safety at Work Act 1974 | Abigail Harris | Health and Safety | | | 6/27/2019 | | Failed to comply with requirements of safety order. Schedule of works required included:<br>3 x management<br>1 x compliance<br>1 x estates | | |
| | | Fire and Rescue Services | West 3 Anwen Ward UHL | Health and Safety at Work Act 1974 | Abigail Harris | Health and Safety | | | 7/9/2019 | | Failed to comply with requirements of safety order. Schedule of works required included:<br>1 x management<br>1 x estates | | |
| | | Fire and Rescue Services | Cerys Ward ICU | Health and Safety at Work Act 1974 | Abigail Harris | Health and Safety | | | 9/10/2019 | | Failed to comply with requirements of safety order. Schedule of works required included:<br>1 x compliance<br>1 x estates | | |
| | | Fire and Rescue Services | Ward A5 | Health and Safety at Work Act 1974 | Abigail Harris | Health and Safety | | | 9/19/2019 | | Failed to comply with requirements of safety order. Schedule of works required included:<br>1 x estates | | |
| | | Fire and Rescue Services | Ward B5 | Health and Safety at Work Act 1974 | Abigail Harris | Health and Safety | | | 9/19/2019 | | Failed to comply with requirements of safety order. Schedule of works required included:<br>1 x compliance<br>1 x estates<br>1 x management | | |
| | | Fire and Rescue Services | Operating Theatres | Health and Safety at Work Act 1974 | Abigail Harris | Health and Safety | | | 9/30/2019 | | Failed to comply with requirements of safety order. Schedule of works required included:<br>2 x compliance<br>1 x estates | | |
| | | Health and Safety Executive | | Health and Safety at Work Act 1974 | Martin Driscoll | Health and Safety | | | | | | | |
| | | Health Education and Improvement Wales | | | | | | | | | | | |
| Specialist | Rehabilitation | HIW (Unannounced) | Rookwood Hospital | HIW | Ruth Walker | QSE | Director of Nursing, Specialist | | 10/2/2019 | | | | |

**REGULATORY BODY REVIEW TRACKER - September 2019**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine | Stroke Rehabilitation | HIW (Unannounced) | Stroke Rehabilitation Centre, UHL | HIW | Ruth Walker | QSE | Director of Nursing, Medicine | | 17 & 18/09/19 | | Immediate assurance was required in realtion to appropriate checks on resuscitation trolleys. Action plan completed. | | |
| PCIC | Dental | HIW (Announced visit) | BUPA Dental Care, Canton | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 9/2/2019 | | Non-compliance notice issued regarding incorrect and hazardous storage of healthcare waste and innaccurate dental records. Improvement plan required by 11th September 2019. | | |
| PCIC | Dental | HIW (Announced visit) | Family Dental Care | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 8/19/2019 | | 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. | | |
| PCIC | GP Practice | HIW (GP Announced visit) | Waterfront Medicial Centre | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 8/12/2019 | | | | |
| PCIC | Dental | HIW | Cathays Dental Practice | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 8/5/2019 | | Non-compliance notice - storage of healthcare waste. | | |
| PCIC | Dental | HIW | High Street Dental Practice, Cowbridge | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 7/23/2019 | | Non-compliance notice - The service must ensure healthcare waste is being stored appropriately and securely within the dental practice in line with best practice guidelines. HIW found evidence that the practice was not fully compliant with current regulations, standards and best practice guidelines | | |
| PCIC | GP Practice | HIW | Birchgrove Surgery | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 7/10/2019 | | 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. | | |
| PCIC | Dental | HIW (Announced visit) | Penarth Dental Healthcare | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 7/1/2019 | | 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. | | |

**REGULATORY BODY REVIEW TRACKER - September 2019**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PCIC | Dental | HIW (Announced visit) | Llanederyn Dental Practice | Private Dentistry Regulations/All Healthcare Standards | Ruth Walker | QSE | Director of Nursing, PCIC | | 5/23/2019 | | 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.<br>There were a number of policies and procedures in place, but they were not dated, not version controlled, did not contain a review date and in the majority of instances did not include a staff signature demonstrating that the policies and procedures had been read and understood. HIW recomended that the practice need to ensure that all staff are appropriately trained with evidence of this training held on file. HIW recommended a number of improvements should be made including the review of policies and procedures which should be communicated to staff; training to be given to all staff as required and evidence maintained of this training on a training matrix; introduction of a programme of clinical and quality audits; provision of more information to patients in the reception area; completion of patient clinical records as required by clinical guidelines and the provision of more robust management of the practice going forward. Whislt this has not resulted in the issue of a non compliance notice, HIW expectation is that meaninful action is taken to address these matters as failure to do so could result in non compliance with the regulations | | |
| PCIC | Dental | HIW (Announced visit) | Tynewydd Dental Care | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 5/13/2019 | | HIW found some evidence that the practice was not fully compliant with Private Dentistry Regulations and all Health and Care Standards and a non compliance issue was issued. Copy of immediate assurance letter dated 24.05.19 received. | | |
| PCIC | Dental | HIW | Park Place Dental | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 5/1/2019 | | HIW recommend improvements could be made regarding advising patients of the results of their feedback and any changes. Review the management of emergency drugs and ancillary equipment. | | |
| PCIC | | HIW (Clinical Review) | Her Majesty's Prison, Cardiff | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 5/1/2019 | | 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 :<br>• Action to be taken to determine the cause of the non-attendance<br>• 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<br>• If there is any hindrance, as was the situation in this case, the nature of this hindrance should be documented<br>• Any action that needs to take place to overcome the hindrance should be documented.<br>• The situation should be reviewed after a reasonable length of time to ensure that the hindrance had been overcome.<br>• In the case of patients who choose not to attend, this should be addressed during routine chronic disease management appointments and opportunistically and should be documented.<br>• Appropriate Read Codes should be used for all of the above to enable accurate searches and recalls to take place. These should also allow for comparisons between episodes of a similar nature. | | |
| PCIC | Dental | HIW (Announced visit) | Cathedral Dental Clinic | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 3/26/2019 | | Due to the CCTV cameras located within the practice, including the surgeries HIW have asked for CCTV signage to be clear and prominent to all patients and visitors attending the practice. Policies and procedures need to be updated to reflect current CCTV guidelines. The patient records HIWreviewed were detailed, but they identified some areas where improvement is required. | | |
| Medicine | Emergency Care | HIW (Unannounced) | Emergency Unit/Assessment Unit | HIW | Ruth Walker | QSE | Director of Nursing, Medicine | | 3/25/2019 | | 28th March 2019 - immediate improvement plan required - letter; response 05-04-19; HIW response 11-04-19 - immediate assurance plan not accepted; 2nd UHB reponse 29th April 2019; HIW response accepting immediate assurance. Response sent 07.06.19. HIW assurance received 20.06.19. | | |

**REGULATORY BODY REVIEW TRACKER - September 2019**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental Health | | HIW (Unannounced) | Hafan Y Coed | HIW | Ruth Walker | QSE | Director of Nursing, Mental Health | | 3/18/2019 | | 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<br>Garden areas on all wards are in need of maintenance and the responsibility for this, needs to be confirmed<br>Inconsistency of information displayed for patients and relatives across the wards<br>Page 7 of 34<br>HIW report template version 2<br>Areas of good practice employed on some wards are not shared with others to maintain consistency<br>Some patients are sleeping out1 from their designated ward due to additional demand and clinical need | | |
| PCIC | Dental | HIW (Announced visit) | Danescourt Dental Practice | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 3/18/2019 | | 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.<br><br>The Primary Care team has also audited fridge temperature logs and noted that temperatures were recorded on all working days. | | |
| PCIC | Dental | HIW (Announced visit) | Alison Jones, Barry | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 12/17/2018 | | 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. | | |
| PCIC | Community | HIW | Mental Health Team, Western Vale | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 12/4/2018 | | | | |
| PCIC | Dental | HIW (Announced visit) | Penylan Dental Practice | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 11/28/2018 | | 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 | | |
| PCIC | GP Practice | HIW (Announced visit) | Pontprennau Medical Centre | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 11/5/2018 | | 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. | | |
| PCIC | Dental | HIW | Windsor Road Dental Care, Cardiff | HIW | Ruth Walker | QSE | Director of Nursing, PCIC | | 10/29/2018 | | 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. | | |
| | Radiology | HIW | Radiology | The Ionising Radiation (Medical Exposure) Regulations 2017 | Ruth Walker | | Andrew Wood/Kathy Ikin | ad hoc | 10/4/2017 | | 3 non conformances | 2/28/2018 | 1 |
| | Medical Physics | HIW - MARS associated with IR(ME)R | Medical Physics | The Medicines (Administration of Radioactive Substances) Regulations 1978 | Ruth Walker | | Andrew Wood/Kathy Ikin | ad hoc | not inspected in the last 10 years | | n/a | n/a | |
| | Radiology | HSE | Radiology | The Ionising Radiations Regulations 2017 | Martin Driscoll | | Andrew Wood/Kathy Ikin | ad hoc | not inspected in the last 10 years | | last inspections pre 2004, no inspeciton data currently available | | |

**REGULATORY BODY REVIEW TRACKER - September 2019**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Medical Physics | HSE | Medical Physics | Control of Artificial Optical Radiation at Work Regulations 2010 | Martin Driscoll | | Andrew Wood/Kathy Ikin | ad hoc | not inspected in the last 10 years | | last inspections pre 2004, no inspeciton data currently available | | |
| | Medical Physics | HSE | Medical Physics | The Control of Electromagnetic Fields at Work Regulations 2016 | Martin Driscoll | | Andrew Wood/Kathy Ikin | ad hoc | not inspected in the last 10 years | | last inspections pre 2004, no inspeciton data currently available | | |
| | Haematology | HTA | Stem Cell processing Unit (HTA) | Human Tissue Act | Fiona Jenkins | | Alun Roderick/Sarah Phillips | 730 | 1/22/2019 | | 1 major 4 minors | 9/6/2019 | 1 |
| | Cellular Pathology | HTA | Mortuary (Cell Path - HTA) | Human Tissue Act | Fiona Jenkins | | Adam Christian/Scott Gable | 730 | 11/22/2018 | | 3 criticals, 14 majors, 9 minor | 1/31/2019 | 1 |
| | | Joint Education Accreditation Committee | | Stuart Walker | | | | | | | | | |
| | Lab Med | MHRA | Blood transfusion (BSQR) | Blood and Safety Quality Regulations | Fiona Jenkins | | Andrew Gorringe/Alun Roderick | 365 | 12/13/2018 | | 2 majors 1 other | 2/28/2019 | 1 |
| | Pharmacy | MHRA | Pharmacy SMPU | Good manufacturing practice (GMP) and good distribution practice (GDP) | Stuart Walker | | Darrel Baker | 365 | 7/23/2019 | | 3 majors 2 others | 12/3/2019 | 1 |
| | Pharmacy | MHRA | Pharmacy UHL | Good manufacturing practice (GMP) and good distribution practice (GDP) | Stuart Walker | | Darrel Baker | 730 | 1/21/2015 | | 2 majors 6 minors | 6/30/2015 | 1 |
| | Medical Physics | MHRA | radiopharmacy | Good manufacturing practice (GMP) and good distribution practice (GDP) | Fiona Jenkins | | Andrew Wood/Kathy Ikin | 730 | 7/23/2019 | | 5 majors, 2 others | tbc with regulator | 1 |
| | 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 | | Andrew Wood/Kathy Ikin | ad hoc | 1/2/2011 | no inspection notified | No inspection to date in this area | n/a | n/a |
| | Medical Physics | MHRA | Medical Physics | Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use 2015. | Fiona Jenkins | | Andrew Wood/Kathy Ikin | ad hoc | 1/3/2011 | no inspeciton notified | no inspection to date in this area | n/a | n/a |
| | Medical Physics | MHRA | Medical Physics | Managing Medical Devices 2015 | Fiona Jenkins | | Andrew Wood/Kathy Ikin | ad hoc | 1/5/2011 | no inspeciton notified | no inspection to date in this area | n/a | n/a |
| | Haematology | Natural Resources Wales | Medical Physics UHL | The Environmental Permitting (England and Wales) Regulations 2010 (EPR 2010) | Fiona Jenkins | | Andrew Wood/Kathy Ikin | annual | 1/26/2018 | 11/1/2019 | 1 action, 1 reccomendation | 2/28/2018 | 1 |
| | Medical Physics UHW | Natural Resources Wales | Medical Physics UHW | The Environmental Permitting (England and Wales) Regulations 2010 (EPR 2010) | Fiona Jenkins | | Andrew Wood/Kathy Ikin | annual | 4/30/2019 | | 0 | n/a | 1 |
| | | Natural Resources Wales | Radiopharmacy Laboratory | The Environmental Permitting (England and Wales) Regulations 2010 (EPR 2010) | Fiona Jenkins | | Matthew Talboys / Nicola O'Callaghan | | 9/24/2019 | | This is approved until 31/12/2019 | | |
| | Medical Physics | Office for Nuclear regulation | Medical Physics | The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 | Fiona Jenkins | | Andrew Wood/Kathy Ikin | biannual | 3/17/2017 | | 4 non conformances, 3 reccomendaitons | 5/1/2017 | 1 |
| | | Quality in Primary Immunodeficiency Services (QPIDS) | | | Stuart Walker | QSE Committee | | | 10/1/2019 | | Accreditation declined | | |

**REGULATORY BODY REVIEW TRACKER - September 2019**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Haematology** | Research and Development | | | Stuart Walker | | | | | | | | |
| | Haematology | UKAS | Haematology/Blood Transfusion (UKAS) | ISO 15189 | | | Andrew Gorringe/Alun Roderick | 365 | 5/2/2019 | | 25 findings | 5/5/2019 | 1 |
| | Haematology | UKAS | Phlebotomy (UKAS) | ISO 15189 | | | Andrew Gorringe/Alun Roderick | 365 | 5/2/2019 | | included in Heamatology findings above | 5/5/2019 | 1 |
| | Cellular Pathology | UKAS | Cellular Patholgy/ (Mortuary - UKAS) | ISO 15189 | Fiona Jenkins | | Adam Christian/Scott Gable | 365 | 2/27/2019 | | 14 findings | 3/27/2019 | 1 |
| | Biochemistry | UKAS | Biochemistry (UKAS) | ISO 15189 | Fiona Jenkins | | Carol Evans/Nigel Roberts | 365 | 1/14/2019 | | 25 findings | 2/16/2019 | 1 |
| | Biochemistry | UKAS | Specimen Reception (UKAS) | ISO 15189 | | | Carol Evans/Nigel Roberts | 365 | 1/14/2019 | | 2 findings and 1 reccomendation Included in findings of Biochemistry UKAS | 2/16/2019 | 1 |
| | | Welsh Water | | | Abigail Harris | | | | | | | | |
| | audiology | WSAC | audiology - adults | audiology quality standards | | | lorraine Lewis | 3 yearly | 6/1/2019 | Jun-22 | compliant with 8 of 9 standards and meeting 85% target | 7/12/1905 | 1 |
| | audiology | WSAC | Newborn hearing screeing wales | audiology quality standards | | | Jackie Harding | 2 yearly | 6/1/2018 | Jun-20 | 80% target met in all standards and 85% overall target met | 1/1/2019 | 1 |
| | audiology | WSAC | audiology - paediatrics | audiology quality standards | | | Jackie Harding/Rhian Hughes | 2 yearly | 6/1/2018 | Jun-20 | 80% target met in all standards and 85% overall target met | 7/12/1905 | 1 |
| Specialist Services | Haematology | JACIE | South Wales BMT Programme | 6th edition of JACIE standards | Stuart Walker | | Keith Wilson | Every 4 years | 4-5/02/2019 | Feb-23 | Minor deficiencies noted | 10/1/2019 | 1 |
| Specialist Services | Haematology | HTA | South Wales BMT Programme | Human Tissue Act | Fiona Jenkins | | Xiujie Zhao | 730 | 22-23/01/2019 | | 1 minor | 9/6/2019 | 1 |
| Specialist Services | Immunology | QPIDS | Immunology | Quality in Primary Immunodeficiency Services Standards | Stuart Walker | | Stephen Jolles/Richard Cousins | 365 | | 10/1/2019 | | | |
| Specialist Services | N&T | HTA | South Wales Transplant and NORS programme | Human Tissue Act | Fiona Jenkins | | Rafael Chavez | Every 2 years | 5-6/12/2016 | self reported compliance due by 18/10/2019 | Number of areas of good practice noted | 2/7/2017 | 1 |
| Specialist Services | ALAS | MHRA | ALAS (CAV) | Managing Medical Devices 2015 | Fiona Jenkins | | Paul Rogers | ad hoc | | | | | |
| Specialist Services | ALAS | SGS/UKAS | ALAS (CAV) | ISO 9001:2015 | Fiona Jenkins | | Paul Rogers | 185 (Twice Yearly) | 19/20 and 06/19 | Jan-20 | 2 x Major Corrective Actiions, 1 X Minor Corrective Action, Several Opportunities for Improvement | 9/6/2019 | 1 |
| Surgical Services | Perioperative | SGS/UKAS | SSSU | ISO 13485:2016 | Fiona Jenkins | | Clare Jacobs | annually | 1/1/2019 | Sep-19 | 3 minors | 1/1/2020 | 1 |
| Surgical Services | Perioperative | SGS/UKAS | HSDU | ISO 13485:2017 | Fiona Jenkins | | Mark Campbell | annually | 8/1/2019 | Aug-20 | 2 minors | 8/1/2020 | 1 |
| Specialist Services | Haematology | SGS/UKAS | | ISO 15189:2012 | Fiona Jenkins | | Alun Roderick | | 11/6/2019 | | Accreditation extra visit: Action Mandatory x 2<br>Require Evidence to UKAS x 1<br>Action Recommended x 1 | 6.12.19 | |
| CD&T | Medical Genetics | SGS/UKAS | | ISO 15189:2012 | Fiona Jenkins | | Peter Thompson | | 2 and 5/11/19 | | Action Mandatory x 14<br>Require Evidence to UKAS x 14<br>Action Recommended x 5 | 5.12.19 | |
| 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)<br>Clare Rowntree (Clinical Director) | 3 years | 10/1/2019 | Oct-22 | In need of investment from WHSSC and ini stafff | 12/1/2019 | 1 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Report Title:** | **Internal Audit Recommendation Tracking Report** | | | | | | | | |
| **Meeting:** | Audit Committee | | | | | | **Meeting Date:** | 03.12.2019 | |
| **Status:** | **For Discussion** | | **For Assurance** | **x** | **For Approval** | **x** | **For Information** | | |
| **Lead Executive:** | **Director of Corporate Governance** | | | | | | | | |
| **Report Author (Title):** | **Director of Corporate Governance** | | | | | | | | |

**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.

**BACKGROUND**

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 2 financial years and shows progress made against recommendations from 17/18 and18/19. It also show recommendations which have been made during 19/20.

**ASSESSMENT**

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

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

| | Substantial Assurance | Reasonable Assurance | Limited Assurance | Total |
|---|---|---|---|---|
| **Internal Audits 17/18** | 7 | 25 | 5 | 37 |
| **Internal Audits 18/19** | 10 | 26 | 7 | 43 |
| **Internal Audits 19/20** | 3 | 4 | - | 7 |

Attached at Appendix 1 are summary tables which provide an update on the September 2019 position.

As can be seen from the above tables there is further work to be done to ensure that recommendations made by internal audit and agreed by Executive Directors are implemented in a timely manner.

Reports will, in future, be discussed at Management Executives and HSMB which includes the entire leadership team of the organization.

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

**RECOMMENDATION**

The Audit Committee Members are asked to:

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

| **Shaping our Future Wellbeing Strategic Objectives**<br>*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**<br>*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~~<br>*If "yes" please provide copy of the assessment. This will be linked to the report when published.* |

**INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2017/18**

| | Baseline | | Update Nov 2019 | | | Baseline | | Update Nov 2019 | | | Baseline | | Update Nov 2019 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Recommendation Status** | **High** | **%** | **C** | **PC** | **NA** | **Medium** | **%** | **C** | **PC** | **NA** | **Low** | **%** | **C** | **PC** | **NA** |
| **Complete** | 2 | 8% | 2 | - | - | 12 | 18% | 12 | - | | 6 | 18% | 6 | - | - |
| **Overdue under 3 months** | - | | - | - | - | 1 | 1% | - | - | 1 | - | | - | - | - |
| **Overdue over 6 months under 12 months** | 1 | 4% | 1 | - | - | 7 | 10% | 2 | - | 5 | 1 | 3% | 1 | - | - |
| **Overdue more than 12 months** | 17 | 68% | 3 | 2 | 12 | 36 | 53% | 7 | 2 | 27 | 20 | 59% | 5 | 2 | 13 |
| **Superseded** | 5 | 20% | 2 | - | 3 | 12 | 18% | 2 | 2 | 8 | 7 | 20% | 3 | - | 4 |
| | | | | | | | | | | | | | | | |
| **Total** | **25** | **100%** | **8** | **2** | **15** | **68** | **100%** | **23** | **4** | **41** | **34** | **100%** | **15** | **2** | **17** |

From the above it can be summarised that since the last meeting-

- 8 High level actions have been completed
- 2 High level actions have been partially completed
- 15 High level actions have had no action
- 68% of High actions are more than 12 months overdue
- 23 Medium level actions have been completed
- 4 Medium level actions have been partially completed
- 41 Medium level actions have had no action
- 53% of Medium level actions are more than 12 months overdue
- 15 Low level actions have been completed
- 2 Low level actions have been partially completed
- 17 Low level actions have had no actions
- 59% of Low level actions are more than 12 months overdue

**INTERNAL AUDIT REPORT RECOMMENDATION FOR 2018/19**

| | Baseline | | Update Nov 2019 | | | Baseline | | Update Nov 2019 | | | Baseline | | Update Nov 2019 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Recommendation Status** | **High** | **%** | **C** | **PC** | **NA** | **Medium** | **%** | **C** | **PC** | **NA** | **Low** | **%** | **C** | **PC** | **NA** |
| **Date not reached** | 12 | 30 | - | 1 | 11 | 27 | 28 | 3 | 1 | 23 | 9 | 16 | 1 | - | 8 |
| **Complete** | 6 | 15 | 6 | - | - | 16 | 17 | 16 | | | 18 | 32 | 18 | - | - |
| **Overdue under 3 months** | 11 | 28 | 11 | - | 11 | 18 | 18 | 2 | 1 | 15 | - | | - | - | - |
| **Overdue by over 3 months under 6 months** | 7 | 17 | - | - | 7 | 11 | 11 | 2 | 1 | 8 | 7 | 12 | 3 | - | 4 |
| **Overdue over 6 months under 12 months** | 3 | 8 | - | - | 3 | 21 | 22 | - | - | 21 | 8 | 15 | 3 | 1 | 4 |
| **Overdue more than 12 months** | 1 | 2 | 1 | - | - | 2 | 2 | - | - | 2 | 14 | 25 | - | 1 | 13 |
| **Superseded** | | | | | | 2 | 2 | - | - | 2 | | | - | - | - |
| **Total** | **40** | **100** | **18** | **1** | **32** | **97** | **100** | **23** | **3** | **71** | **56** | **100** | **25** | **2** | **29** |

From the above it can be summarised that since the last meeting-

- 18 High level actions have been completed
- 1 High level actions have been partially completed
- 32 High level actions have had no action
- 30% of High actions haven't met their target date
- 23 Medium level actions have been completed
- 3 Medium level actions have been partially completed
- 71 Medium level actions have had no action
- 28% of Medium level actions haven't met their target date
- 25 Low level actions have been completed
- 2 Low level actions have been partially completed
- 29 Low level actions have had no actions
- 32% of Low level actions are complete

**INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2019/20**

| | Baseline | | Baseline | | Baseline | |
|---|---|---|---|---|---|---|
| **Recommendation Status** | **High** | **%** | **Medium** | **%** | **Low** | **%** |
| **Date not reached** | - | | | | | |
| **Complete** | 1 | 20 | 3 | 33 | 1 | 50 |
| **Overdue under 3 months** | - | | - | | 1 | 50 |
| **Overdue by over 3 months under 6 months** | 1 | 20 | - | | - | |
| **Overdue over 6 months under 12 months** | 3 | 60 | 6 | 67 | - | |
| **Overdue more than 12 months** | - | | - | | - | |
| **Superseded** | | | | | | |
| **Total** | **5** | **100** | **9** | **100** | **2** | |

From the above it can be summarised that since the last meeting-

- 1 High level actions have been completed
- 60% of High actions are overdue by 6-12 months however, these are from a follow up from a limited assurance internal audit report
- 3 Medium level actions have been completed
- 67% of Medium level actions are overdue by 6-12 months however, these are from a follow up from a limited assurance internal audit report.
- 1 Low level actions have been completed

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1819 | 10/1/2018 | Shaping Our Future Wellbeing – | Director of Planning | Reasonable | 2 | M | Terms of Reference should be developed for the Programme Team and Project Teams to cover the all stages of the process after the submission and approval of the business cases, i.e. delivery of the capital projects and commissioning of the facilities. Responsibilities of the Teams should include overseeing programme and project budget management, as appropriate. | Terms of reference are reviewed at each stage of the project / Programme, so that they are relevant to the current stage of the process. We will review the current wording to ensure that the responsibility for budget monitoring is clear. Audit has now been provided with a revised structure document and terms of reference for the Delivery Group and the Penarth Project Team. | Director of Planning | 11/30/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 10/1/2018 | Shaping Our Future Wellbeing – | Director of Planning | Reasonable | | L | Delivery of the required project business cases should be carefully performance monitored in-house to ensure that resources are adequate and that there are no unnecessary slippages in the target dates. | Supply Chain Partners have now been appointed for the Maelfa and Penarth schemes and their programmes confirm that the schemes can be delivered within the required timescales. The risks of delay have consequently been reduced. The risks of delay on the Park View scheme will continue to be monitored by the Project Team. | Director of Planning | 10/8/2019 | Overdue by over 6 months under 12 months |
| IA 1819 | 8/30/2018 | Dental CB – Theatre Sessions | Chief Operating Officer | Reasonable | 3 | H | The Dental administration staff should ensure that Patient Dental files contain copies of all necessary documentation relating to the procedures undertaken. | Urgent meeting to be arranged with Clinical Lead and Peri-Operative Care Manager to define a process to manage documentation | Chief Operating Officer | 9/1/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 8/30/2018 | Dental CB – Theatre Sessions | Chief Operating Officer | Reasonable | | M | The majority of patients cancelled by Dental staff are due to oversubscribed and overrun lists. Therefore, list management should be monitored and improvements made where necessary. | Reviewed PasPlus regarding start and finish times. Clinical Lead to speak with Maxillofacial Consultants | Chief Operating Officer | 9/1/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 8/30/2018 | Dental CB – Theatre Sessions | Chief Operating Officer | Reasonable | | M | Dental management should ensure that cancelled operations are re-bookedwithin the required timescales. | Where possible this is always the case but many lists are held only on a monthly basis. Dental are limited in the number of lists that are dedicated to Dental Patients and therefore if a cancer patient requires theatre we have to utilise a dedicated list and cancelled patients will be re-listed at the next scheduled list. | Chief Operating Officer | 9/1/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 8/30/2018 | Dental CB – Dental Nurse Provision | Chief Operating Officer | Reasonable | 6 | M | The Dental Nurse Management team should consider formalising ratios of Dental Nurse staff per operators /patients/procedures. This should include reevaluation of any ratios that are currently in place in agreement with the University. When these ratios have been produced they should ensure that weekly numbers allocations are adhering to these staffing levels. | To reduce duplication of lists, a meeting will be set up with Senior Dental Nurse's and colleagues working in medical records to review the current clinical staffing allocated to each department on PMS.Once complete work will begin on allocating core numbers of DN to each department. | Chief Operating Officer | 10/1/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 8/30/2018 | Dental CB – Dental Nurse Provision | Chief Operating Officer | Reasonable | | M | The Dental Nurse Management team should consider bringing forward the numbers allocation to mid-week. Consideration should be given to producing fortnightly numbers with weekly review once patient lists stabilise closer to the scheduled date. | To reduce duplication of lists, a meeting will be set up with Senior Dental Nurse's and colleagues working in medical records to review the current clinical staffing allocated to each department on PMS. Once complete work will begin on allocating core numbers of DN to each department. | Chief Operating Officer | 10/1/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 8/30/2018 | Dental CB – Dental Nurse Provision | Chief Operating Officer | Reasonable | | M | Dental Nurse Management should attend the Clinical Staffing meeting and Performance Group meeting hosted by the Medical Records team.This forum should be used to escalate dental nurse staffing issues caused by changes to clinic schedules. | Dental Nurse Manager attends Clinical staffing meeting, at this meeting Dental Nurse Manager provides feedback on concerns raised by SDN | Chief Operating Officer | Closed | Complete |
| IA 1819 | 8/30/2018 | Dental CB – Dental Nurse Provision | Chief Operating Officer | Reasonable | | L | It is recommended that the Senior Dental Nurses maintain a log that documents changes to schedules or nursing allocations as they occur and discuss these at the Senior Dental Nurse meeting to establish patterns or identify root causes. These can also be escalated to the weekly meetings with Medical records, ie. Clinical Staffing and Performance Group. | Implement feedback tool; that will be used to collect weekly changes that take place on each department. This information will form part of the weekly SDN staff discussion meeting | Chief Operating Officer | 10/1/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 8/30/2018 | Dental CB – Dental Nurse Provision | Chief Operating Officer | Reasonable | | L | The Senior Dental Nurse weekly meeting should continue to function in order to force justification of requested allocation by each clinic. | The weekly Senior Dental Nurse meeting will continue to function, chaired by the Dental Nurse manager /Deputy Dental Nurse Manager A records of attendance will also be kept. | Chief Operating Officer | 9/1/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 8/30/2018 | Dental CB – Dental Nurse Provision | Chief Operating Officer | Reasonable | | L | Consideration should be given to adding in the Senior Dental Nurses into the ESR hierarchy to delegate responsibility and distribute the administrative task of approving and recording annual leave. The use of ESR self-service by Dental Nurses should be enforced. | Where appropriate, work will begin on rolling out ESR hierarchy access to Senior Dental Nurses | Chief Operating Officer | 12/1/2018 | Overdue by over 6 months under 12 months |

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1819 | 8/23/2018 | Environmental Sustainability Re | Director of Planning | Reasonable | 4 | M | Future Sustainability Reports should only report on water supply costs. This may be achieved by: using different subjective codes to pay water and sewerage charges; by maintaining a manual record of the split between water and sewerage charges; or by apportioning annual costs based on a sample of paid water and sewerage charges. | Future Sustainability reports will include water supply costs, but will be determined on an apportionment basis from the invoices we receive from Welsh Water. The calculations will be determined from a limited sample of Welsh Water invoices. | Director of Planning | 4/1/2019 | Overdue by under 3 months |
| IA 1819 | 8/23/2018 | Environmental Sustainability Re | Director of Planning | Reasonable | | M | A requirement to draw up a timetable annually to cover the preparation of the Sustainability Report should be incorporated into the documented sustainability reporting procedure. The timetable should ensure that the draft report is signed off by the Director of Capital Estates and Facilities prior to publication in line with the required deadline. The timetable should also specify the date that the report will be approved by the Environmental Management Steering Group (EMSG) / Health & Safety Group. Where possible this should also be prior to publication, although it is acknowledged that to ensure compliance with the Welsh Government submission deadline it may sometimes be necessary to obtain retrospective approval from the EMSG / H & S Group. | A timetable will be developed in April 2019 detailing key milestones. Where possible approval will be granted prior to publication, but depending on the timing of the meetings to present the report and obtain approval, retrospective approval may also have to be considered. | Director of Planning | 4/1/2019 | Overdue by under 3 months |
| IA 1819 | 8/23/2018 | Environmental Sustainability Re | Director of Planning | Reasonable | | L | The sustainability reporting procedure notes should be supplemented with detailed information on how to prepare each of the 3 mandatory tables included in the report. The procedure should detail where the source data for each entry in the table should be obtained. | The sustainability reporting procedure now includes detailed information on how to prepare each of the 3 mandatory tables included in the report. The Energy manager has completed this exercise. This action is therefore complete. | Director of Planning | Closed | Complete |
| IA 1819 | 8/23/2018 | Environmental Sustainability Re | Director of Planning | Reasonable | | L | Future Sustainability Reports should include references / links to where further sustainability and estate management performance is published. For example this could include links to information such as the Estates Strategy, EMSG Terms of Reference and selected meeting minutes, ISO Certificate and audit reports / ISO website, Cost Reduction Programme, Re:fit programme, further information on CHP units and Solar PV Schemes and the Sustainable Travel Plan. | Consideration will be given to include references / links to where further sustainability and Estate management performance is published depending on its relevance. | Director of Planning | 4/1/2019 | Overdue by under 3 months |
| IA 1819 | 9/10/2018 | Electronic Staff Record | Director of Workforce and Organisational Development | Reasonable | 4 | H | The Workforce Department need to ensure that where ESR has been rolled out to departments that it is utilised fully and consistently with requirements, and provide further support and advice to departments where utilisation levels are not satisfactory. | During rollout (now 100% completed) managers and staff were made aware of the facility to record and manage annual leave using ESR. The facility to manage annual leave using ESR has been made available to managers and supervisors. The responsibility for ensuring staff apply for annual leave via ESR lies with the manager/supervisor. It also must be noted that where the Rosterpro system is in place, annual leaveis recorded on this system instead of ESR The Workforce Team will send a reminder to all anagers/Supervisors to use the ESR Annual Leave Functionality or use the Rostering systems that interface with ESR. They will also offer any further training if this is needed and signposting to Guidelines which are available. | Director of Workforce and Organisational Development | 9/30/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 9/10/2018 | Electronic Staff Record | Director of Workforce and Organisational Development | Reasonable | | M | Appropriate staff will be reminded that paperwork needs to be sent to Medical Recruitment on a timely basis, so that an accurate picture of compliance can be represented. | It is the responsibility of the Clinical Board Management team to identify problems area in relation to job plan compliance and send the completed/up to date job plan summaries to the generic Job Plan inbox for ESR entry by Medical Workforce.<br>The Medical Director will write to remind all Clinical Board Directors to ensure that they comply with Job Plan reporting. The Workforce & OD Team will explore how to further automate the recording of job plan updates into ESR through Manager Self Service under the supervision of the Medical Workforce Team. It is hoped this should enable updates to be done at source by Clinical Boards and Directorate Management. It is hoped that any future investment in rostering systems will interface with ESR to automate job planning updates. | Director of Workforce and Organisational Development | 10/31/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 9/10/2018 | Electronic Staff Record | Director of Workforce and Organisational Development | Reasonable | | M | Management will ensure a singular and consistent approach to reporting compliance performance with the Health Board. | This has already been actioned as the Learning Education & Development team are no longer providing PADR compliance rates as individual managers/supervisors are able to easily identify the compliance rates of all staff within their ESR hierarchies. One source of statistics is now provided to formal Meetings and Committees e.g., LPF, HSMB by the Workforce Information Manager | Director of Workforce and Organisational Development | Closed | Complete |

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1819 | 9/10/2018 | Electronic Staff Record | Director of Workforce and Organisational Development | Reasonable | | L | Workforce to ensure that Health Board staff are aware of the support and guidance that is available either through online documents or face to face to ensure staff can use ESR effectively and efficiently. Consideration should also be given to producing shortened management selfservice quick guides for wards and departments that can be easily accessed. | Contact details of the new All-Wales ESR Self-Service Support Hub (helpdesk) have been widely circulated to managers. The Hub will provide 'how-to' support for Self-Service users, and signpost to nline user guides. The C&V ESR Internet page also contains links to the same online user guides. Gong forward a survey will be undertaken with Departments to identify any further identified training needs. This will provide an opportunity to develop ocal, tailored support interventions for teams of users as the majority of helpdesk routine enquiries are covered off by the Helpdesk. | Director of Workforce and Organisational Development | 3/31/2019 | Overdue by under 3 months |
| IA 1819 | 9/10/2018 | Management of the Disciplinary | Director of Workforce and Organisational Development | Reasonable | 6 | M | A fully complete initial assessment should be on every case file, which provides the rationale for the disciplinary method. This will allow early consideration of the different disciplinary methods to drive efficient working. | The current initial assessment process has been reviewed and a more robust process will be introduced in September 2018. This new process will ensure that there is consistency in how we approach issues/concerns as an organisation. ◾ The fast track process is lways encouraged. The All Wales Policy states that all parties have to be in agreement, which has resulted in a few cases proceeding to formal investigation because the employee has not been in agreement. The HR Operations Team are currently reviewing cases that have progressed inappropriately previously and discussions are taking place with the managers and HR Practitioners who have been involved in commissioning the investigation to learn from this review. The new WOD restructure and ways of working within the HR team, will resultin higher levels of consistency. | Director of Workforce and Organisational Development | 9/30/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 9/10/2018 | Management of the Disciplinary | Director of Workforce and Organisational Development | Reasonable | | H | Management will implement mechanisms, i.e. a root cause analysis, to highlight the main constraints to timescales not being met and implement enhancements to enable an increased level of compliance with the target timescales. | The Director of Workforce & OD is leading the challenge and engagement with Trade Union Colleagues support to speed up the disciplinary process. A review has been undertaken by the Head of Operational HR to identify the main constraints in regard to unacceptable delays and the following actions have been agreed/implemented: ◾ Assistant Heads of Workforce (AHWODs) are now responsible for case management; ◾ Monthly monitoring/performance meetings are being held with the AHWODs; ◾ Monthly case review meetings are being held with the Deputy Executive Nurse Director to support progress and blockages; ◾ The previous system for coaching IO's has been changed as it often created delays in the process; The team are working with Disciplining Officers and Investigating Officers to ensure they understand their responsibilities; We are seeking commitment from the organisation to release IO's so that they can undertake investigations in an efficiently and effective manner. | Director of Workforce and Organisational Development | 3/31/2019 | Overdue by under 3 months |
| IA 1819 | 9/10/2018 | Management of the Disciplinary | Director of Workforce and Organisational Development | Reasonable | | M | Management will put processes in place to enhance file management for both fast track and full investigation methods e.g. chronology. Management should explore and consider the use of electronic file management and digitising of files in order to drive efficient and effective working. | The HR team have revised the Guidance and Information Pack for Investigating Officer's which will be implemented in September; The format of the investigation report has been revised and streamlined for consistency and will be implemented in September 2018. ◾ The HR team are piloting electronic hearing packs for all grievances and some of the appropriate disciplinary cases; ◾ HR are currently working with the Head of IT to determine how we can implement an electronic file storage system so that documents can be shared<br>securely. This will stop the need to photocopy disciplinary sharing packs. | Director of Workforce and Organisational Development | 3/31/2019 | Overdue by under 3 months |
| IA 1819 | 9/10/2018 | Management of the Disciplinary | Director of Workforce and Organisational Development | Reasonable | | M | Management will identify trends in delays and take appropriate action in order that performance improves. | The organisation of Appeals will be centralised within the HR Operations Centre in the Autumn with the ongoing support of the HR Governance Team; ◾ Greater focus has been placed on arranging appeal hearings in the last 2 months which has resulted in an improvement in timescales; ◾ The new HR Case Manager system will improve the Appeal process and ensure consistency and follow through. ◾ The way in which the HR administrator arrange both appeal and disciplinary hearings has been streamlined and we anticipate that this will result in timescale improvements. | Director of Workforce and Organisational Development | 10/30/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 9/10/2018 | Management of the Disciplinary | Director of Workforce and Organisational Development | Reasonable | | M | Training will be undertaken by all investigators to help with the efficient running of the disciplinary process. A review of the roles the coaches play in investigation will be undertaken to ensure the most effective use of resource. | The HR team are currently reviewing the UHB list of IO's to ascertain their status, i.e. have they been trained, how experienced are they, have they completed an investigation recently, etc. This will ensure that we have an accurate list of both trained and xperienced IO's to choose from; ◾ The IO training is currently being enhanced to ensure that following the training IO's are capable to undertake investigations; ◾ It was evident following the review that HR practitioners are too involved in the investigation process. This has been rectified and roles have been clarified. | Director of Workforce and Organisational Development | 11/30/2018 | Overdue by over 6 months under 12 months |

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1819 | 9/10/2018 | Management of the Disciplinary | Director of Workforce and Organisational Development | Reasonable | | M | Management should review their performance/ summary documents to ensure all information is included appropriately and a focus on outcomes. | The main ER tracker is being updated to ensure that we capture the performance data in a more streamlined way; Employee Relations reports will be reviewed to ensure that they are meaningful and outcome focused; The appeals monitoring spreadsheet has een amended and now captures the timescales; The department are currently exploring the implementation of an ER Tracker. There will be a system demonstration on 26th September, following which we will determine whether the system can deliver significant efficiency improvements and proceed to a business case proposal. | Director of Workforce and Organisational Development | 10/30/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 11/21/2018 | National Standards for Cleaning | Director of Planning | Reasonable | 6 | M | The Health Board should ensure that there is a Multi-Disciplinary Group in place in line with the requirements of the 'National Standards for Cleaning in NHS Wales' or that the Healthcare Environment Steering Group referred to in the Cleaning Strategy is reconvened. | Formerly add the Cleaning Standards requirement into one of the existing forums described above into the same agenda. This will save additional meetings and labour resources. | Director of Planning | 1/1/2018 | Overdue more than 12-months: Follow up Audit confirmed partially completed |
| IA 1819 | 11/21/2018 | National Standards for Cleaning | Director of Planning | Reasonable | | M | The Health Board should ensure that a consistent approach is used for reporting the technical audit scores across the 2 sites and that accurate scores are reported for all completed audits. | On checking with C4C both approaches were in accordance with the system and standards, however Facilities will review their approach and standardise when and if appropriate. | Director of Planning | 1/1/2018 | Follow-up Audit Confirmed Fully Complete |
| IA 1819 | 11/21/2018 | National Standards for Cleaning | Director of Planning | Reasonable | | H | An appropriate member of the Ward staff should sign off the technical audits undertaken by the domestic supervisor. | Facilities to coordinate and request clinical support on audit. Ward Sisters and Charge Nurses will be reminded of their responsibility to, when requested check the validity of the audit and sign off. | Director of Planning | 11/1/2017 | Overdue more than 12-months: Follow up Audit confirmed partially completed |
| IA 1819 | 11/21/2018 | National Standards for Cleaning | Director of Planning | Reasonable | | H | The Health Board should carry out managerial audits on a quarterly basis in line with the requirements of the Standards. | Facilities Staff to arrange audit schedule and invite ward staff to participate with good prior arrangements in place. | Director of Planning | 1/1/2018 | Follow-up Audit Confirmed Fully Complete |
| IA 1819 | 11/21/2018 | National Standards for Cleaning | Director of Planning | Reasonable | | M | Management should update the Cleaning Strategy and develop an Operational Cleaning Plan in line with the requirements of the Standards. | Facilities Senior Management to develop and disseminate to the Cleaning Group for sign off and approval. | Director of Planning | 3/1/2018 | Overdue more than 12-months: Follow up Audit confirmed partially completed |
| IA 1819 | 11/21/2018 | National Standards for Cleaning | Director of Planning | Reasonable | | M | nagement should ensure that technical audits are completed on all high / very high risk areas as per required timescales. | Facilities to review audit schedule and make clear programme to Senior Management, stating UHB priorities. | Director of Planning | 1/1/2018 | Follow-up Audit Confirmed Fully Complete |
| IA 1819 | 10/25/2018 | CRC Energy Efficiency Scheme | Director of Planning | Reasonable | 2 | M | Bureau data will be compared at meter level with supplier statements (on a like for like basis) to better inform review and compilation of the annual report. | For sites with multiple meters, the bureau data in the 2018/19 CRC reporting spreadsheet will be presented on a meter by meter basis. If there are instances where this cannot be achieved an alternative approach will be developed and adopted. | Director of Planning | 2018/2019 | Overdue by over 3 months but under 6 months |
| IA 1819 | 10/25/2018 | CRC Energy Efficiency Scheme | Director of Planning | Reasonable | | L | The CRC working paper summary page should clearly show those figures that are to be uploaded to the CRC register, including on-site electricity generation and net of the 10% estimation uplifts. | For 2018/19 the CRC working summary page will show the figures that are to be uploaded to the CRC Register, including on site electricity generation and net of the 10% estimation uplifts. | Director of Planning | 2018/2019 | Overdue by over 3 months but under 6 months |
| IA 1819 | 11/19/2018 | PCIC CB – District Nursing Rotas | Chief Operating Officer | Reasonable | 5 | M | The District Nurses should ensure they are enforcing rules over how many staff can take annual leave on the same day. This should be reviewed periodically to ensure compliance. They should also ensure that Annual Leave requests are fully complete, updated when changes are made and authorised. | A local annual leave procedure has been developed since the audit to ensure that staff understand how the annual leave can be requested approved and rostered. | Chief Operating Officer | Closed | Complete |
| IA 1819 | 11/21/2018 | PCIC CB – District Nursing Rotas | Chief Operating Officer | Reasonable | | L | District Nurses should work in conjunction with the Rosterpro team to ensure details in Rosterpro are correct to enable use of the automated generation of rotas. Rotas should be entered into Rosterpro prior to shifts being worked. | District Nursing sisters will be expected to use Rosterpro to roster all staff, this will be reviewed through regular 1-1's with them and the Locality senior nurse. | Chief Operating Officer | 11/28/2019 | Overdue by over 6 months under 12 months |
| IA 1819 | 11/21/2018 | PCIC CB – District Nursing Rotas | Chief Operating Officer | Reasonable | | L | District Nurse Sisters should ensure rotas are prepared on a timely basis. Where rotas are prepared manually, these should be formally signed and the date of preparation recorded. | District Nursing sisters will be expected to use Rosterpro to roster all staff, rosters will be audited quarterly to ensure that rosters are provided 4-6 weeks in advance, and signed off, this will be reviewed through regular 1-1's with them and the Locality senior nurse | Chief Operating Officer | 11/28/2019 | Overdue by over 6 months under 12 months |

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1819 | 11/21/2018 | PCIC CB – District Nursing Rotas | Chief Operating Officer | Reasonable | | L | District Nurse Sisters should verify rotas weekly, within 72 hours of the last shift worked. This should be reviewed periodically to ensure compliance. | District Nursing sisters will be required to verify rosters weekly and this will bemonitored through regular 1-1's with the Locality Senior nurse | Chief Operating Officer | 11/28/2019 | Overdue by over 6 months under 12 months |
| IA 1819 | 11/21/2018 | PCIC CB – District Nursing Rotas | Chief Operating Officer | Reasonable | | L | District Nurse Sisters should be reminded of the importance of recording shortfalls on the rota. Compliance should be reviewed periodically. | A revised process for recording gaps in staffing is to be developed | Chief Operating Officer | 1/1/2019 | Overdue by over 3 months but under 6 months |
| IA 1819 | 11/16/2018 | Mental Health Clinical Board – Section 17 Leave | Chief Operating Officer | Reasonable | 4 | M | The Guideline for Section 17 Leave of Absence Mental Health Act 1983 should be approved as soon as possible. | The Guideline for Section 17 Leave of Absence Mental Health Act 1983 will be presented for approval at the Clinical Board Quality and Safety Committee in December 2018. | Chief Operating Officer | 12/13/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 11/16/2018 | Mental Health Clinical Board – Section 17 Leave | Chief Operating Officer | Reasonable | | M | The Health Board should clarify if there is a requirement for specific risk assessments and intervention plans to be produced before patients go on leave. The Guideline should then be updated to reflect the clarified requirements and management should ensure that these are followed in all instances. Risk assessments and intervention plans should be updated and reviewed on a regular basis. | Consideration of the risk assessment and care and treatment plan will have taken place during a review with the Responsible Clinician prior to any Section 17 leave being granted. This is documented on the CPA 3 Review record and in the relevant case note entry. The Guideline for Section 17 Leave will be updated to remove the requirement for a specific Section 17 risk assessment and care plan. Wards have been reminded to ensure current contact details are correct prior to a patient commencing Section 17 leave. | Chief Operating Officer | 12/1/2018 | Overdue by over 6 months under 12 months |
| IA 1819 | 11/16/2018 | Mental Health Clinical Board – Section 17 Leave | Chief Operating Officer | Reasonable | | M | Management should consider updating the Section 17 Leave of Absence form to record the reason why leave has been granted to the patient. | The recording of the reason why leave has been granted is not a requirement of the MHA or Code of Practice. The conditions attached to the leave that are documented on the form, is the record if the leave is granted for a specific reason. The form does not therefore require updating. | Chief Operating Officer | Closed | Complete |
| IA 1819 | 11/16/2018 | Mental Health Clinical Board – Section 17 Leave | Chief Operating Officer | Reasonable | | L | Staff should ensure that they complete all sections of the signing in and out book when patients leave and return to the wards. | | Chief Operating Officer | Closed | Complete |
| IA 1819 | 12/1/2018 | Renal IT system | Chief Operating Officer | Reasonable | 10 | H | Both UNIX and MySQL should updated to a more recent, supported version. | Early investigations have taken place between Vitalpulse and Summerside. Monies will need to be found to either see how viable the MySQL version 5.7 is with a more recent AIX version. It may not be compatible and a Windows or Linux infrastructure (Live and DR) will need to be considered.<br><br>Whilst the appropriate Hardware and Software vendor companies, who are contractually obliged to support and maintain the renal IT infrastructure (Summerside Computers Ltd and Vitalpulse Ltd respectively) review and consider the viable options available, we are unable to action any immediate change, either as a HB or as part of the WRCN. We will continue to monitor and review until a suitable solution is identified and can be implemented. | Chief Operating Officer | 6/1/2019 | Agreed date not reached |
| IA 1819 | 12/1/2018 | Renal IT system | Chief Operating Officer | Reasonable | | M | The minimum password length should be set to 8 and all users have a forced password change enacted. | The minimum length has now been amended to 8.<br><br>With regard to forced change, this will be required when VitalData v1.7 is implemented across Wales this financial year. v1.7 has Active Directory authentication, which will mean Users will be required (and forced) to change their VitalData password every 90 days – the same as is required with User's everyday NADEX domain login. | Chief Operating Officer | 6/1/2019 | Agreed date not reached |
| IA 1819 | 12/1/2018 | Renal IT system | Chief Operating Officer | Reasonable | | M | Recommendation: The backups should be subject to periodic testing. | This has been brought to the attention of the IT Server Team but is outside of the Directorate's direct control. We will continue to seek an appropriate response | Chief Operating Officer | 4/1/2019 | Overdue by under 3 months |
| IA 1819 | 12/1/2018 | Renal IT system | Chief Operating Officer | Reasonable | | M | The DR plan should be revised to include contact details of support organisations, user departments and management.<br><br>The DR plan should be tested and subject to subsequent review. | Dialogue with the Vendor parties has already started regarding the failback process. Action is underway to test and resolve, and identify an appropriate timetable for follow-up to ensure regular review. The BCP will be revised with immediate attention | Chief Operating Officer | 4/1/2019 | Overdue by under 3 months |
| IA 1819 | 12/1/2018 | Renal IT system | Chief Operating Officer | Reasonable | | M | A review of users should be undertaken to ensures that leavers access is revoked. | Action has been taken as identified and a process implemented to regularly review leavers. This will ensure access is revoked at the earliest opportunity. | Chief Operating Officer | 4/1/2019 | Overdue by under 3 months |
| IA 1819 | 12/1/2018 | Renal IT system | Chief Operating Officer | Reasonable | | M | Generic accounts should not be used for data entry. | Agreed, On request, Auditor provided a list of affected accounts and these have been reviewed. | Chief Operating Officer | Closed | Complete |
| IA 1819 | 12/1/2018 | Renal IT system | Chief Operating Officer | Reasonable | | M | The local user group should seek to identify fields which could benefit from improved entry controls. | Communication with users is ongoing and agreed changes will be actioned where appropriate. | Chief Operating Officer | 6/1/2019 | Agreed date not reached |

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1819 | 12/1/2018 | Renal IT system | Chief Operating Officer | Reasonable | | M | A local user group should be established with leads from each of the user departments with the remit to:<br>- Share knowledge over how departments use the system;<br>- Identify areas where improvements to design or functionality could be made;<br>- Identify areas where additional training should be provided to users.<br>- identify areas where poor or late data entry has impacts on downstream departments. | Partially agree. There is an all Wales VitalData Group to which Users can feed into via their Renal IT lead or via each Health Board Clinical IT Lead. As the VitalData system is use within four out of the five Renal Units in Wales any developments or suggestions to change are to benefit all the renal community and a Request for Change process is in place in relation to any system improvements.<br>In Cardiff, local drop-in How-To sessions were established but with little buy-in; they were soon disbanded. | Chief Operating Officer | 6/1/2019 | Agreed date not reached |
| IA 1819 | 12/1/2018 | Renal IT system | Chief Operating Officer | Reasonable | | L | The ROOT account should be renamed and the anonymous account deleted. | The anonymous account was deleted Oct 2018.<br><br>The ROOT account will be kept as such to maintain consistency in the database. | Chief Operating Officer | Closed | Complete |
| IA 1819 | 12/1/2018 | Renal IT system | Chief Operating Officer | Reasonable | | L | The UHB should consider enabling logging | Database enables logging of every action, be it viewing, editing, deleting etc. all stored in an Activity Log table, where identification of Users can be analysed. The Activity audit facility can be used for system screens, or in the case of the binary logs, can focus on specific screen fields. | Chief Operating Officer | Closed | Complete |
| IA 1819 | 2/14/2019 | Contract Compliance | Director of Finance | Reasonable | 4 | H | Capital & Estates staff should be formally reminded of the requirement to comply with Procurement procedures and ensure all work awarded achieves value for money and contractors are able to compete for work on a fair and equal basis. Identified non-compliance with the above requirement should be reported to the Audit Committee through the Procurement Compliance Report. | Procurement Services has put in place a system to identify additional expenditure sub £5k, and are working with Estates Services to tender a Framework for these services to ensure competition and governance is managed.<br>Capital & Estates staff are reminded to comply with Procurement Procedures.<br>All non-compliance is reported to Audit Committee. | Director of Finance | 8/1/2019 | Agreed date not reached |
| IA 1819 | 2/14/2019 | Contract Compliance | Director of Finance | Reasonable | | M | Staff raising purchase orders should be reminded of the requirement to obtain quotations and retain evidence of such, prior to raising orders in accordance with procurement procedures. The uploading of catalogue items to Oracle for new contracts should be undertaken on a timely basis. | Procurement Services will continue to support, provide training, guidance and reinforce SFI's to all departments. | Director of Finance | 9/21/2019 | Complete |
| IA 1819 | 2/14/2019 | Contract Compliance | Director of Finance | Reasonable | | L | An overview of the procurement process should be included in the Corporate staff induction programme. This could take the form of a summary guidance sheet that could be handed out to new employees and / or a presentation to new employees by the procurement team. | Procurement Services will provide a summary guidance sheet to the Induction | Director of Finance | 4/1/2019 | Overdue by under 3 months |
| IA 1819 | 2/14/2019 | Contract Compliance | Director of Finance | Reasonable | | L | The Procurement Guide should be reviewed and updated as necessary. The current year's Procurement Services Business Plan should be posted to theintranet if available. An up to date Procurement Services Business Plan should be drawn up for 2019/20 and made available to all staff via the procurement section of the C & V UHB intranet. | Since the C&V intranet was tested, the revised Business Plan has been approved by NWSSP and updated on the C&V website in January. | Director of Finance | 1/1/2019 | Overdue by over 3 months but under 6 months |
| IA 1819 | 2/15/2019 | Clinical Diagnostic and Therape | Chief Operating Officer | Reasonable | | H | The Clinical Board should develop a process to ensure that all overtime sessions worked in excess of 6 hours include a clearly documented 30 minute unpaid break. This process should then be communicated to all relevant managers and consistently implemented in the future. | All departments have received a communication instructing them to amend their current processes to include a documented 30 min break. This was done in advance of the production of a new Standard operating procedure which will include this guidance and elevant recording mechanisms as per finding 2 | Chief Operating Officer | Closed | Complete |

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1819 | 2/15/2019 | Clinical Diagnostic and Therape | Chief Operating Officer | Reasonable | Medium | M | The Clinical Board should consider producing a Standard Operating Procedure detailing the process to follow when booking bank, agency and utilisation of overtime, in order to ensure that there is a consistent approach throughout the clinical Board. As a minimum, Individual directorates should ensure that their own processes are formally documented in order to ensure consistent application and effective continuity in the event of staff changes / absence. | CD+T will review the current processes in place across departments to produce an overarching SOP to be utilised across departments. Where there are individual practices in place that are necessarily bespoke they can remain and will be referenced within the procedure | Chief Operating Officer | 3/1/2019 | Overdue by over 3 months but under 6 months |
| IA 1819 | 2/15/2019 | Clinical Diagnostic and Therape | Chief Operating Officer | Reasonable | Medium | M | The department should ensure that all agency shifts worked are appropriately authorise prior to payment and evidence of authorisation should be retained. | The management team associated with this department has been requested to provide the relevant recording to the clinical board for review and the need for this on an ongoing basis will for part of the SOP. | Chief Operating Officer | 3/15/2019 | Overdue by over 3 months but under 6 months |
| IA 1819 | 2/15/2019 | Clinical Diagnostic and Therape | Chief Operating Officer | Reasonable | Low | L | Where staff work less than the Agenda for Change hours of 37.5 hours any additional hours worked must be recorded as 'Additional Hours' on the Pay Card returned to Payroll Delegated Budget Holders should review the pay-cards submitted to Payroll to establish whether additional hours have been incorrectly classed as overtime. | This will form part of the SOP, and a reminder email will be sent to all departments | Chief Operating Officer | Closed | Complete |
| IA 1819 | 2/15/2019 | Kronos Time Recording System | Director of Planning | Reasonable | 6 | H | Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system. | Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system. | Director of Planning | 6/1/2019 | Agreed date not reached |
| IA 1819 | 2/15/2019 | Kronos Time Recording System | Director of Planning | Reasonable | | M | Management should review the current M & E Rotas to establish if the practice of paying staff for their breaks can be stopped. | The Estates Department is currently in the process of consultation with staff on modernisation of the department including changes to the shift patterns which would eliminate the need to pay staff for breaks. However until this is resolved the risk associated with enforcing an unpaid meal break for shifts outside normal hours is considered high. In so much that if an emergency (eg electrical failure) occurs when the shift electrician is on an unpaid break they could refuse to respond and put the service at risk. | Director of Planning | | Agreed date not reached |
| IA 1819 | 2/15/2019 | Kronos Time Recording System | Director of Planning | Reasonable | | M | The development of an automatic interface between Kronos and ESR is a key factor in determining whether Kronos should be rolled out across Estates. A timetable and deadline should therefore be set for the development and introduction of a suitable interface between Kronos and ESR. | Refer to Management Response to Finding 1; which includes investigating the interface with ESR. Interface has now been developed and is currently being tested. | Director of Planning | 6/1/2019 | Agreed date not reached |
| IA 1819 | 2/15/2019 | Kronos Time Recording System | Director of Planning | Reasonable | | 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. | Director of Planning | 6/1/2019 | Agreed date not reached |

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1819 | 2/15/2019 | Kronos Time Recording System | Director of Planning | Reasonable | | M | Staff should be instructed to clock in no more than 27 minutes before the start of their shift. Where staff do clock in more than 27 minutes before the start of their shift, supervisors should amend the timesheet start time to the scheduled start time if the additional time is not to be paid as overtime. Supervisors should update timesheets with reasons why staff have not clocked in or out of the system prior to authorising them, for example annual leave, special leave, unpaid leave, working off site, system down etc.<br>Supervisors should amend shift start and finish times on Kronos where it has been agreed that staff can work alternative shift patterns. Disciplinary action should be taken against staff that are persistently late and fail to work their assigned shift pattern. | Staff clock in on arrival on site but are not paid from this point, unless authorisation is given for overtime. Staff will be advised not to clock in as suggested and this will be monitored but the risk associated with this practice is considered low. | Director of Planning | 6/1/2019 | Agreed date not reached |
| IA 1819 | 2/15/2019 | Kronos Time Recording System | Director of Planning | Reasonable | | L | Estates Admin staff should be instructed to only input hours for enhancements into Rosterpro, i.e. overtime, standby and callout, plus any adjustments to basic pay. The Kronos WFR system is being used primarily as a time and attendance recording system. Supervisors should therefore be instructed to ensure that timesheets accurately record the attendance and absences of all staff under their control. | Supervisors are fully aware of their responsibilities in respect of recording absence and attendance. Senior Managers will reiterate the process. | Director of Planning | 6/1/2019 | Agreed date not reached |
| IA 1819 | 5/10/2018 | Specialist Neuro & Spinal Rehab | Director of Planning | Reasonable | 3 | M | The Procurement Strategy will be defined, within the FBC and consider all of the advantages / disadvantages if utilising the chosen framework and the options therein (D) | Other contractual options available in the SCAPE Framework were not considered so as to align the contract with Designed for Life parameters i.e. the use of NEC Option C. The contract option adopted is indicated in the FBC. **ACTIONED SINCE FIELDWORK** | Director of Planning | Closed | Complete |
| IA 1819 | 5/10/2018 | Specialist Neuro & Spinal Rehab | Director of Planning | Reasonable | | L | At future schemes contract documentation will be signed prior to the commencement of the respective commissions/works (O) | At future schemes contract documentation will be signed prior to the commencement of the respective commissions/works (O) | Director of Planning | 5/17/2019 | complete |
| IA 1819 | 5/10/2018 | Specialist Neuro & Spinal Rehab | Director of Planning | Reasonable | | M | Appropriate, timely internal approval will be sought for the change in capital cost and supporting assumptions, prior to submission to the WG (O) | After completion of the audit fieldwork, Chair's Action approved the FBC prior to submission to the WG. **ACTIONED SINCE FIELDWORK** | Director of Planning | Closed | Complete |
| IA 1819 | 4/1/2019 | PCIC Interface Incidents | Chief Operating Officer | Reasonable | 9 | H | Plan should be devsed for the proposed roll out of Datix to GPs, this should include, but not be limited to:<br>Establishing realist timescales for implementation<br>· Engagement with GPs<br>· Communication with other Health Boards who have already rolled out Datix to their Primary Care providers<br>· Developing a training and education plan for use fo the system; and<br>· Consideration of access leveels and role assignments | The patient safety team (PST) have already carried out some preparatory work which has include:<br>· Work with IT to explore Firewall issues<br>· Visits to AMBUHB and BCUHB to share learning from their experiences of rolling this out<br>· Consultation with All Wales Datix administrators group<br>November 2018 - the Patient Safety Team is currently recruiting to a key vacancy in the Datix team<br><br>Once the vacancy has been filled, the PST can review the current Datix workplan and re-commence an implementation plan for the roll out of the incident reporting module of Datix to GPs by December 2020 | Chief Operating Officer | 3/1/2019 | Overdue by under 3 months |
| IA 1819 | 4/1/2019 | PCIC Interface Incidents | Chief Operating Officer | Reasonable | | M | There should be continued engagement and education with GPs to ensure they are categorising issues correctly within the interface incidents remit and are highlighting those reports that contain a major risk or potential harm | In July 2018 the PST in partnership with PCIC have undertaken<br>work to develop an incident trigger list, to improve the quality of and the appropriateness of what is reported on the system. Regular contact is made with practices and the LMC relating to patient safety issues | Chief Operating Officer | Closed | Complete |
| IA 1819 | 4/1/2019 | PCIC Interface Incidents | Chief Operating Officer | Reasonable | | L | PCIC should communicate the importance of reporting interface incidents in a timely manner | Practices already deal with serious issues relating to interface<br>incidents by contacting the secondary care dept themselves and dealing with the matter direct, this is supported by the LMC and GMC in their guidance for independent contracts working within the GMS contract | Chief Operating Officer | Closed | Complete |
| IA 1819 | 4/1/2019 | PCIC Interface Incidents | Chief Operating Officer | Reasonable | | L | In addition to the recommendation to consider future workplans, a Standard Operating Procedure should be writen that encompasses the entire Q&S Officer role in relation to Interface Incidents | An agreed pathway is already in place that has been supported by<br>the LMC, staffing pressures sometimes result in delays inputting the information into Datix from PCIC staff, however the risk of the delay affecitng patient care or patient outcomes is extremely low as practices will have already dealt with the incident and are sending the information to PCIC for informtion and recording to the Interface incident process | Chief Operating Officer | Closed | Complete |

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1819 | 4/1/2019 | PCIC Interface Incidents | Chief Operating Officer | Reasonable | | M | The Patient Safety Team should remind Clinical Boards and Directorates of the rquirement to ensure that interface incident reports within Datix contain sufficient detail of actions taken and outcomes are clear | This would not be the role fo the PST. The UHB incident, Hazard and near miss reporting procedure clarifies the roles and responsibilities of the Clinical Boards: `The Clinical / Service Board Management teams are responsible for ensuring that staff within their Board are briefed on their indiidual and collective responsibilities within the incidnet reporing process. They must ensure that all incidents are reported, investigated and analysed, so that learning and improvements can be embedded in practice.<br>The Patient Safety Team and Health, Safety and Environment Unit are responsible for supporting and implementation of this procedure. They will also undertake to raise staff awareness and training on incident reporting and investigaiton. | Chief Operating Officer | Closed | Complete |
| IA 1819 | 4/1/2019 | PCIC Interface Incidents | Chief Operating Officer | Reasonable | | M | Efforts should be made to engage with all GP practices, especially those that do not regularly report interface incidents<br>Consideration should be given to developing a training and education plan to improve the quality, timeliness and completeness of reporting from GPs | The Patient Safety Team will work with PCIC as part of the Datix implementation plan to provide an appropriate training and education programme ot GPs and other practice staff | Chief Operating Officer | 9/1/2019 | Complete |
| IA 1819 | 4/1/2019 | PCIC Interface Incidents | Chief Operating Officer | Reasonable | | M | The Q&S Officer should review the list of Datix Reports opened by themselves, paying particular attention to those with overdue flags, to monitor that interface incidents are being progressed and closed.<br>Engagement with Secondary Care directorates to ensure they are aware of the benefit of feeding back investigation results to Primary Care | PST - the way that permissions and profiles are set up in Datix means that once the incident is assigned to another user (eg if an incident which involves the laboratories is passed on to the laboratory manager) it remains visible to staff within the reporting area but also to those who need to respond and investigate the issue | Chief Operating Officer | Closed | Complete |
| IA 1819 | 4/1/2019 | PCIC Interface Incidents | Chief Operating Officer | Reasonable | | L | Regular communicatoin with GPs should be undertaken to make them aware of the actions taken following their reporting of interface incidents. This will inform them of improvements ot processes as a result and encourage future engagement | A paragraph in relation to the interface process was included in the winter Patient Safety and Quality newsletter. The UHB Medical Director and LMC are kept up to date with the interface incident process through the regular Primary / Secondary Care interface meetings. | Chief Operating Officer | Closed | Complete |
| IA 1819 | 4/1/2019 | PCIC Interface Incidents | Chief Operating Officer | Reasonable | | L | Consideration should be given to how feedback and incident reporting can be made a two way process with continued engagement between primary and secondary care. This will need to include training of secondary care professionals in the current process of interface incidents reporting | PCIC does not receive incident notification from internal depts within the UHB which are managed in line with the agreed UHB process for incident management/<br>PST - this issue has also been presented at the Datix Super User Gropu. Further information will be included on the Datix Intranet page. | Chief Operating Officer | Closed | Complete |
| IA 1819 | 4/9/2019 | Medicine CB - Sickness Absence Management | Chief Operating Officer | Reasonable | 5 | H | Management must ensure that all future sickness episodes are managed and documentation is completed in accordance with the requirements of the All Wales Managing Attendance at Work Policy.<br>Management should ensure that a self-certificate is completed correctly and a return to work interview is held with the employee including the completion of the return to work form.<br>Clinical Board management should consider introducing further periodic training on the sickness management process in order to increase awareness and compliance levels. | Re-circulate the All Wales Managing Attendance at Work Policy.<br>🖬 Support and appraises have been set up for A6 South to ensure consistency in completing Self-certification.<br>🖬 Review Ward Base sickness processes to ensure that they reflect current policy and provide efficiency to complete necessary actions. | Chief Operating Officer | 3/12/2019 | Overdue by under 3 months |
| IA 1819 | 4/9/2019 | Medicine CB - Sickness Absence Management | Chief Operating Officer | Reasonable | | M | Management should ensure that the sickness triggers are being managed correctly and all future required informal discussions and formal sickness interviews are carried out in accordance with the requirements of the All Wales Managing Attendance at Work Policy. | Support and appraises have been set up for A6 South to ensure consistency in completing Self-certification.<br>🖬 Confirm management expectations with Ward Managers in following the All Wales Managing Attendance at Work Policy.<br>🖬 Review Ward Base sickness processes to ensure that they reflect current policy and provide efficiency to complete necessary actions. | Chief Operating Officer | 4/1/2019 | Overdue by under 3 months |
| IA 1819 | 4/9/2019 | Medicine CB - Sickness Absence Management | Chief Operating Officer | Reasonable | | M | Management should ensure that the sickness triggers are being managed correctly and all future required informal discussions and formal sickness interviews are carried out in accordance with the requirements of the All Wales Managing Attendance at Work Policy. | 🖬 Support and appraises have been set up for A6 South to ensure consistency in completing Self-certification.<br>🖬 Confirm management expectations with Ward Managers in following the All Wales Managing Attendance at Work Policy.<br>🖬 Review Ward Base sickness processes to ensure that they reflect current policy and provide efficiency to complete necessary actions. | Chief Operating Officer | 4/1/2019 | Overdue by under 3 months |

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1819 | 4/9/2019 | Medicine CB - Sickness Absence Management | Chief Operating Officer | Reasonable | | M | Management should ensure that all current ward managers are provided with appropriate training to enable them to effectively manage sickness absence. A robust process should also be implemented to ensure that timely training is provided to any new ward managers.<br>Regular information on sickness absence levels should be consistently provided to all ward managers. | ▪ Within Stroke Services, engaged with Human resources to provide further training for all members of the Leadership team.<br>▪ Discussed with HR and now regularly circulating sickness data.<br>▪ HR currently undertaking deep dives with high rate areas to provide useful supportive information about absence. | Chief Operating Officer | 4/1/2019 | Overdue by under 3 months |
| IA 1819 | 4/9/2019 | Medicine CB - Sickness Absence Management | Chief Operating Officer | Reasonable | | L | Management should remind ward staff that the recording of sickness dates should reconcile between sickness documentation and ESR, and all sickness dates should be accurately and consistently recorded. | Within Stroke Services, engaged with Human resources to provide further training for all members of the Leadership team.<br>▪ Through Support and appraise, challenge can be placed upon the ward staff to ensure that appropriate input of data is reconciled. | Chief Operating Officer | 5/1/2019 | Overdue by under 3 months |
| IA 1819 | 2/15/2019 | CRI Safeguarding Works | Director of Planning | Reasonable | 5 | M | Progression at risk should be fully documented, approved and recorded at the risk register (O). | Agreed.<br>**ALL FUTURE PROJECTS** | Director of Planning | 5/22/2020 | Overdue by over 3 months but under 6 months |
| IA 1819 | 2/15/2019 | CRI Safeguarding Works | Director of Planning | Reasonable | | L | A Project Execution Plan should be prepared at the outset of a project, in accordance with the Capital Projects Manual and best practice (O). | Agreed.<br>**ALL FUTURE PROJECTS** | Director of Planning | 5/22/2020 | Overdue by over 3 months but under 6 months |
| IA 1819 | 2/15/2019 | CRI Safeguarding Works | Director of Planning | Reasonable | | M | Sufficient contractual arrangements should be in place to safeguard the Health Board interests (O). | Agreed.<br>**ALL FUTURE PROJECTS** | Director of Planning | 5/22/2020 | Overdue by over 3 months but under 6 months |
| IA 1819 | 2/15/2019 | CRI Safeguarding Works | Director of Planning | Reasonable | | L | 4) Project benefits should be clearly identified and documented in the business case, including:<br>▪ Baseline value;<br>▪ Method of measurement;<br>▪ Target improvement;<br>▪ Timing of when the benefit would be achieved; and<br>▪ Lead responsibility for the benefit (D).<br>(This recommendation being for implementation at future projects).<br>Post project evaluations should be delivered in accordance with agreed Business Case requirements, or a revised approach should be appropriately approved (O). | Agreed.<br>**ALL FUTURE PROJECTS** | Director of Planning | 5/22/2019 | Overdue by over 3 months but under 6 months |
| IA 1819 | 2/15/2019 | CRI Safeguarding Works | Director of Planning | Reasonable | | 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. | Director of Planning | 6/1/2019 | Agreed date not reached |
| IA 1819 | 4/11/2019 | Commissioning | Director of Transformation and Informatics | Reasonable | 3 | H | Strategic Commissioning Group Terms of Reference document should be revised and updated to state the quorate attendance level and its current membership. Additionally, its membership should include representation from the Clinical Boards to ensure a broad contribution and as such an improved strategic approach in full alignment with the Group's Terms of Reference. | The Strategic Commissioning Groups Terms of Reference, including membership was reviewed at a facilitated workshop on 20th Feb 2019. The first draft of a refreshed Terms of reference is scheduled for discussion at the May 2019 meeting of the Strategic Commissioning and Finance Group. Clinical Board representation will be fully considered. | Director of Transformation | 5/1/2019 | Overdue by under 3 months |
| IA 1819 | 4/11/2019 | Commissioning | Director of Transformation and Informatics | Reasonable | | M | The Commissioning Team should as part of its ongoing programme of work publicise their presence via their intranet pages and create an internet page thereby promoting the Commissioning Framework and Commissioning Intentions so as to maximise awareness of content to both internal/external stakeholders and the wider general public. | The development of the commissioning intranet pages, alongside commissioning toolkits, and awareness raising remains on the Commissioning Team's work plan.<br>These actions were not progressed following publication of the Framework due to capacity of the team, and other urgent priorities.<br>Progression of these actions will be included in the team's work plan for 2019-20, but capacity to implement remains an issue. | Director of Transformation | 4/1/2020 | Agreed date not reached |

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1819 | 4/11/2019 | Commissioning | Director of Transformation and Informatics | Reasonable | | L | The Commissioning Framework document should be updated to reflect its creation date and should be subject to version control stating a timescale of applicability and use. | The Commissioning Framework has been amended, and now includes version control, and timescale of applicability, which is 5 years. The Framework will be reviewed for currency and accuracy on an annual basis. | Director of Transformation | 4/1/2019 | Overdue by under 3 months |
| IA 1819 | 4/12/2019 | E IT Training | Director of Transformation and Informatics | Reasonable | 7 | M | An assessment of the impact of these measures should be carried out and procedures developed for actions in similar circumstances in the future. | An assessment of the reduced course duration is to be undertaken by the PARIS training senior officer at the point the team regain their second training staff member (long term sick, meant the two person PARIS training complement was reduced by half). The PARIS programme has service representation embedded in its 'change structure'. These staff have been asked for concerns and feedback regularly (to the fortnightly MHCS team meetings) since this 'new training model' was made necessary (due to long term loss of staff). No operational risks or concerns have been raised from scoped services to date. | Director of Transformation | 9/1/2019 | Agreed date not reached |
| IA 1819 | 4/12/2019 | E IT Training | Director of Transformation and Informatics | Reasonable | | M | Relevant policies and procedures should be put in place to set out the circumstances under which this kind of drift can be allowed (if at all), any mitigation measures, how many versions the training system can be allowed to be behind and any other provisions to ensure adequate quality levels of training are preserved. | The 'relevance' of the PARIS training system is under constant review through both the fortnightly PARIS team meeting and the fortnightly PARIS Technical Design Team (TDT). The functionality that is 'trained' upon is a hugely limited subset of all the capability of PARIS 'live' (as there are, for example, c400 assessment types on PARIS LIVE, and c50 casenote types etc…). As such the Health Board trains on one or two examples, thus negating the necessity for 'LIVE' and 'TRAIN' systems to be 'identical'.<br>Approximately 6000 changes have been made to the PARIS 'live' system over a decade, including c20 PARIS 'version' changes. An assessed evaluation is constantly undertaken by the PARIS senior trainer to assure that what we 'train' upon, is 'suitably reflective' of what is currently (or sometimes due) to be on the LIVE system.<br>As an example, in any 'version' change to PARIS there will be a range of changes.<br>These changes may have no bearing upon what is 'trained' upon, and as such there would be no purpose in upgrading the training system. Further, doing so would reduce delivery capacity, leading to a greater wait for training, and inducing unnecessary 'training issues'.<br><br>This review is ongoing and assessment is documented at team meeting, else TDT minutes. As such the issue is mitigated and considered closed. | Director of Transformation | Closed | Complete |
| IA 1819 | 4/12/2019 | E IT Training | Director of Transformation and Informatics | Reasonable | | L | To introduce a relevant pre-assessment process and procedures to ensure that staff with learning difficulties are able to learn the systems to the required level. | The Health Board will:<br>1. Agree a process for ensuring any LD is captured.<br>2. Develop the Training Booking system to include a mandatory Learning Difficulties field within the user profile screen. The LD will automatically display against the user when booking them in for training sessions.<br>Initially the LD field will default to NONE however the IT Trainers are to check/update the LD field when requests for training received. | Director of Transformation | 6/30/2019 | Agreed date not reached |
| IA 1819 | 4/12/2019 | E IT Training | Director of Transformation and Informatics | Reasonable | | L | Document control information to be standardised and completed in full on training documents. | Training documents are currently version controlled but not standardised.<br>Standardising them would be a very low priority within the current resource. | Director of Transformation | 9/1/2019 | Agreed date not reached |
| IA 1819 | 4/12/2019 | E IT Training | Director of Transformation and Informatics | Reasonable | | L | A sign off process should be introduced involving training customers for the Welsh Clinical Portal | A review and sign off procedure for the Welsh Clinical Portal involving the service coordinators who represent the training customers (attendants) will be considered and discussed with the WCP trainer on return to work from Work Life Balance absence. This could take the form of a WCP 'super user' group who review and comment on new versions of the training package before they are made available for general use. | Director of Transformation | 9/1/2019 | Agreed date not reached |
| IA 1819 | 4/12/2019 | E IT Training | Director of Transformation and Informatics | Reasonable | | L | An impact assessment process should be introduced in order to gather and evaluate the feedback from training attendants after they have had the opportunity to use the relevant systems. The feedback emails should be reviewed on a regular basis. | An impact assessment process is in draft but has been suspended due to the Work Life Balance absence of the WCP trainer. This and the regular review of feedback emails will recommence once the trainer has returned to post. | Director of Transformation | 9/1/2019 | Agreed date not reached |
| IA 1819 | 4/12/2019 | E IT Training | Director of Transformation and Informatics | Reasonable | | L | The training material should be updated to include a range of options for post learning support other than just helpdesk contact information.<br>The need for refresher sessions should be reviewed in conjunction with service customers. | It would not be appropriate to provide Service Coordinator details since these will be subject to change at effectively no notice. Training materials include contact information for the "IT User Support" team which is managed by the IT Trainers and Implementation Officer. Both e-mail and telephone contact details are included. Users are able to contact for advice, refresh and support to meet their requirements. If e-learning material is available the link to the learning is also included. As such full support is demonstrably available post training from the user's perspective.<br>Refresh sessions have previously been included into a rolling schedule however take up from end users (and support from managers to ensure attendance) was so poor that it was deemed a waste of the limited resource within the training team.<br>Refresh sessions can be (and are) delivered on request by the service customers. | Director of Transformation | Closed | Complete |
| IA 1819 | 5/15/2019 | Water Safety | Director of Planning | Reasonable | 7 | M | Attendances of the Water Safety Group should be reviewed, with staff reminded of their responsibilities to attend, to ensure key groups are appropriately represented (O). | Agreed | Director of Planning | 6/30/2019 | Agreed date not reached |

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1819 | 5/15/2019 | Water Safety | Director of Planning | Reasonable | | 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 Planning | 6/30/2019 | Agreed date not reached |
| IA 1819 | 5/15/2019 | Water Safety | Director of Planning | Reasonable | | M | Training should be updated for all key staff with assigned water management responsibilities (O). | Agreed | Director of Planning | 7/30/2019 | Agreed date not reached |
| IA 1819 | 5/15/2019 | Water Safety | Director of Planning | Reasonable | | 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.<br>b) Key person dependency should be reviewed and removed, where possible, to facilitate the timely identification and completion of remedial work (O).<br>See also recommendation 2 in relation to assessment and reporting of the backlog of remedial jobs. | Agreed | Director of Planning | 6/30/2019 | Agreed date not reached |
| IA 1819 | 5/15/2019 | Water Safety | Director of Planning | Reasonable | | 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.<br>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 Planning | 7/30/2019 | Agreed date not reached |
| IA 1819 | 5/15/2019 | Water Safety | Director of Planning | Reasonable | | H | The risk assessment process, including preparation of appropriate prioritised action plans to address the identified risks, should be completed as soon as possible (D). | Agreed | Director of Planning | 11/1/2019 | Overdue by over 3 months but under 6 months |
| IA 1819 | 5/15/2019 | Water Safety | Director of Planning | Reasonable | | M | Progress, including highlighting of any delays, should be regularly reported to the Water Safety Group (O). | Agreed | Director of Planning | 11/1/2019 | Overdue by under 3 months |
| IA 1819 | 5/15/2019 | UHB Core Financial Systems | Director of Finance | Reasonable | 5 | M | Management should ensure that the main Asset Register is updated to reflect the correct position and steps are undertaken to ensure the required follow up is commenced as soon as possible on all applicable assets. | Agreed and accepted. The follow up visits with clinical gerontology will be completed by the week ending May 24th 2019. The remaining transfers will be actioned by the end of July 2019. | Director of Finance | 7/30/2019 | Agreed date not reached |
| IA 1819 | 5/15/2019 | UHB Core Financial Systems | Director of Finance | Reasonable | | L | Management should ensure departments are aware that all assets should have asset numbers, where this is not the case Finance should be informed.<br>Management should advice Departments that where assets are to be disposed or no longer in use a disposal form should be completed and passed to Finance as soon as possible.<br>The asset register should also be updated with asset serial numbers. | The Director of Finance will again write to departments during 2019/20 emphasising the need to place the asset identification labels provided onto new capital assets purchased and to ask for replacement labels where necessary.<br>Departments will also be reminded of the need to inform finance of asset disposals on a timely basis and to provide details of missing serial numbers when they respond to the annual asset verification request. This will once again be supported with training sessions for directorate managers. | Director of Finance | 10/31/2019 | Agreed date not reached |
| IA 1819 | 5/15/2019 | UHB Core Financial Systems | Director of Finance | Reasonable | | M | Management should inform responsible staff to promptly notify eEnablement of changes to the Purchasing Oracle hierarchy list. The required forms should be completed to process updates. | Recommendation Accepted. The UHB's current procedure will be updated to clarify the responsibility to review approvers at the Clinical Board level and within Corporate Finance. | Director of Finance | 7/31/2019 | Agreed date not reached |
| IA 1819 | 5/15/2019 | UHB Core Financial Systems | Director of Finance | Reasonable | | 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. | Director of Finance | 7/31/2019 | Agreed date not reached |

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1819 | 5/15/2019 | UHB Core Financial Systems | Director of Finance | Reasonable | | M | Management should ensure that the required forms are completed, signed and forwarded to eEnablement for all additions to the Oracle Hierarchy.<br>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. | Director of Finance | 7/31/2019 | Agreed date not reached |
| IA 1819 | 5/15/2019 | Health and Care Standards | Director of Nursing | Reasonable | N/A | N/A | N/A | N/A | N/A | | |
| IA 1819 | 5/17/2019 | Specialist Services Clinical Board – Medical Finance Governance | Chief Operating Officer | Reasonable | 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.<br>This should include review of the current service model. | | Chief Operating Officer | 4/1/2020 | Agreed date not reached |
| IA 1819 | 5/17/2019 | Specialist Services Clinical Board – Medical Finance Governance | Chief Operating Officer | Reasonable | | L | Each 20 week Consultant rota should be subject to formal approval by the Clinical Director and evidence of this approval should be retained on file. | A process to sign off the rota by the Clinical Director will be developed by the Directorate Management Team, and a record of which will be retained on file along with existing job planning information. | Chief Operating Officer | 8/31/2019 | Agreed date not reached |
| IA 1819 | 1/18/2019 | Legislative/Regulatory Complair | Director of Corporate Governance | Reasonable | | H | The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report. | Agreed | Director of Corporate Governance | 2/1/2019 | Overdue by 6 months under 12 months |

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1819 | 5/22/2019 | MHRA Compliance | Chief Operating Officer | Reasonable | 4 | H | The current tracker should be effectively updated to ensure that the outstanding deficiencies are retified and an appropriate audit trail is maintained | The UHL (PSU) tracker has now been updated (3 June 2019) in future, accepted practice will be for any deficiencies identified through self-inspection, audit or via business inelligence e.g. regulatory inspection of other units or via a formal directice from MHRA (where new standards are implemented) will be raised as a new issue and tracked accordingly | Chief Operating Office | 6/3/2019 | Complete |
| IA 1819 | 5/22/2019 | MHRA Compliance | Chief Operating Officer | Reasonable | | M | Management will amend the tracker to ensure an appropirate audit trail on how actions are progressing. | The SMPU internal tracker has been amended to include the revised target date(s) for the 6 deficiences noted above. They will be annotated to include narrative for the reasons for delay and updated target date. | Chief Operating Office | 6/30/2019 | overdue over 3 months under 6 months |
| IA 1819 | 5/22/2019 | MHRA Compliance | Chief Operating Officer | Reasonable | | M | The terms of reference should be reviewed for appropriateness and staff should be reminded of the importance of attending and contributing to the compliaince and governance meetings.<br>Management should also consider setting up an equivalent meeting for the Llandough site or extending the remit of the current meeting to cover SMPU and Llandough. | A single Compliance and Governance group for Pharmacy Technical Service i.e. UHL and SMPU had been agreed. The terms of refernce were orginally agreed before the establishment of a Clinical Diagnostic and Therapeutics | Chief Operating Office | 6/30/2019 | overdue over 3 months under 6 months |
| IA 1819 | 5/22/2019 | MHRA Compliance | Chief Operating Officer | Reasonable | | M | The risk register should be assessed for appropriateness and updated accordingly. | The Pharmacy Directorate Risk Register has been reviewed and ownership of individual sections clarified. This includes the technical services components and a monthly review/update included in the senior team meeting agenda. In addition, our internal process for handling and escalating risks associated with pharmacy and medicines management activities and review through the Clinical Board has been agreed. | Chief Operating Office | 7/31/2019 | overdue over 3 months under 6 months |
| IA 1819 | 6/30/2019 | E-Advice | Director of Transformation and Informatics | Reasonable | 4 | M | Management should undertake an exercise to review and quantify benefits from the ongoing use of the e-Advice system to ensure benefits are maximised and the system is sufficiently supported and resourced. | With the resource available an exercise will be carried out to review and quantify the original key benefit identified in the project outline document 'a minimum of 10% avoidance of attendance in Outpatients is likely to be achieved by GPs implementing an e-advice service'. As part of the restructure process of the wider Digital team, we will look to increase our capacity for benefits realisation and evaluation. A wider benefits review will be carried as our service users recognise the benefits that e-Advice brings. | Director of Transformation and Informatics | 6/1/2019 | overdue over 3 months under 6 months |
| IA 1819 | 6/30/2019 | E-Advice | Director of Transformation and Informatics | Reasonable | | M | Management should document the approach to testing and implementing changes. This should include documentation of requirements around change categorisation, the extent of testing required, the approval process, the approach to rolling back changes, and criteria to be used when assigning a severity to changes. | There are processes in place to manage testing, approvals, roll back and assigning a severity to changes which allow for a quick response. It is recognised that these processes have lacked some formality due to the resource available.<br>However work has already started on formal cumentation to support ease of handover to other members of the department. This will be light-touch, with minimum documentation, aimed at supporting the change and testing process without being overly bureaucratic. | Director of Transformation and Informatics | 7/1/2019 | overdue over 3 months under 6 months |
| IA 1819 | 6/30/2019 | E-Advice | Director of Transformation and Informatics | Reasonable | | M | A regular, at least annual, exercise should be undertaken to confirm the validity of user accounts and ensure any leavers accounts are identified and disabled. | A report to identify account inactivity of 90 days will auto-run daily following which inactive accounts will be closed. Accounts can be reactivated on request. | Director of Transformation and Informatics | 7/1/2019 | overdue over 3 months under 6 months |
| IA 1819 | 6/30/2019 | E-Advice | Director of Transformation and Informatics | Reasonable | | L | Management should consider the use of local e-Advice super users. | The team are looking at ways to relieve the administration workload on them. A service announcement will be sent out to all super users reminding them of the actions that they can carry out e.g. authorising of accounts, closing accounts. New users are now able to self-register. Super users will be encouraged to take an increased role in user acceptance testing. | Director of Transformation and Informatics | 6/1/2019 | overdue 3 months under 6 months |
| IA 1819 | 9/12/2019 | UHB Transformation Process | Director of Digital and Health Intelligence | Reasonable | 3 | M | The Transformation Enabler Steering Group should consider including nominated Clinical Board Leads to contribute directly into each Enabler where appropriate and actively inform the development of progress. | Each enabler task and finish group links with Clinical Boards and have involvement of staff . We will review this with the Boards in order to improve engagement. We will consider whether a lead or link person from each Board would improve engagement. | Director of Digital and Health Intelligence | 5/24/2019 | overdue over 6 months under 12 months |
| IA 1819 | 9/12/2019 | UHB Transformation Process | Director of Digital and Health Intelligence | Reasonable | | M | The Accessible Information Enabler should implement a formal Task and Finish Group that oversees and provides governance of delivery of the Enabler's objectives and interfaces with the Transformation Enablers Steering Group. | The Accessible information enabler work is being reported to a number of different groups, which ensures oversight and assurance. These include HSMB, the "signals from Noise" steering group chaired by the CEO and the new Digital Design Group being established in October 2019 which will include membership from the Executive Management team and Clinical Boards. In addition, the accessible information enabler work will be reported into the new Digital & Health Intelligence committee, a new formal committee of the Board. | Director of Digital and Health Intelligence | 9/30/2019 | overdue over 6 months under 12 months |
| IA 1819 | 9/12/2019 | UHB Transformation Process | Director of Digital and Health Intelligence | Reasonable | | M | Progress relating to the Accessible Information Enabler should be recorded and reported via a monthly Highlight Report to the Transformation Enablers Steering Group in parity with the four other Enablers. | Following discussion between the ADI of Information and the steering group project manager, it is proposed that given the breadth and complexity of the accessible information enabler, the monthly reporting continues to be provided in the format that conveys the issues, actions and updates previously shared. This has been agreed with the AD of organisational change/transformation. | Director of Digital and Health Intelligence | 5/24/2019 | overdue over 6 months under 12 months |
| IA 1920 | 7/22/2019 | Mental Health Clinical Board - Sickness Management Follow-up | Chief Operating Officer | Reasonable | 4 | H | Management should ensure that the sickness triggers are being managed correctly with informal discussions and formal sickness interviews being carried out in accordance with the All Wales Sickness Policy. | Directorates to send "trigger table" out to all managers, reminding them to check with line managers if they have any doubt or queries with individual cases.<br>Senior Nurse Managers to conduct random sickness file checks as part of 1:1 with managers. | Chief Operating Officer | 4/1/2019 | Overdue by over 6 months |

| Audit | Final Report Issued on | Audit Title | Executive Lead for Report | Audit Rating | No. of Recs Made | Rec. Rating | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IA 1920 | 8/16/2019 | Environmental Sustainability Report | Director of Planning | Reasonable | 3 | M | Evidence of the retrospective approval of the sustainability report by the Environmental Steering Group / Health & Safety Group and sign off by the Director of Capital Estates and Facilities should be provided to audit each year. The documented procedural guidance should be updated to reflect the actual review and approval process currently in place. | Future Sustainability reports will be approved and signed off at the Capital Estates and Facilities Health & Safety Group. Depending on timescales retrospective approval may need to be provided, however the approval and sign<br>off of the report shall be documented in the relevant minutes of the group. | Director of Planning | Immediately | Overdue under 3 months |
| IA 1920 | 8/16/2019 | Environmental Sustainability Report | Director of Planning | Reasonable | | M | The staff roles and responsibilities highlighted in the procedural guidance should be reviewed and updated as necessary. The guidance should be supplemented with detailed information on how to prepare each of the three mandatory tables. | Future Sustainability report guidance will be reviewed and updated for staff roles and responsibilities as necessary. Where necessary guidance will be supplemented with detailed information on how to prepare each of the three<br>mandatory tables. | Director of Planning | 10/31/2019 | Overdue under 3 months |
| IA 1920 | 8/16/2019 | Environmental Sustainability Report | Director of Planning | Reasonable | | M | Management should draw up a timetable each year to help ensure appropriate time is allocated for the sustainability report preparation, review process, audit, approval and submission to the Communications Team. The requirement to produce a timetable each year should be incorporated into the procedural<br>guidance. | Once the timescale for the Sustainability report submission is known an indicative timetable will be developed. Timings however may change depending on when information is available for inclusion in the report and the availability of Officers to verify and audit information and data. | Director of Planning | Immediately | Compelte |
| IA 1920 | 9/12/2019 | Specialist Clinical Board - Rosterpro | Chief Operating Officer | Reasonable | 5 | H | Management should ensure employees contracted hours are managed<br>appropriately. | As a Directorate Management Team we welcome the audit and accept its recommendations. As we recognise we can't change some of the findings detailed above, our focus has been upon implementing new systems and<br>process to ensure that such incidences do not occur in the future.<br>⬓ It is important to note that whilst the audit was undertaken in June 2019, the sample of rosters audited covered January to March 2019. At the end of January 2019 a new nurse leadership team, including a Lead and two Senior Nurses commenced their roles within Critical Care. Under the leadership of this team several initiatives have been put in place to manage rostering across the UHW and UHL sites. The Senior Nurses now hold monthly 1:1 meetings with each Band 7 responsible for a team or rostering. The purpose of these meetings is to ensure that high positive/negative balances are no longer<br>accrued, and historic high positive/negative balances are reduced back to a reasonable level. The meetings have been well received and appear to be making the requisite improvements albeit formal review of the rostering<br>process is scheduled for the end of September when we will have six months of data. | Chief Operating Officer | Completed | Complete |
| IA 1920 | 9/12/2019 | Specialist Clinical Board - Rosterpro | Chief Operating Officer | Reasonable | | M | Appropriate staff will be reminded of the procedural requirement for drawing up rotas 6 weeks in advance and timely signing off within Rosterpro. | A new process for developing the Critical Care rota was implemented in May 2019.<br>⬓ Rotas are now generated monthly by two Band 7's on a rotational basis. The Lead & Senior Nurse review each prior to publication. This means that rosters<br>are now routinely issued in accordance with the procedural requirement of 6 weeks advance notice. Audit of the efficacy of the new process will be undertaken by the Senior Nurse in December 2019.<br>⬓ UHW and UHL rotas are generated and published at the same time, as they need to be written in conjunction with each other to ensure safe staffing across both sites. | Chief Operating Officer | Completed | Complete |
| IA 1920 | 9/12/2019 | Specialist Clinical Board - Rosterpro | Chief Operating Officer | Reasonable | | M | A process map should be devised and distributed to appropriate staff. This should include a robust system for utilising staff with negative balances prior to booking bank or agency staff. | Process map will be devised and distributed to all Critical Care Flow Coordinators by Lead / Senior Nurse. | Chief Operating Officer | 9/1/2019 | Overdue under 3 months |
| IA 1920 | 9/12/2019 | Specialist Clinical Board - Rosterpro | Chief Operating Officer | Reasonable | | M | Management should remind staff that accurate and up to date records are to be kept at all times. | New ways of working have been instigated across Critical Care since May 2019, with Band 7's having clearly defined duties and accountability for the production and maintenance of accurate records.<br>⬓ Oversight of the records and rostering is now a key component of the Senior Nurse and Band 7 1:1 meetings that occur on a monthly basis, with review of the efficacy and impact of the new system scheduled for December 2019. | Chief Operating Officer | Completed | Complete |
| IA 1920 | 9/12/2019 | Specialist Clinical Board - Rosterpro | Chief Operating Officer | Reasonable | | L | Optimum requirements for Llandough will be reviewed and if necessary updated appropriately. | Staffing levels at Llandough have been reviewed since the time of the audit. As a result a 1wte Band 7 has been added to the establishment for UHL. | Chief Operating Officer | 27/08/19<br>30/09/19 | Overdue under 3 months |
| IA 20 | 9/23/2019 | Legislative / Regulatory Compliance | Director of Corporate Governance | Reasonable | | H | The Corporate Governance Team should ensure that all the relevant information that is required for the completion of the Tracking Report is obtained and up to date. | Agreed the information should be up to date and accurate | Director of Corporate Governance | 2/1/2019 | Overdue by 6 months under 12 months |
| IA 1920 | 7/22/2019 | Mental Health Clinical Board - Sickness Management Follow-up | Chief Operating Officer | Reasonable | 4 | L | Management should remind ward staff that the recording of sickness dates should reconcile between sickness documentation and ESR, and all sickness dates should be accurately and consistently recorded. | All band 6 / 7 managers to attend refresher sickness training. | Chief Operating Officer | 5/1/2019 | Overdue by over 6 months |

| | |
|---|---|
| Audit | (All) |
| Audit Log Ref No. | (All) |

| Audit Title | Rec No. | Executive Lead for Report | Recommendation Narrative | Management Response | Status of Report Overall |
|---|---|---|---|---|---|
| | | | The Health Board should ensure that the Action Plan details realistic timesca | | |
| **Action plan on Deloitte Financial Governance Review** | R1/2 | Director of Finance | | A further progress report will be taken to the April meeting of the Finance Committe | Audit open for more than 12-months |
| | R2/2 | Director of Finance | The Health Board should ensure that the reported status recorded on the actionplan accurately reflects the actual progress made towards implementing theagreed actions. | | |
| **Action plan on WAO Audit of RKC Associates** | R1/3 | Director of Corporate Governance | Action timescales should be reasonably considered and further updates to tl | Accepted.We will continue to emphasise the importance of realistic timescales wher | Audit Closed as Complete |
| | R2/3 | Director of Corporate Governance | Further updates to the audit committee should include Conclusion 3, Action | Accepted.ActionUpdate report for the February Audit Committee will contain this in | Audit Closed as Complete |
| | R3/3 | Director of Corporate Governance | Action timescales should be reasonably considered and realistic and achieva | Accepted.We will continue to emphasise the importance of realistic timescales wher | Audit Closed as Complete |
| **Annual Quality Statement** | R1/1 | Director of Nursing | Consideration should be given to how the UHB plans to satisfy the requirem | The QSI Framework did not include Staying Healthy and Our Staff as domains, as the | Superseded |
| | R1/3 | Director of Nursing | Consideration should be given to the development of a tracker in the form o | A database will be created to support the tracking of all improvement measures that | Audit open for over 6 months |
| | R2/3 | Director of Nursing | A check on the accuracy of all data sets obtained from the Datix system shou | The specified data has been changed in line with the recommendation. Some of the | Audit open for over 6 months |
| | R3/3 | Director of Nursing | The UHB should consider the impact of the much earlier deadline for publish | The development and coordination of the AQS is planned in advance with time sche | Audit open for over 6 months |
| | (blank) | Director of Nursing | A check on the accuracy of all data sets obtained from the Datix system shou | The specified data has been changed in line with the recommendation. Some of the | Audit Closed as actions complete |
| | | | Consideration should be given to the development of a tracker in the form o | A database will be created to support the tracking of all improvement measuresthat | Audit Closed as actions complete |
| | | | The UHB should consider the impact of the much earlier deadline for publish | The development and coordination of the AQS is planned in advance with timesched | Audit Closed as actions complete |
| **Business Continuity Planning Follow-Up** | R1/1 | Director of Planning | The significant, high priority, issue that remains from the original review can | Not Provided | Audit open for more than 12-months |
| **Charitable Funds** | R1/2 | Director of Finance | The Finance Department should undertake a regular review of dormant Chai | Agreed | Audit open for over 6 months |
| | R1/4 | Director of Finance | Management will review the appropriateness of this expenditure items and | Professional Fees should be paid by the individual members of staff. Clinical Boards t | Superseded |
| | R2/2 | Director of Finance | Dormant Fund balances should be periodically reported to the Charitable Fu | Agreed | Audit open for over 6 months |
| | R2/4 | Director of Finance | The Health Board need to further review the monitoring arrangements of dc | Finance department to continue working with Clinical Boards to deliver appropriate | expenditure plans. The 8 funds are not part of the Clinical Boards and these have n |
| | R3/4 | Director of Finance | Management will ensure that there are wider representation from Clinical B | The Fundraising team will continue to engage with the Clinical Boards to ensure appı | Superseded |
| | R4/4 | Director of Finance | Documentation surrounding the governance of charitable funds will be revie | Fundraising Policy to be reviewed as per governance arrangements. | Superseded |
| **Children & Women Clinical Board – Medical Staff Rotas** | R1/7 | Chief Operating Officer | The Clinical Board will monitor the number of study days taken by medical st | Directorate Management Teams will be reminded to monitor the requests and apprc | Audit open for more than 12-months |
| | R2/7 | Chief Operating Officer | The profile and accountabilities in relation to study leave requirements neec | Updated study leave procedures will be circulated to DMT and onwards to all medic | Audit open for more than 12-months |
| | R3/7 | Chief Operating Officer | Staff will be reminded of their responsibilities when requesting and approvir | Updated study leave procedures will be circulated to DMT and onwards to all medic | Audit open for more than 12-months |
| | R4/7 | Chief Operating Officer | Proactive monitoring will be undertaken to ensure all appropriate staff are u | Assurance to be provided through Directorate Performance Reviews from each DMT | Audit open for more than 12-months |
| | R5/7 | Chief Operating Officer | Staff will be reminded of the procedural requirements and updates to stand | A review of the format of the claims forms used within C&W Clinical Board will be ur | Audit open for more than 12-months |
| | R6/7 | Chief Operating Officer | Guidance should be produced and made available throughout the Clinical Bc | The current document will be reviewed and consideration given to broadening its sc | Audit open for more than 12-months |
| | R7/7 | Chief Operating Officer | Management should remind staff around the requirements of the working ti | The current requirements of the working time policy will be shared with all DMT and | Audit open for more than 12-months |
| **Claims Reimbursement** | N/A | Director of Finance | N/A | N/A | Superseded |
| | R1/2 | Director of Nursing | Management should ensure that staff members complete the status section | This will be audited through regular peer datix reviews of files by each claims manag | Audit Closed as actions complete |
| | R2/2 | Director of Nursing | Signatories should ensure that all documents are appropriately dated.Manag | There was no problem with any authorities in signing off the Appendix forms; these | Audit Closed as actions complete |
| **Clinical Diagnostic and Therapeutic Clinical Board – Ban** | R1/4 | Director of Operations | The Clinical Board should develop a process to ensure that all overtime sessi | All departments have received a communication instructing them to amend their cu | Audit open under 6 months and some dates breached |
| | R2/4 | Director of Operations | The Clinical Board should consider producing a Standard Operating Procedur | CD+T will review the current processes in place across departments to produce an o | Audit open under 6 months and some dates breached |
| | R3/4 | Director of Operations | The department should ensure that all agency shifts worked are appropriate | The management team associated with this department has been requested toprovi | Audit open under 6 months and some dates breached |
| | R4/4 | Director of Operations | Where staff work less than the Agenda for Change hours of 37.5 hours any a | This will form part of the SOP, and a reminder email will be sent to all departments | Audit open under 6 months and some dates breached |
| **Commissioning** | R1/3 | Director of Transformation, Improvements and Informatics | Strategic Commissioning Group Terms of Reference document should be rev | The Strategic Commissioning Groups Terms of Reference, including membership wa | Audit open under 6 months and some dates breached |
| | R2/3 | Director of Transformation, Improvements and Informatics | The Commissioning Team should as part of its ongoing programme of work p | The development of the commissioning intranet pages, alongside commissioning toc | Audit open under 6 months and some dates breached |
| | R3/3 | Director of Transformation, Improvements and Informatics | The Commissioning Framework document should be updated to reflect itscr | The Commissioning Framework has been amended, and now includes version contrc | Audit open under 6 months and some dates breached |
| **Consultant Job Planning** | R1/6 | Medical Director | Clinical Boards must ensure that all consultants complete a job plan or have | Processes are in place to support the completion and reporting of job planning activi | Audit open for more than 12-months |
| | R2/6 | Medical Director | The UHB job planning guidance should require consultants to use the standa | Clinical Board Directors and Clinical Directors should ensure that summary job plans | Audit open for more than 12-months |
| | R3/6 | Medical Director | Clinical Board management must ensure that all consultants complete the o | Review of job planning guidance with regard to job plan template and re-issue to Clir | Audit open for more than 12-months |
| | R4/6 | Medical Director | In accordance with the guidance, Clinical Board management should ensure | Review of job planning guidance with regard to job plan template and re-issue to Clir | Audit open for more than 12-months |
| | R5/6 | Medical Director | The UHB should consider developing additional methods of communication | A planned schedule for training should be refreshed and communicated, including sc | Audit open for more than 12-months |
| | R6/6 | Medical Director | All completed job plans must be signed by the Consultant and the clinical ma | The job plan review does not require an actual signature but there does need to be a | Audit open for more than 12-months |
| **Continuing Health Care (CHC)** | R1/8 | Chief Operating Officer | The UHB should accept the residual risk relating to these changes in care rec | A recent Ombudsman ruling in 2015 has expressly advised the UHB when triggers be | COMPLETE |
| | R2/8 | Chief Operating Officer | A timescale should be set to ensure the Head of Service Agreement is agree | The Heads of Service agreement is being reviewed following the Operation Jasmin w | PARTIALLY COMPLETE |
| | R3/8 | Chief Operating Officer | PCIC should ensure an annual review is carried out on existing CHC placemer | A schedule is in place to meet statutory requirements for review which is monitored | COMPLETE |
| | R4/8 | Chief Operating Officer | The Children CHC team should develop a local procedure that sets out how t | The Community Child Health Directorate will develop a local Operational Policy base | Audit open for more than 12-months |
| | R5/8 | Chief Operating Officer | Individual Service User Agreements should be produced to cover health aspe | The Community Child Health Directorate will agree a process for KPI's to be measur | Audit open for more than 12-months |
| | R6/8 | Chief Operating Officer | All new placements should have a placement agreement in place and be pro | This is in place | COMPLETE |
| | R7/8 | Chief Operating Officer | A list of QA dates should be maintained with corresponding patients reviewe | QA is held every Tuesday each week for 52 weeks (Whitchurch Locality Meeting roor | COMPLETE |
| | R8/8 | Chief Operating Officer | PCIC should ensure an initial 3 month review is carried out on new CHC placı | Agreed – this will be undertaken if the staffing resource is available. | COMPLETE |
| **Contract Compliance** | R1/4 | Director of Finance | Capital & Estates staff should be formally reminded of the requirement to cc | Procurement Services has put in place a system to identify additional expendituresul | Audit open under 6 months and some dates breached |
| | R2/4 | Director of Finance | Staff raising purchase orders should be reminded of the requirement to obt | Procurement Services will continue to support, provide training, guidance and reinfo | Audit open under 6 months and some dates breached |
| | R3/4 | Director of Finance | An overview of the procurement process should be included in the Corporat | Procurement Services will provide a summary guidance sheet to the Induction | Audit open under 6 months and some dates breached |
| | R4/4 | Director of Finance | The Procurement Guide should be reviewed and updated as necessary. The | Since the C&V intranet was tested, the revised Business Plan has been approved by | Audit open under 6 months and some dates breached |
| **Core Financial Systems** | R1/6 | Director of Finance | Management should issue a reminder to all departments that debtor reques | The Financial Services Manager will write to All Heads of Finance emphasising the ne | Superseded |
| | R2/6 | Director of Finance | Management should issue a reminder that credit note requests should not b | The Financial Services Manager will write to All Heads of Finance emphasising the ne | Superseded |
| | R3/6 | Director of Finance | Management should remind staff that all debts referred for write off should | The Financial Services Manager will write to All Heads of Finance emphasising the ne | Superseded |
| | R4/6 | Director of Finance | Management should review all reconciliations where there are a large numb | Finding agreed and understood. The department has been one member of staff dow | Superseded |
| | R5/6 | Director of Finance | Management should ensure that a review is undertaken for all staff that hav | Discussions with the NWSSP E-enablement team have taken place to request the dis | Superseded |
| | R6/6 | Director of Finance | Management should ensure that a review is undertaken on the PO approval | A list of UHB authorised signatories is produced on a quarterly basis (last done Janua | Superseded |
| **Cost Improvement Programme** | R1/3 | Director of Finance | Management should ensure that sufficient detailed supporting documentati | CIP Impact statements have been developed and filtered through Clinical Boards for | Audit open for over 6 months |
| | R2/3 | Director of Finance | Where it is identified that actual savings are higher or lower than originally a | Actual savings delivered are reported on a monthly basis as part of the monthly acco | Audit open for over 6 months |
| | R3/3 | Director of Finance | NHS Wales Audit & Assurance Services Page 11 of 12 Recommendation 3 Pri | A process merging pay and non-pay elements of savings schemes will be put in place | Audit open for over 6 months |
| **Costing Review** | R1/6 | Director of Finance | Management will look to increase the level of clinical engagement throughc | The PCB platform provides the UHB with an effective dashboard for analysing costin | Audit open for more than 12-months |
| | R2/6 | Director of Finance | The concerns highlighted will be further investigated to ensure appropriate | Agreed.Costing is an exercise of mass data linkage reliant on basic administrative fur | Audit open for more than 12-months |
| | R3/6 | Director of Finance | The Welsh Government returns should be subject to formal scrutiny by the F | Agreed. The costing returns will be reported to the Finance Committee to provide su | Audit open for more than 12-months |
| | R4/6 | Director of Finance | Management will ensure the future accuracy of costing return. | We agree that the statement was misleading as submitted, indicating that aspecific i | Audit open for more than 12-months |
| | R5/6 | Director of Finance | Wider verification should be sought to ensure accuracy and increaseengager | Agreed.There is an ongoing engagement with Clinical Boards to better understand cc | Audit open for more than 12-months |
| | R6/6 | Director of Finance | Mechanisms will be established to monitor and report more widely on costir | This point is noted and it is accepted that the relationship between the UHB IMTP an | Audit open for more than 12-months |
| **CRC Energy Efficiency Scheme** | R1/2 | Director of Planning | Bureau data will be compared at meter level with supplier statements (on a | For sites with multiple meters, the bureau data in the 2018/19 CRC reporting spread | Audit open for over 6 months |
| | R1/3 | Director of Planning | Approval will be sought in advance of all future purchases being made. Shou | Future carbon credit purchases will only be required for the final year of the scheme | Superseded |
| | | | Management will amend the evidence pack for the errors / anomalies identi | The evidence pack was amended for the errors / anomalies at the date of the audit. | Superseded |
| | | | Management will work with the Estates team to determine the ownership o | The ownership of the Lansdowne gas meter will be progressed with our current UHB | Superseded |
| | R2/2 | Director of Planning | The CRC working paper summary page should clearly show those figures tha | For 2018/19 the CRC working summary page will show the figures that are to be uplc | Audit open for over 6 months |
| **CRI Safeguarding Works** | R1/5 | Director of Planning | Progression at risk should be fully documented, approved and recorded at tl | Agreed. | Audit open under 6 months and some dates breached |
| | R2/5 | Director of Planning | A Project Execution Plan should be prepared at the outset of a project, in acc | Agreed. | Audit open under 6 months and some dates breached |
| | R3/5 | Director of Planning | Sufficient contractual arrangements should be in place to safeguard the Hea | Agreed. | Audit open under 6 months and some dates breached |
| | R4/5 | Director of Planning | 4) Project benefits should be clearly identified and documented in the busin | Agreed. | Audit open under 6 months and some dates breached |
| | R5/5 | Director of Planning | 5) The required approach to post project evaluation and benefits assessmen | Agreed. | Audit open under 6 months and some dates breached |
| **Cyber Security** | R1/8 | Director of Transformation and Informatics | A review of the resources available within IM&T and the requirements of tha | A review of the current IT and Information departments has been completed and a r | Audit open under 6 months and no dates breached |
| | R2/8 | Director of Transformation and Informatics | An active monitoring process which feeds into KPI reporting should be devel | The restructure of the directorate includes additional resource to manage cyber secu | Audit open under 6 months and no dates breached |
| | R3/8 | Director of Transformation and Informatics | Resources should be provided to allow for a cyber security role to be proper | The restructure of the IT and information functions being proposed will result inthe e | Audit open under 6 months and no dates breached |
| | R4/8 | Director of Transformation and Informatics | Active monitoring should be established.A Cyber response plan should be de | The creation of new cyber security roles in the restructured directorate will mean th | Audit open under 6 months and no dates breached |
| | R5/8 | Director of Transformation and Informatics | A formal, resourced plan for the removal of old software and devices should | A formal plan is in the early stages of production and will address removal of aged ar | Audit open under 6 months and no dates breached |
| | R6/8 | Director of Transformation and Informatics | A formal patch management procedure should be developed that sets out tl | Patching of PCs is being investigated as time allows to identify the scale of the risk. A | Audit open under 6 months and no dates breached |
| | R7/8 | Director of Transformation and Informatics | Regular cyber security "bulletins" should be published via the intranet, with | The profile of cyber security will be raised via the creation of regular proactive bullet | Audit open under 6 months and no dates breached |
| | R8/8 | Director of Transformation and Informatics | The IT Security Policy should be reviewed and updated. | The current IT security policy is scheduled to be reviewed to reflect changes in legisl | Audit open under 6 months and no dates breached |

| | | | | | |
|---|---|---|---|---|---|
| **Delayed Transfers of Care Reporting** | R2/2 | Chief Operating Officer | Due to the patient impact of delayed discharge, it would be beneficial to incl | Clinical Boards will be provided with the monthly DToC reportClinical Board Director: | Audit open under 6 months and some dates breached |
| **Delayed Transfers of Care Reporting** | R1/2 | Chief Operating Officer | The Medically Fit spreadsheet used to identify DToCs weekly is updated usin | The date of referral and compliance with time scales is checked verbally within the w | Audit open under 6 months and some dates breached |
| **Dental CB – Dental Nurse Provision** | R1/6 | Chief Operating Officer | The Dental Nurse Management team should consider formalising ratios of D | To reduce duplication of lists, a meeting will be set up with Senior Dental Nurse's an | Audit open for over 6 months |
| | R2/6 | Chief Operating Officer | The Dental Nurse Management team should consider bringing forward the r | To reduce duplication of lists, a meeting will be set up with Senior Dental Nurse's an | Audit open for over 6 months |
| | R3/6 | Chief Operating Officer | Dental Nurse Management should attend the Clinical Staffing meeting and P | Dental Nurse Manager attends Clinical staffing meeting, at this meeting Dental Nurs | Audit open for over 6 months |
| | R4/6 | Chief Operating Officer | It is recommended that the Senior Dental Nurses maintain a log that docum | Implement feedback tool; that will be used to collect weekly changes that take place | Audit open for over 6 months |
| | R5/6 | Chief Operating Officer | The Senior Dental Nurse weekly meeting should continue to function in orde | The weekly Senior Dental Nurse meeting will continue to function, chaired by the De | Audit open for over 6 months |
| | R6/6 | Chief Operating Officer | Consideration should be given to adding in the Senior Dental Nurses into the | Where appropriate, work will begin on rolling out ESR hierarchy access to Senior Der | Audit open for over 6 months |
| **Dental CB – Theatre Sessions** | R1/2 | Chief Operating Officer | The Dental administration staff should ensure that Patient Dental files conta | Urgent meeting to be arranged with Clinical Lead and Peri-Operative Care Manager t | Audit open for over 6 months |
| | R2/3 | Chief Operating Officer | The majority of patients cancelled by Dental staff are due to oversubscribed | Reviewed PasPlus regarding start and finish times. Clinical Lead to speak with Maxill | Audit open for over 6 months |
| | R3/3 | Chief Operating Officer | Dental management should ensure that cancelled operations are re-booked | Where possible this is always the case but many lists are held only on a monthly basi | Audit open for over 6 months |
| **Deprivation of Liberties Safeguards Follow-Up** | R1/2 | Medical Director | There is still a low uptake with the number of staff having DoLS training.139 | The Medical Director has provided the following additional information about some | Audit open for more than 12-months |
| | R2/2 | Medical Director | The number of DoLS requests have increased but there has been no corresp | See above | Audit open for more than 12-months |
| **E IT Training** | R1/7 | Director of Transformation, Improvements and Informatics | An assessment of the impact of these measures should be carried out andpr | An assessment of the reduced course duration is to be undertaken by the PARIS trair | Audit open under 6 months and no dates breached |
| | R2/7 | Director of Transformation, Improvements and Informatics | Relevant policies and procedures should be put in place to set out the circun | The 'relevance' of the PARIS training system is under constant review through both t | Audit open under 6 months and no dates breached |
| | R3/7 | Director of Transformation, Improvements and Informatics | To introduce a relevant pre-assessment process and procedures to ensure th | The Health Board will:1. Agree a process for ensuring any LD is captured.2. Develop t | Audit open under 6 months and no dates breached |
| | R4/7 | Director of Transformation, Improvements and Informatics | Document control information to be standardised and completed in full onto | Training documents are currently version controlled but not standardised.Standardis | Audit open under 6 months and no dates breached |
| | R5/7 | Director of Transformation, Improvements and Informatics | A sign off process should be introduced involving training customers for the | A review and sign off procedure for the Welsh Clinical Portal involving the service co | Audit open under 6 months and no dates breached |
| | R6/7 | Director of Transformation, Improvements and Informatics | An impact assessment process should be introduced in order to gather and e | An impact assessment process is in draft but has been suspended due to the Work Li | Audit open under 6 months and no dates breached |
| | R7/7 | Director of Transformation, Improvements and Informatics | The training material should be updated to include a range of options for po | It would not be appropriate to provide Service Coordinator details since these will be | Audit open under 6 months and no dates breached |
| **Electronic Staff Record** | R1/4 | Director of Workforce and Organisational Development | The Workforce Department need to ensure that where ESR has been rolled o | During rollout (now 100% completed) managers and staff were made aware of the fa | Audit open for over 6 months |
| | R2/4 | Director of Workforce and Organisational Development | Appropriate staff will be reminded that paperwork needs to be sent to Medi | It is the responsibility of the Clinical Board Management team to identify problems a | Audit open for over 6 months |
| | R3/4 | Director of Workforce and Organisational Development | Management will ensure a singular and consistent approach to reportingcon | This has already been actioned as the Learning Education & Development team are r | Audit open for over 6 months |
| | R4/4 | Director of Workforce and Organisational Development | Workforce to ensure that Health Board staff are aware of the support and gu | Contact details of the new All-Wales ESR Self-Service Support Hub (helpdesk) have b | Audit open for over 6 months |
| **Emergency Unit - 12 Hour Target** | R1/2 | Chief Operating Officer | Management will remind staff around the importance of timely and correct | Reminder sent to all staff in Emergency Medicine. | Audit Closed as Complete |
| | R2/2 | Chief Operating Officer | Management will ensure that the results of the internal monitoring process | A report on the monitoring of the application of Stop Clocks will be a standing item c | Audit Closed as Complete |
| **Environmental Sustainability Report** | R1/4 | Director of Planning | Future Sustainability Reports should only report on water supply costs. This | Future Sustainability reports will include water supply costs, but will be determined | Audit open for over 6 months |
| | R2/4 | Director of Planning | A requirement to draw up a timetable annually to cover the preparation of t | A timetable will be developed in April 2019 detailing key milestones. Where possible | Audit open for over 6 months |
| | R3/4 | Director of Planning | The sustainability reporting procedure notes should be supplemented withd | The sustainability reporting procedure now includes detailed information on how to | Audit open for over 6 months |
| | R4/4 | Director of Planning | Future Sustainability Reports should include references / links to where furtl | Consideration will be given to include references / links to where further sustainabili | Audit open for over 6 months |
| **Health and Care Standards** | N/A | Director of Nursing | N/A | N/A | Audit closed as no recommendations |
| | | | | | No Action Required - complete |
| **IM&T Server Virtualisation** | R1/5 | Director of Therapies and Health Science | The UHB should consider widening the pool of staff with the skills to manage | The IT Department will review potential opportunities for recruitment and training a | Audit open for more than 12-months |
| | R2/5 | Director of Therapies and Health Science | A formal SOP should be developed setting out the basis for patching / updat | Agreed | Audit open for more than 12-months |
| | R3/5 | Director of Therapies and Health Science | A SOP for VM creation should be developed, setting out the process and the | Agreed | Audit open for more than 12-months |
| | R4/5 | Director of Therapies and Health Science | A separate network adapter should be installed for the management netwo | The documented recommendation for a separate Management Network dates back | Audit open for more than 12-months |
| | R5/5 | Director of Therapies and Health Science | The UHB should fully investigate the possibility of datacentre licencing.Shoul | The UHB has investigated the licence requirements and costs associated with VMotic | Audit open for more than 12-months |
| **IM&TMTeD Deployment** | R1/2 | Director of Therapies and Health Science | Repeat the benefits measurements (MBPM described above) which was carr | The benefits measurements carried out as part of the MTED Pilot Project and set out | Audit open for more than 12-months |
| | R2/2 | Director of Therapies and Health Science | The membership of ISEC should be reviewed to ensure it is still valid. Subseq | The membership of ISEC has been recently reviewed to ensure validity. | Audit open for more than 12-months |
| **IM&TWelsh Patient Referral System** | R1/2 | Director of Therapies and Health Science | The membership of ISEC should be reviewed to ensure it is still valid. Subseq | Agreed.The membership of ISEC has been recently reviewed to ensure validity. | Audit open for more than 12-months |
| | R2/2 | Director of Therapies and Health Science | Encryption should be applied to all data transfers. | The feasibility of applying encryption to this data transfer will be raised /discussed w | Audit open for more than 12-months |
| **Information Governance: General Data Protection Regul** | R1/12 | Director of Transformation and Informatics | The UHB should consider establishing a GDPR group with representation fro | The UHB has adapted the all Wales IG policy. As part of the process to formal adopti | Audit open under 6 months and some dates breached |
| | R10/12 | Director of Transformation and Informatics | The IAR process should pick up information flows and also consider the basis | In line with the approach taken across NHS Wales which has been discussed openly v | Audit open under 6 months and some dates breached |
| | R11/12 | Director of Transformation and Informatics | The UHB should make clear the requirement to gain explicit consent for thes | As above – there is no requirement for consent where the data processing by a non l | Audit open under 6 months and some dates breached |
| | R12/12 | Director of Transformation and Informatics | Directorates should be reminded to display the GDPR information. | Accept – SIRO will write to Directorate Managers & CDs to remind them of this requi | Audit open under 6 months and some dates breached |
| | R2/12 | Director of Transformation and Informatics | The resource requirement for the Information Governance team should be f | In the context of the UK wide economy growing at a lower rate than: patient expecta | Audit open under 6 months and some dates breached |
| | R3/12 | Director of Transformation and Informatics | A revised Subject Access Procedure should be completed, placed on the intr | Accepted | Audit open under 6 months and some dates breached |
| | R4/12 | Director of Transformation and Informatics | The IG webpages should be updated to ensure they present current, accurat | The contact details will be updated shortly.As noted above the department has beer | Audit open under 6 months and some dates breached |
| | R5/12 | Director of Transformation and Informatics | The UHB should seek to ensure all staff complete the IG training module. | Management Response Accept – The UHB is engaged nationally in the development | Audit open under 6 months and some dates breached |
| | R6/12 | Director of Transformation and Informatics | Training on GDPR should be enhanced and provided to all staff acting in an I | Training is via the mandatory training route described in recommendation 5.The UHI | Audit open under 6 months and some dates breached |
| | R7/12 | Director of Transformation and Informatics | All areas should be asked to complete an IAR or feed into an IAR.Further gui | All areas have been asked on numerous occasions to complete asset registers and th | Audit open under 6 months and some dates breached |
| | R8/12 | Director of Transformation and Informatics | A reminder should be sent to all staff to ensure that all IG breaches are ente | National policy is being discussed at IGMAG and Medical Directors (Caldicott Guardia | Audit open under 6 months and some dates breached |
| | R9/12 | Director of Transformation and Informatics | This issue should be raised with WG to confirm that the requirement to keej | National policy is being discussed at IGMAG and Medical Directors (Caldicott Guardia | Audit open under 6 months and some dates breached |
| **Internal Medicine Directorate – Mandatory Training & P** | R1/6 | Chief Operating Offier | Management should ensure that all staff within Internal Medicine undertake | All PADRs are signed by the employee prior to them leaving the room at the end | COMPLETE |
| | R2/6 | Chief Operating Officer | Management should ensure that all members of staff within the directorate | Improved compliance for 85% of staff with completion of 100% mandatory and statu | PC – will be completed by September 2019 |
| | R3/6 | Chief Operating Officer | Management should ensure that workforce runs monthly reports that highli | Monthly Performance Meetings with the MCB to be undertaken monthly (avoid canc | COMPLETE |
| | R4/6 | Chief Operating Officer | Management should ensure that any completed PADRs are retained in empl | TCopies of all completed PADRs must be placed in personal files.Record of a complet | COMPLETE |
| | R5/6 | Chief Operating Officer | Management must ensure that the staff database is regularly maintained, w | No Longer ApplicableNo database is maintained by the directorate office. They are n | Audit open under 6 months and some dates breached |
| | R6/6 | Chief Operating Officer | Management should ensure that all staff using ESR attends the training cour | Timely changes made by ESR when staff or hierarchies change. | COMPLETE |
| **Internal Medicine Directorate Mandatory Training and F** | R1/6 | Chief Operating Officer | Management should ensure that all staff within Internal Medicine undertake | The Directorate has developed a Project Outline Document to support ward areas to | Overdue |
| | R2/6 | Chief Operating Officer | Management should ensure that all members of staff within the directorate | The Directorate has assigned a member of the team to improve the mandatory train | Superseded |
| | R3/6 | Chief Operating Officer | Management should ensure that workforce runs monthly reports that highli | Key links with ESR team will be established and core reports determined, including cl | Superseded |
| | R4/6 | Chief Operating Officer | Management should ensure that any completed PADRs are retained in empl | The Directorate has developed an POD to support ward areas to complete PADR. See | Superseded |
| | R5/6 | Chief Operating Officer | Management should ensure that any completed PADRs are retained in empl | The Directorate has developed an POD to support ward areas to complete. PADR. Se | Superseded |
| | R6/6 | Chief Operating Officer | Management should ensure that all staff using ESR attends the training cour | To be included in the reports for ESR to ensure all have access and training. | Superseded |
| **Kronos Time Recording System - Estates** | R1/6 | Director of Planning | Suitably qualified and experienced staff should be assigned specific respons | Suitably qualified and experienced staff should be assigned specific responsibility for | Audit open under 6 months and no dates breached |
| | R2/6 | Director of Planning | Management should review the current M & E Rotas to establish if the pract | The Estates Department is currently in the process of consultation with staff on mod | Audit open under 6 months and no dates breached |
| | R3/6 | Director of Planning | The development of an automatic interface between Kronos and ESR is a ke | Refer to Management Response to Finding 1; which includes investigating the interfa | Audit open under 6 months and no dates breached |
| | R4/6 | Director of Planning | Where overtime has been worked this should be reflected in the start and fi | The issue will be considered as part of the system review although all overtime is aut | Audit open under 6 months and no dates breached |
| | R5/6 | Director of Planning | Staff should be instructed to clock in no more than 27 minutes before the st | Staff clock in on arrival on site but are not paid from this point, unless authorisation | Audit open under 6 months and no dates breached |
| | R6/6 | Director of Planning | Estates Admin staff should be instructed to only input hours for enhanceme | Supervisors are fully aware of their responsibilities in respect of recording absence a | Audit open under 6 months and no dates breached |
| **Legislative/Regulatory Complaince** | R1/7 | Director of Corporate Governance | The Corporate Governance Team should re-evaluate the processes in place f | Agreed this is an essential responsibility of the Corporate Governance Team which to | PARTIALLY COMPLETE |
| | R2/7 | Director of Corporate Governance | A full list of Regulators that are relevant to the UHB needs to be established | Agreed this should be in place and the fact that it is not places the organisation at ris | COMPLETE |
| | R3/7 | Director of Corporate Governance | The Corporate Governance Team should ensure that all the relevant informa | Agreed the information should be up to date and accurate | PARTIALLY COMPLETE |
| | R4/7 | Director of Corporate Governance | The Corporate Governance department must ensure that the information pr | It has already been agreed at the last Audit Committee that this report would be rev | PARTIALLY COMPLETE |
| | R5/7 | Director of Corporate Governance | The Senior Fire Safety Office should ensure that sufficient evidence is availat | Agreed | n/a |
| | R6/7 | Director of Corporate Governance | The Senior Fire Safety Officer should ensure that there is appropriate attend | Agreed | n/a |
| | R7/7 | Director of Corporate Governance | The Corporate Team should re-evaluate the Report to ensure that all the ne | Recommendation agreed | PARTIALLY COMPLETE |
| **Management of the Disciplinary process.** | R1/6 | Director of Workforce and Organisational Development | A fully complete initial assessment should be on every case file, which provic | The current initial assessment process has been reviewed and a more robust process | Audit open for over 6 months |
| | R2/6 | Director of Workforce and Organisational Development | Management will implement mechanisms, i.e. a root cause analysis, to highl | The Director of Workforce & OD is leading the challenge and engagement with Trade | Audit open for over 6 months |
| | R3/6 | Director of Workforce and Organisational Development | Management will put processes in place to enhance file management for bo | The HR team have revised the Guidance and Information Pack for Investigating Offic | COMPLETE |
| | R4/6 | Director of Workforce and Organisational Development | Management will identify trends in delays and take appropriate action in orc | The organisation of Appeals will be centralised within the HR Operations Centre in th | Audit open for over 6 months |
| | R5/6 | Director of Workforce and Organisational Development | Training will be undertaken by all investigators to help with the efficient run | The HR team are currently reviewing the UHB list of IO's to ascertain their status, i.e. | COMPLETE |
| | R6/6 | Director of Workforce and Organisational Development | Management should review their performance/ summary documents to ens | The main ER tracker is being updated to ensure that we capture the performance da | Audit open for over 6 months |
| **Medicine CB - Sickness Absence Management** | R1/5 | Chief Operating Officer | Management must ensure that all future sickness episodes are managed an | Re-circulate the All Wales Managing Attendance at Work Policy. ▪ Support and appr | Audit open under 6 months and some dates breached |
| | R2/5 | Chief Operating Officer | Management should ensure that the sickness triggers are being managed co | Support and appraises have been set up for A6 South to ensure consistency in compl | Audit open under 6 months and some dates breached |
| | R3/5 | Chief Operating Officer | Management should ensure that the sickness triggers are being managed co | ▪ Support and appraises have been set up for A6 South to ensure consistency in cor | Audit open under 6 months and some dates breached |
| | R4/5 | Chief Operating Officer | Management should ensure that all current ward managers are provided wi | ▪ Within Stroke Services, engaged with Human resources to provide furthertraining | Audit open under 6 months and some dates breached |
| | R5/5 | Chief Operating Officer | Management should remind ward staff that the recording of sickness dates : | Within Stroke Services, engaged with Human resources to provide further training fc | Audit open under 6 months and some dates breached |
| **Mental Health Clinical Board – Section 17 Leave** | R1/4 | Chief Operating Officer | The Guideline for Section 17 Leave of Absence Mental Health Act 1983 shou | The Guideline for Section 17 Leave of Absence Mental Health Act 1983 will be preser | Audit open for over 6 months |
| | R2/4 | Chief Operating Officer | The Health Board should clarify if there is a requirement for specific risk asse | Consideration of the risk assessment and care and treatment plan will have taken pl | Audit open for over 6 months |
| | R3/4 | Chief Operating Officer | Management should consider updating the Section 17 Leave of Absence forr | The recording of the reason why leave has been granted is not a requirement of the | Audit open for over 6 months |
| | R4/4 | Chief Operating Officer | Staff should ensure that they complete all sections of the signing in and outt | (blank) | Audit open for over 6 months |

| | | | | | |
|---|---|---|---|---|---|
| **Mental Health Clinical Board – Sickness Management** | R1/4 | Chief Operating Officer | Management should ensure that all sickness episodes are managed and doc | Directorates to send all managers a link to the sickness policy /NHS Wales Managing | COMPLETE |
| | R2/4 | Chief Operating Officer | Management should ensure that the sickness triggers are being managed co | Directorates to send "trigger table" out to all managers, reminding them to check wi | COMPLETE |
| | R3/4 | Chief Operating Officer | Long term sickness meetings should be held as required to ensure that the e | Directorates to send all managers a general reminder of the need for formal sickness | PARTIALLY COMPLETE |
| | R4/4 | Chief Operating Officer | Management should remind ward staff that the recording of sickness dates : | All band 6 / 7 managers to attend refresher sickness training. | COMPLETE |
| **Mental Health Sickness Management and Rostering** | R1/5 | Chief Operating Officer | Management should ensure that all sickness episodes are managed anddocu | The MHCB has seen significant changes to the inpatient ward management structure | Audit open for more than 12-months |
| | R2/5 | Chief Operating Officer | Ward Managers should ensure that recommended breaks are factored in wh | The MHCB have been working alongside staff side colleagues to agree a process and | Audit open for more than 12-months |
| | R3/5 | Chief Operating Officer | Magement need to ensure that the Medical Team are provided with training | The Clinical Directors support local medical managers in the management of sickness | Audit open for more than 12-months |
| | R4/5 | Chief Operating Officer | Nursing staff should be reminded that all bank and agency time sheets shoul | It was evidenced from our testing that there were a number of inconsistencies acros | Audit open for more than 12-months |
| | R5/5 | Chief Operating Officer | NHS Wales Audit & Assurance Services Page 16 of 17 Recommendation Prior | This issue will be monitored via the sickness surgeries. | Audit open for more than 12-months |
| **Mortality Reviews** | R1/3 | Medical Director | Best practice would dictate that the UHB should introduce a mechanism of c | Work is underway to design an all-Wales Level 2 mortality screening tool. The UHB h | Audit open for more than 12-months |
| | R2/3 | Medical Director | The Health Board must ensure that level 1 mortality reviews are completed i | A review of the current paper trail will be undertaken and improved as necessary. Cli | Audit open for more than 12-months |
| | R3/3 | Medical Director | The Universal Mortality Review form question pertaining to the need to trig | The wording on the form and subsequent IT development was so that any 'yes' answ | Audit open for more than 12-months |
| **National Standards for Cleaning in NHS Wales** | R1/6 | Director of Planning | The Health Board should ensure that there is a Multi-Disciplinary Group in pl | Formerly add the Cleaning Standards requirement into one of the existing forums de | Superseded |
| | R2/6 | Director of Planning | The Health Board should ensure that a consistent approach is used for repor | On checking with C4C both approaches were in accordance with the system and star | Superseded |
| | R3/6 | Director of Planning | An appropriate member of the Ward staff should sign off the technical audit | Facilities to coordinate and request clinical support on audit. Ward Sisters and Charg | Superseded |
| | R4/6 | Director of Planning | The Health Board should carry out managerial audits on a quarterly basis in l | Facilities Staff to arrange audit schedule and invite ward staff to participate with goo | Superseded |
| | R5/6 | Director of Planning | Management should update the Cleaning Strategy and develop an Operatio | Facilities Senior Management to develop and disseminate to the Cleaning Group for | Superseded |
| | R6/6 | Director of Planning | Management should ensure that technical audits are completed on all high / | Facilities to review audit schedule and make clear programme to Senior Managemen | Superseded |
| **National Standards for Cleaning in NHS Wales Follow-up** | R1/6 | Director of Planning | The Health Board should ensure that there is a Multi-Disciplinary Group in pl | Formerly add the Cleaning Standards requirement into one of the existing forums de | Overdue more than 12-months: Follow-up Audit confirmed not fully complete |
| | R2/6 | Director of Planning | The Health Board should ensure that a consistent approach is used forrepor | On checking with C4C both approaches were in accordance with the system and star | Overdue more than 12-months: Follow-up Audit confirmed not fully complete |
| | R3/6 | Director of Planning | An appropriate member of the Ward staff should sign off the technical audit | Facilities to coordinate and request clinical support on audit. Ward Sisters and Charg | Overdue more than 12-months: Follow-up Audit confirmed not fully complete |
| | R4/6 | Director of Planning | The Health Board should carry out managerial audits on a quarterly basis in l | Facilities Staff to arrange audit schedule and invite ward staff to participate with goo | Overdue more than 12-months: Follow-up Audit confirmed not fully complete |
| | R5/6 | Director of Planning | Management should update the Cleaning Strategy and develop an Operatio | Facilities Senior Management to develop and disseminate to the Cleaning Group for | Overdue more than 12-months: Follow-up Audit confirmed not fully complete |
| | R6/6 | Director of Planning | nagement should ensure that technical audits are completed on all high /ver | Facilities to review audit schedule and make clear programme to Senior Managemen | Overdue more than 12-months: Follow-up Audit confirmed not fully complete |
| **Neurosciences - Patient Care IT System** | (blank) | (blank) | (blank) | (blank) | (blank) |
| **Nurse Revalidation** | R1/3 | Director of Nursing | The All Wales policy should be adopted by the Health Board and adapted to | The All Wales Policy is currently under review by Welsh Government expected date f | Audit open for more than 12-months |
| | R2/3 | Director of Nursing | The C&V UHB PADR form should be revised for Nursing Staff to include an aj | The Senior Nurse for Nurse Education will work with the lead for PADR to create a se | Audit open for more than 12-months |
| | R3/3 | Director of Nursing | Where nurses are using their line manager as their confirmer, the confirmer: | An email via the Directors of Nursing will be issued to remind staff of ESR capability r | Audit open for more than 12-months |
| **Ombudsman Report** | N/A | Director of Nursing | N/A | N/A | Audit Closed as no action required |
| **Organisational Values** | R1/3 | Director of Workforce and Organisational Development | Management should review the Communications Plan and revise the dates c | The communications and engagement plan has been revised and updated for 2018 w | Audit open for more than 12-months |
| | R2/3 | Director of Workforce and Organisational Development | Management within the Health Board and Clinical Boards should ensure that | Chief Executive has signed the Formal Pledge and has publicised this via CAV-News ir | COMPLETE |
| | R3/3 | Director of Workforce and Organisational Development | Management need to ensure that there are appropriate measures such as su | Some measure of the organisational values will be collected via the All Wales staff su | COMPLETE |
| **PCIC CB – District Nursing Rotas** | R1/5 | Chief Operating Officer | The District Nurses should ensure they are enforcing rules over how many st | A local annual leave procedure has been developed since the audit to ensure that sta | Audit open for over 6 months |
| | R2/5 | Chief Operating Officer | District Nurses should work in conjunction with the Rosterpro team to ensur | District Nursing sisters will be expected to use Rosterpro to roster all staff, this will b | Audit open for over 6 months |
| | R3/5 | Chief Operating Officer | District Nurse Sisters should ensure rotas are prepared on a timely basis.Wh | District Nursing sisters will be expected to use Rosterpro to roster all staff, rosters wi | Audit open for over 6 months |
| | R4/5 | Chief Operating Officer | District Nurse Sisters should verify rotas weekly, within 72 hours of the last s | District Nursing sisters will be required to verify rosters weekly and this will bemonit | Audit open for over 6 months |
| | R5/5 | Chief Operating Officer | District Nurse Sisters should be reminded of the importance of recording sha | A revised process for recording gaps in staffing is to be developed | Audit open for over 6 months |
| **PCIC Interface Incidents** | R1/9 | Chief Operating Officer | Plan should be devsed for the proposed roll out of Datix to GPs, this should i | The patient safety team (PST) have already carried out some preparatory work which | Audit open under 6 months and some dates breached |
| | R2/9 | Chief Operating Officer | There should be continued engagement and education with GPs to ensure tl | In July 2018 the PST in partnership with PCIC have undertaken work to develop an in | Audit open under 6 months and some dates breached |
| | R3/9 | Chief Operating Officer | PCIC should communicate the importance of reporting interface incidents in | Practices already deal with serious issues relating to interface incidents by contacting | Audit open under 6 months and some dates breached |
| | R4/9 | Chief Operating Officer | In addition to the recommendation to consider future workplans, a Standarc | An agreed pathway is already in place that has been supported by the LMC, staffing | Audit open under 6 months and some dates breached |
| | R5/9 | Chief Operating Officer | The Patient Safety Team should remind Clinical Boards and Directorates of tl | This would not be the role fo the PST. The UHB incident, Hazard and near miss repo | Audit open under 6 months and some dates breached |
| | R6/9 | Chief Operating Officer | Efforts should be made to engage with all GP practices, especially those that | The Patient Safety Team will work with PCIC as part of the Datix implementation pla | Audit open under 6 months and some dates breached |
| | R7/9 | Chief Operating Officer | The Q&S Officer should review the list of Datix Reports opened by themselv | PST - the way that permissions and profiles are set up in Datix means that once the i | Audit open under 6 months and some dates breached |
| | R8/9 | Chief Operating Officer | Regular communicatoin with GPs should be undertaken to make them awar | A paragraph in relation to the interface process was included in the winter Patient Sa | Audit open under 6 months and some dates breached |
| | R9/9 | Chief Operating Officer | Consideration should be given to how feedback and incident reporting can b | PCIC does not receive incident notification from internal depts within the UHB which | Audit open under 6 months and some dates breached |
| **Performance Reporting Data Quality - Non RTT** | R1/3 | Director of Public Health | Consideration should be given to aligning the Performance Report and Tier 1 | Discussions at a national level are happening between Welsh Government and the N | Audit open under 6 months and some dates breached |
| | R2/3 | Director of Public Health | The Performance Report working spreadsheet should be linked to data sourc | As identified above – not all the data is available to achieve this.The UHB is actively c | Audit open under 6 months and some dates breached |
| | R3/3 | Director of Public Health | Consideration should be given to re-formatting the Performance Report toin | Accept | Audit open under 6 months and some dates breached |
| **Pilot Model Ward Review** | R1/5 | Director of Planning | The costing exercise for the potential roll out should be re-examined, agreec | As this was a clear pilot and proof of concept. Outcomes were genuinely not known. | Audit open for more than 12-months |
| | R2/5 | Director of Planning | For future projects the plans for financial costing should be more detailed wi | As this was a clear pilot and proof of concept. Costings were genuinely not known. W | Audit open for more than 12-months |
| | R3/5 | Director of Planning | For future projects a defined terms of reference that identifies membership, | Agreed for applicable future projects. | Audit open for more than 12-months |
| | R4/5 | Director of Planning | For future projects of this nature the project plan should be scrutinised mor | Agreed for applicable future projects. | Audit open for more than 12-months |
| | R5/5 | Director of Planning | If this project was to be expanded, a more structured approach to lessons le | The project took a 'lessons learned' and amendments were made 'live' to the projec | Audit open for more than 12-months |
| **Primary, Community & Intermediate Care Clinical Board** | N/A | Chief Operating Officer | N/A | N/A | No Action Required - complete |
| **Progress against findings from the Human Tissue Author** | R1/1 | Chief Operating Officer | Management must ensure that the terms of reference of the HTA Licence Cc | The Human Tissue Authority compliance group is currently running in parallel to HTA | Audit open for more than 12-months |
| **Renal IT system** | R1/10 | Chief Operating Officer | Both UNIX and MySQL should updated to a more recent, supported version. | Early investigations have taken place between Vitalpulse and Summerside. Monies v | Audit open for over 6 months |
| | R10/10 | Chief Operating Officer | The UHB should consider enabling logging | Database enables logging of every action, be it viewing, editing, deleting etc. all store | Audit open for over 6 months |
| | R2/10 | Chief Operating Officer | The minimum password length should be set to 8 and all users have a forcec | The minimum length has now been amended to 8. With regard to forced change, thi | Audit open for over 6 months |
| | R3/10 | Chief Operating Officer | Recommendation The backups should be subject to periodic testing. | This has been brought to the attention of the IT Server Team but is outside of the Dir | Audit open for over 6 months |
| | R4/10 | Chief Operating Officer | The DR plan should be revised to include contact details of support organisa | Dialogue with the Vendor parties has already started regarding the failback process. | Audit open for over 6 months |
| | R5/10 | Chief Operating Officer | A review of users should be undertaken to ensures that leavers access is rev | Action has been taken as identified and a process implemented to regularly review le | Audit open for over 6 months |
| | R6/10 | Chief Operating Officer | Generic accounts should not be used for data entry. | Agreed, On request, Auditor provided a list of affected accounts and these have beer | Audit open for over 6 months |
| | R7/10 | Chief Operating Officer | The local user group should seek to identify fields which could benefit from i | Communication with users is ongoing and agreed changes will be actioned where ap | Audit open for over 6 months |
| | R8/10 | Chief Operating Officer | A local user group should be established with leads from each of the user d | Partially agree. There is an all Wales VitalData Group to which Users can feed into vi | Audit open for over 6 months |
| | R9/10 | Chief Operating Officer | The ROOT account should be renamed and the anonymous account deleted | Management Response The anonymous account was deleted Oct 2018.The ROOT ac | Audit open for over 6 months |
| **Research & Development** | R1/6 | Medical Director | Lead officers will be required to provide an assessment of the research proje | The R&D Office accepts the concerns raised. There are several issues with the systen | Audit open for more than 12-months |
| | R2/6 | Medical Director | Declarations of interest should be added as a standard agenda item andmin | A Declaration of Interest has been added as a standard agenda item to the Research | Audit open for more than 12-months |
| | R3/6 | Medical Director | Management will ensure data protection checks are undertaken by appropri | A guidance document written by the R&D Office on how the data protection checks | Audit open for more than 12-months |
| | R4/6 | Medical Director | (blank) | The Senior Management Team at C&V UHB has completed and submitted a Narrativ | Audit open for more than 12-months |
| | R5/6 | Medical Director | Management will ensure that all clinical boards have appropriate leads for R | The Medical Director has written to the Children and Womens Clinical Board Directo | Audit open for more than 12-months |
| | R6/6 | Medical Director | Policies and standard operating procedures surrounding research and devel | The R&D Office maintains its own Document Version Control System currently holdir | Audit open for more than 12-months |
| **Residences** | R1/10 | Director of Planning | The new tenancy agreement should be finalised, approved and formally intr | Implementation of new tenancy agreement. Long term tenancy agreement to be rev | Audit open for more than 12-months |
| | R10/10 | Director of Planning | The UHB should refer to the PFI contract/SLA to consider whether expectant | Currently being reviewed by PFI Manager. | Audit open for more than 12-months |
| | R2/10 | Director of Planning | The UHB should prepare, approve and implement a formal pricing structure | The pricing structure is currently under review to simplify. | Audit open for more than 12-months |
| | R3/10 | Director of Planning | The UHB should prepare Standard Operating Procedures to cover all admini: | Daily standard operating procedures is being further developed and cross cover by a | Audit open for more than 12-months |
| | R4/10 | Director of Planning | The UHB should consider and document any risks relating to the provision ol | Risk Register for Residences to be developed. Estate compliance is already addressec | Audit open for more than 12-months |
| | R5/10 | Director of Planning | The UHB should prepare, approve and implement a cancellation policy; this : | The priority will be focussed on the appropriate collection of bonds which will requir | Audit open for more than 12-months |
| | R6/10 | Director of Planning | The UHB should document future plans for the provision and utilisation of re | The UHB is currently embarking on a significant master planning exercise for the UHI | Audit open for more than 12-months |
| | R7/10 | Director of Planning | The UHB should ensure that all figures within the Commercial Services dashl | Dashboards to be updated via hotel perfect (accommodation database) on a monthl | Audit open for more than 12-months |
| | R8/10 | Director of Planning | The UHB should discuss these drawbacks with the Hotel Perfect System own | Hotel Perfect are working with the Health Board to address any issues with thedatal | Audit open for more than 12-months |
| | R9/10 | Director of Planning | The UHB should ensure all rents are paid in full within the agreed timescales | The process and management for the collection of rents will be addressed with imm | Audit open for more than 12-months |
| **RTT Performance Reporting** | R1/4 | Director of Transformaiton and Informatics | The Health Board should ensure there is a formalised policy that encompass | We accept that there is a need to review the appropriateness of our RTT policy, ensu | Audit open for more than 12-months |
| | R2/4 | Director of Transformaiton and Informatics | The Health Board should consider validating data of patients that are 'in targ | We accept the point made in the context that data quality audits should extend to re | Audit open for more than 12-months |
| | R3/4 | Director of Transformaiton and Informatics | The Performance Report should include a note next to the SCP compliance fi | Accepted | Audit open for more than 12-months |
| | R4/4 | Director of Transformaiton and Informatics | The Performance Report should include data on the related Cancer patientw | The reporting of volumes occurs infrequently. There is a balance to be had in the det | Audit open for more than 12-months |
| **Serious Incidents Management** | R1/5 | Director of Nursing | Management must ensure that closure forms are submitted to WG within th | NHS Wales Audit & Assurance Services Page 11 of 17 Management Response Respor | Audit open for more than 12-months |
| | R2/5 | Director of Nursing | Management must ensure that the policy is up to date and available to all th | The Incident Reporting Policy was approved at the July 2017 Health and Safety Comr | Audit open for more than 12-months |
| | R3/5 | Director of Nursing | Management must ensure that the policy is up to date and available to all th | The Incident Reporting Policy was approved at the July 2017 Health and Safety Comr | Audit open for more than 12-months |
| | R4/5 | Director of Nursing | The Patient Safety team should communicate the importance of uploading t | Action plans will have been developed and signed off as part of the investigation pro | Audit open for more than 12-months |
| | R5/5 | Director of Nursing | Management should ensure that SIs are reported to WG within the required | Whenever possible the Patient Safety team will attempt to report within 24 hours. T | Audit open for more than 12-months |
| | (blank) | Director of Nursing | Management should ensure that SIs are reported to WG within the required | Whenever possible the Patient Safety team will attempt to report within 24 hours. T | Audit open for more than 12-months |
| | | | The Patient Safety Team should encourage management to use the feedbacl | It is well recognised that the success of a reporting system depends on the level of fe | Audit open for more than 12-months |

| | | | | | |
|---|---|---|---|---|---|
| **Shaping Our Future Wellbeing – Capital Projects** | R1/2 | Director of Planning | Terms of Reference should be developed for the Programme Team and Proje | Terms of reference are reviewed at each stage of the project / Programme, so that t | Audit open for over 6 months |
| | R2/2 | Director of Planning | Delivery of the required project business cases should be carefully performa | Supply Chain Partners have now been appointed for the Maelfa and Penarth scheme | Audit open for over 6 months |
| **Specialist Neuro & Spinal Rehabilitation and Older Peop** | R1/3 | Director of Planning | The Procurement Strategy will be defined, within the FBC and consider all of | Other contractual options available in the SCAPE Framework were not considered so | COMPLETE |
| | R2/3 | Director of Planning | At future schemes contract documentation will be signed prior to the comm | Noted and accepted. | COMPLETE |
| | R3/3 | Director of Planning | Appropriate, timely internal approval will be sought for the change in capital | After completion of the audit fieldwork, Chair's Action approved the FBC prior to sub | COMPLETE |
| **Specialist Neuro & Spinal Rehabilitation and Older Peop** | R1/3 | Director of Planning | The Procurement Strategy will be defined, within the FBC and consider all of | Other contractual options available in the SCAPE Framework were not considered so | Audit Closed as actions complete |
| | R2/3 | Director of Planning | At future schemes contract documentation will be signed prior to the comm | At future schemes contract documentation will be signed prior to the commenceme | Audit Closed as actions complete |
| | R3/3 | Director of Planning | Appropriate, timely internal approval will be sought for the change in capital | After completion of the audit fieldwork, Chair's Action approved the FBC prior to sub | Audit Closed as actions complete |
| **Specialist Services Clinical Board – Medical Finance Gove** | R1/2 | Chief Operating Officer | Management should carry out a comprehensive review of the current and fu | (blank) | Audit open under 6 months and no dates breached |
| | R2/2 | Chief Operating Officer | Each 20 week Consultant rota should be subject to formal approval by the Cl | A process to sign off the rota by the Clinical Director will be developed by the Directo | Audit open under 6 months and no dates breached |
| **Specialist ServicesFollow up - Patientcare IT System** | R1/1 | Chief Operating Officer | A process should be established to periodically test the backups. | Discussions are underway with IM&T and a test of the backup is due to be scheduled | Audit open for over 6 months |
| **Standards of Business Conduct (DoI & GH&S)** | R1/6 | Director of Corporate Governanace | A system is introduced that will ensure that declarations are received from a | Recommendation Agreed – a process will be developed to ensure that key staff grou | COMPLETE |
| | R2/6 | Director of Corporate Governanace | The Corporate Team must put processes in place to help raise awareness of | Recommendation agreed. Review of the information available on the intranet will b | PARTIALLY COMPLETE |
| | R3/6 | Director of Corporate Governanace | The Corporate Team should ensure that all forms are compliant with the SoI | Recommendation agreed – all submitted forms to be reviewed in line with the Policy | COMPLETE |
| | R4/6 | Director of Corporate Governanace | The directorate should ensure that the policy is reviewed and updated accor | Recommendation Agreed – policy to be reviewed and updated in line with best prac | PARTIALLY COMPLETE |
| | R5/6 | Director of Corporate Governanace | The Corporate Team should ensure that all forms are compliant with the SOI | Recommendation Agreed – Forms will be reviewed for compliance with the new poli | COMPLETE |
| | R6/6 | Director of Corporate Governanace | The Corporate Governance department must ensure that the information pr | Recommendation Agreed – Future reporting to the Committee will ensure that the r | PARTIALLY COMPLETE |
| **Statutory Compliance** | R1/1 | Director of Strategic Planning | Processes will be implemented to reduce the exposure to human/transposit | Agreed. As outlined, a software solution is presently being piloted through August ar | Audit open for more than 12-months |
| **Strategic Planning/IMTP** | R1/1 | Director of Planning | Management should ensure that the plans for Clinical Boards are produced ( | A revised monitoring process for reporting clinical board progress on IMTPs will be ir | Audit open under 6 months and no dates breached |
| | R1/2 | Director of Planning | Management must ensure that the Ophthalmology Directorate produce thei | As identified the Ophthalmology IMTP was not completed for 17/18 due to particula | Superseded |
| | R2/2 | Director of Planning | The Strategy Development and Delivery Group's terms of reference should b | We will review the functioning of the Strategy Development and Delivery Group as p | Superseded |
| **Surgery Clinical Board - Anaesthetist Rota Management** | R1/1 | Chief Operating Officer | Standard Operating Procedure notes covering the administration of the CLW | It is accepted by the Directorate that there is no written SOP for staff, although all th | Audit open for more than 12-months |
| **Surgery Clinical Board – Medical Finance Governance** | R1/6 | Chief Operating Officer | The Directorate should ensure that consultants carry out all planned session | A new system to accurately record consultant activity in theatre is being develop | PARTIALLY COMPLETE |
| | R2/6 | Chief Operating Officer | The Directorates should ensure that any displaced SPA sessions are appropri | Systems will be put in place to ensure that the governance for displaced SPA will l | COMPLETE |
| | R3/6 | Chief Operating Officer | General Surgery should ensure that they follow the correct procedure for re | Ensure CD signs off paperwork for locum highlighting rationale for locum Creat | COMPLETE |
| | R4/6 | Chief Operating Officer | Management should produce desk top procedures to ensure that Consultan | Standardised procedure notes to be created and shared with key personnel (March 2 | PARTIALLY COMPLETE |
| | R5/6 | Chief Operating Officer | In conjunction with the actions already being taken following the Consultant | All job plans will be completed and recorded appropriately (March 2019) | PARTIALLY COMPLETE |
| | R6/6 | Chief Operating Officer | Management should ensure that request for Locum cover documentation is | SOP/DTP will be developed and standardised for all Directorates to record adherenc | COMPLETE |
| **Sustainability Reporting** | R1/3 | Director of Planning | The lead responsible for preparing the Sustainability Report should ensure tl | The preparation of future Sustainability reports will have deadlines for data submissi | Superseded |
| | R2/3 | Director of Planning | The lead should ensure that an in-depth review of the report is completed p | The final report and data was reviewed however future reports will be further scruti | Superseded |
| | R3/3 | Director of Planning | The UHB should ensure references are made to further sources of informati | Agreed, references shall be included in future reports where appropriate. | Superseded |
| **UHB Core Financial Systems** | R1/5 | Director of Finance | Management should ensure that the main Asset Register is updated to reflec | Agreed and accepted. The follow up visits with clinical gerontology will be completed | Audit open under 6 months and no dates breached |
| | R2/5 | Director of Finance | Management should ensure departments are aware that all assets should ha | The Director of Finance will again write to departments during 2019/20 emphasising | Audit open under 6 months and no dates breached |
| | R3/5 | Director of Finance | Management should inform responsible staff to promptly notify eEnablemer | Recommendation Accepted. The UHB's current procedure will be updated to clarify t | Audit open under 6 months and no dates breached |
| | R4/5 | Director of Finance | Management should ensure that a standard procedural guide is produced to | Recommendation accepted. The UHB's current procedure will be updated to clarify r | Audit open under 6 months and no dates breached |
| | R5/5 | Director of Finance | Management should ensure that the required forms are completed, signed a | Recommendation accepted. The UHB's revised procedure will be updated to clarify r | Audit open under 6 months and no dates breached |
| **University Hospital of Wales Neo Natal Development** | R1/7 | Director of Planning | The design for the MRI new build will be concluded and frozen as soon as po | The design solution has been informed, as far as is practicable, by considering the sp | Audit open for more than 12-months |
| | R2/7 | Director of Planning | The value of identified risk will be included within the assessment of afforda | Whilst the recommendation is accepted regarding inclusion in the Cost Adviser repo | Audit open for more than 12-months |
| | R3/7 | Director of Planning | An agreed timetable should be developed for design completion and validati | The design has been developed in conjunction with a design development programn | Audit open for more than 12-months |
| | R4/7 | Director of Planning | A formal evaluation of the adequacy of the ground investigation reports will | The ability to carry out an extensive ground investigation survey was impeded by the | Audit open for more than 12-months |
| | R5/7 | Director of Planning | Risk mitigation plans will continue to be actively managed by the UHB, contr | The finding is factually correct at time of compiling the report. Risk has been actively | Audit open for more than 12-months |
| | R6/7 | Director of Planning | The Capital Procedures Manual should be revised to include the requiremen | Agreed | Audit open for more than 12-months |
| | R7/7 | Director of Planning | Requests for 'Single Tender Action' should be approved and reported to the | Agreed | Audit open for more than 12-months |
| **Ward Nursing Staff Levels** | R1/4 | Director of Nursing | The Nurse Staffing Levels - Working Planning Template should be signed off | The completion of signing off the staffing templates has proved a challenge, given th | Audit open under 6 months and some dates breached |
| | R2/4 | Director of Nursing | Management should ensure that all wards display the ward staffing levels to | We have found that at times, there have been oversights in the ward displaying the i | Audit open under 6 months and some dates breached |
| | R3/4 | Director of Nursing | Management should ensure that following the consistency check of the Ope | The Operating framework is with the All Wales Group for final approval. | Audit open under 6 months and some dates breached |
| | R4/4 | Director of Nursing | The Finance budgeted report for the WTE staff should be amended to align v | It is proposed that the finance report will align to the correct Nurseestablishment fol | Audit open under 6 months and some dates breached |
| **Water Safety** | R1/7 | Director of Planning | Attendances of the Water Safety Group should be reviewed, with staff remir | Agreed | Audit open under 6 months and no dates breached |
| | R2/7 | Director of Planning | The current position in respect of the backlog of remedial jobs, should be ro | Agreed | Audit open under 6 months and no dates breached |
| | R3/7 | Director of Planning | Training should be updated for all key staff with assigned water managemen | Agreed | Audit open under 6 months and no dates breached |
| | R4/7 | Director of Planning | a) An audit trail should be maintained where routine checks are not complet | Agreed | Audit open under 6 months and no dates breached |
| | R5/7 | Director of Planning | a) For those clinical boards identified in this audit as being non-compliant wi | Agreed | Audit open under 6 months and no dates breached |
| | R6/7 | Director of Planning | The risk assessment process, including preparation of appropriate prioritisec | Agreed | Audit open under 6 months and no dates breached |
| | R7/7 | Director of Planning | Progress, including highlighting of any delays, should be regularly reported t | Agreed | Audit open under 6 months and no dates breached |
| **Wellbeing of Future Generations Act** | R1/5 | Director of Public Health | The Health Board/ Management should produce an Action Plan to provide a | The Steering Group agreed the need to develop an Action Plan at its meeting on 12 M | Audit open for more than 12-months |
| | R2/5 | Director of Public Health | The Terms of Reference for the WFG Steering Group should be formalised ar | Draft Terms of Reference were discussed at the meeting of the Steering Groupon 12 | Audit open for more than 12-months |
| | R3/5 | Director of Public Health | The Health Board should formalise and approve the role and responsibility o | A draft WFG Champion role was discussed at the Steering Group on 12 March. Final v | Audit open for more than 12-months |
| | R4/5 | Director of Public Health | The Health Board must ensure that its obligations in respect of the Act are a | The Chair of the Steering Group met with UHB Director Communications and the UH | Audit open for more than 12-months |
| | R5/5 | Director of Public Health | The Health Board should update their WFG internet page to ensure that it pr | UHB WFG Internet page to be updated to reflect the recommendations. | Audit open for more than 12-months |
| **WLI Payments Follow-Up** | R1/2 | Chief Operating Officer | The UHB has produced a WLI Payments Policy/Procedure and this has been r | Not Provided | Audit open for more than 12-months |
| | R2/2 | Chief Operating Officer | Testing identified that whilst Cardiac Surgery make the appropriate checks a | Not Provided | Audit open for more than 12-months |
| **(blank)** | (blank) | (blank) | (blank) | (blank) | (blank) |
| **Grand Total** | | | | | |

| Audit | (All) |
|---|---|

| Audit Log Ref No. | Financial Year Fieldwork Under | Audit Title | Audit Rating | Executive Lead for Report | Status of Report Overall | Age Group |
|---|---|---|---|---|---|---|
| IA 02_1718 | 2017-18 | Claims Reimbursement | Substantial | Director of Finance | Superseded | Closed/Not Open |
| IA 03_1718 | 2017-18 | Action plan on Deloitte Financial Governance Review | Substantial | Director of Finance | Audit open for more than 12-months | Over One Year |
| IA 03_1718 | 2017-18 | Progress against findings from the Human Tissue Authority (HTA) Inspection of UHW | Substantial | Chief Operating Officer | Audit open for more than 12-months | Over One Year |
| IA 05_1718 | 2017-18 | Action plan on WAO Audit of RKC Associates | Substantial | Director of Corporate Governance | Audit Closed as Complete | Closed/Not Open |
| IA 06_1718 | 2017-18 | IM&TWelsh Patient Referral System | Substantial | Director of Therapies and Health Science | Audit open for more than 12-months | Closed/Not Open |
| IA 07_1718 | 2017-18 | IM&TMTeD Deployment | Substantial | Director of Therapies and Health Science | Audit open for more than 12-months | Over One Year |
| IA 07_1718 | 2017-18 | IM&TMTeD Deployment | | Director of Therapies and Health Science | Audit open for more than 12-months | Closed/Not Open |
| IA 07_1718 | 2017-18 | IM&TWelsh Patient Referral System | Substantial | Director of Therapies and Health Science | Audit open for more than 12-months | Over One Year |
| IA 08_1718 | 2017-18 | Charitable Funds | Substantial | Director of Finance | Superseded | Closed/Not Open |
| IA 10_1718 | 2017-18 | Primary, Community & Intermediate Care Clinical BoardLocality Stock Follow-Up | Reasonable | Chief Operating Officer | No Action Required - complete | Closed/Not Open |
| IA 11 _1718 | 2017-18 | WLI Payments Follow-Up | Reasonable | Chief Operating Officer | Audit open for more than 12-months | Over One Year |
| IA 11 _1718 | 2017-18 | WLI Payments Follow-Up | | Chief Operating Officer | Audit open for more than 12-months | Date not Specified |
| IA 11 1819 | 2017-18 | Shaping Our Future Wellbeing – Capital Projects | Reasonable | Director of Planning | Audit open for over 6 months | Over 6 Months |
| IA 11 1819 | 2017-18 | Shaping Our Future Wellbeing – Capital Projects | | Director of Planning | Audit open for over 6 months | Date not Specified |
| IA 12_1718 | 2017-18 | Residences | Reasonable | Director of Planning | Audit open for more than 12-months | Over One Year |
| IA 12_1718 | 2017-18 | Residences | | Director of Planning | Audit open for more than 12-months | Date not Specified |
| IA 13_1718 | 2017-18 | Surgery Clinical Board - Anaesthetist Rota Management | Reasonable | Chief Operating Officer | Audit open for more than 12-months | Date not Specified |
| IA 14_1718 | 2017-18 | Pilot Model Ward Review | Reasonable | Director of Planning | Audit open for more than 12-months | Over One Year |
| IA 14_1718 | 2017-18 | Pilot Model Ward Review | | Director of Planning | Audit open for more than 12-months | Date not Specified |
| IA 15_1718 | 2017-18 | IM&T Server Virtualisation | Reasonable | Director of Therapies and Health Science | Audit open for more than 12-months | Closed/Not Open |
| IA 15_1718 | 2017-18 | IM&T Server Virtualisation | | Director of Therapies and Health Science | Audit open for more than 12-months | Date not Specified |
| IA 16_1718 | 2017-18 | Organisational Values | Reasonable | Director of Workforce and Organisational Development | Audit open for more than 12-months | Closed/Not Open |
| IA 16_1718 | 2017-18 | Organisational Values | | Director of Workforce and Organisational Development | COMPLETE | Over 6 Months |
| IA 16_1718 | 2017-18 | Organisational Values | | Director of Workforce and Organisational Development | COMPLETE | Over One Year |
| IA 17_1718 | 2017-18 | Wellbeing of Future Generations Act | Reasonable | Director of Public Health | Audit open for more than 12-months | Over One Year |
| IA 17_1718 | 2017-18 | Wellbeing of Future Generations Act | | Director of Public Health | Audit open for more than 12-months | Date not Specified |
| IA 18_1718 | 2017-18 | Children & Women Clinical Board – Medical Staff Rotas and Study | Reasonable | Chief Operating Officer | Audit open for more than 12-months | Over One Year |
| IA 18_1718 | 2017-18 | Children & Women Clinical Board – Medical Staff Rotas and Study | | Chief Operating Officer | Audit open for more than 12-months | Date not Specified |
| IA 19_1718 | 2017-18 | Serious Incidents Management | Reasonable | Director of Nursing | Audit open for more than 12-months | Over One Year |
| IA 19_1718 | 2017-18 | Serious Incidents Management | | Director of Nursing | Audit open for more than 12-months | Date not Specified |
| IA 20_1718 | 2017-18 | Research & Development | Reasonable | Medical Director | Audit open for more than 12-months | Over One Year |
| IA 20_1718 | 2017-18 | Research & Development | | Medical Director | Audit open for more than 12-months | Closed/Not Open |
| IA 20_1718 | 2017-18 | Research & Development | (blank) | Medical Director | Audit open for more than 12-months | Date not Specified |
| IA 21_1718 | 2017-18 | Mental Health Sickness Management and Rostering | Reasonable | Chief Operating Officer | Audit open for more than 12-months | Over One Year |
| IA 21_1718 | 2017-18 | Mental Health Sickness Management and Rostering | | Chief Operating Officer | Audit open for more than 12-months | Closed/Not Open |
| IA 22_1718 | 2017-18 | Nurse Revalidation | Reasonable | Director of Nursing | Audit open for more than 12-months | Over One Year |
| IA 23 1718 | 2017-18 | Sustainability Reporting | Reasonable | Director of Planning | Superseded | Closed/Not Open |
| IA 24 1718 | 2017-18 | CRC Energy Efficiency Scheme | Reasonable | Director of Planning | Superseded | Closed/Not Open |
| IA 25 1718 | 2017-18 | Strategic Planning/IMTP | Reasonable | Director of Planning | Superseded | Closed/Not Open |
| IA 26 1718 | 2017-18 | Emergency Unit - 12 Hour Target | Reasonable | Chief Operating Officer | Audit Closed as Complete | Closed/Not Open |
| IA 27 1718 | 2017-18 | University Hospital of Wales Neo Natal Development | Reasonable | Director of Planning | Audit open for more than 12-months | Over One Year |
| IA 27 1718 | 2017-18 | University Hospital of Wales Neo Natal Development | | Director of Planning | Audit open for more than 12-months | Closed/Not Open |
| IA 28 1718 | 2017-18 | Health and Care Standards | Reasonable | Director of Nursing | No Action Required - complete | Closed/Not Open |
| IA 29 1718 | 2017-18 | Business Continuity Planning Follow-Up | Reasonable | Director of Planning | Audit open for more than 12-months | Closed/Not Open |
| IA 30 1718 | 2017-18 | Mortality Reviews | Reasonable | Medical Director | Audit open for more than 12-months | Over 6 Months |
| IA 30 1718 | 2017-18 | Mortality Reviews | | Medical Director | Audit open for more than 12-months | Over One Year |
| IA 31 1718 | 2017-18 | Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation) | Reasonable | Director of Planning | COMPLETE | Closed/Not Open |
| IA 32 1718 | 2017-18 | RTT Performance Reporting | Reasonable | Director of Transformaiton and Informatics | Audit open for more than 12-months | Over 6 Months |
| IA 32 1718 | 2017-18 | RTT Performance Reporting | | Director of Transformaiton and Informatics | Audit open for more than 12-months | Over One Year |
| IA 32 1718 | 2017-18 | RTT Performance Reporting | | Director of Transformaiton and Informatics | Audit open for more than 12-months | Date not Specified |
| IA 33 1718 | 2017-18 | Costing Review | Reasonable | Director of Finance | Audit open for more than 12-months | Over 6 Months |
| IA 33 1718 | 2017-18 | Costing Review | | Director of Finance | Audit open for more than 12-months | Over One Year |
| IA 34 1718 | 2017-18 | National Standards for Cleaning in NHS Wales | Limited | Director of Planning | Superseded | Closed/Not Open |
| IA 35 1718 | 2017-18 | Internal Medicine Directorate Mandatory Training and PADRs | Limited | Chief Operating Officer | Overdue | Closed/Not Open |
| IA 35 1718 | 2017-18 | Internal Medicine Directorate Mandatory Training and PADRs | | Chief Operating Officer | Superseded | Closed/Not Open |
| IA 36 1718 | 2017-18 | Neurosciences - Patient Care IT System | Limited | (blank) | (blank) | Closed/Not Open |
| IA 37 1718 | 2017-18 | Deprivation of Liberties Safeguards Follow-Up | Limited | Medical Director | Audit open for more than 12-months | Date not Specified |
| IA 39 1718 | 2017-18 | Consultant Job Planning | Limited | Medical Director | Audit open for more than 12-months | Over One Year |
| IA 39 1718 | 2017-18 | Consultant Job Planning | | Medical Director | Audit open for more than 12-months | Date not Specified |
| Grand Total | | | | | | |

| Status | Open |
|---|---|

| Count of Audit Log Ref No. | Age Group | | | | | | |
|---|---|---|---|---|---|---|---|
| **Audit** | **Date not Specified** | **Due Date Not Reached** | **Less Than 3 Months** | **Over 3 Months** | **Over 6 Months** | **Over One Year** | **Grand Total** |
| IA 1718 | 30 | | | | 8 | 51 | 89 |
| IA 1819 | 22 | 7 | 31 | 42 | 36 | 7 | 145 |
| **Grand Total** | **52** | **7** | **31** | **42** | **44** | **58** | **234** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Report Title:** | **External Audit Recommendation Tracking Report** | | | | | | | | |
| **Meeting:** | Audit Committee | | | | | | **Meeting Date:** | 3rd December 2019 | |
| **Status:** | **For Discussion** | | **For Assurance** | **x** | **For Approval** | **x** | **For Information** | | |
| **Lead Executive:** | **Director of Corporate Governance** | | | | | | | | |
| **Report Author (Title):** | **Director of Corporate Governance** | | | | | | | | |

**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.

**BACKGROUND**

The External Audit Tracking report details recommendations made by Wales Audit Office through the work they undertake at the UHB. The External Audit Tracking report was first presented to the Audit Committee in September 2019. Since then all recommendations have been sent to Executive Leads, for the areas within their areas of responsibility, for updating.

**ASSESSMENT**

A review of all outstanding recommendations has been undertaken since September 2019 and this will now continue on a quarterly basis and will be reported to the Audit Committee each quarter providing a quarterly update in movement of recommendations completed.

The Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken in **17/18, 18/19 and 19/20** as at 26th November 2019.

As can be seen from the above table there is further work to be done to ensure that recommendations made by WAO and agreed by Executive Directors are implemented in a timely manner. With tracking now starting to take place on a quarterly basis there is an expectation that this will improve.

Reports will, in future, be discussed at Management Executives and HSMB which includes the entire leadership team of the organisation.

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

**RECOMMENDATION**

The Audit Committee Members are asked to:

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

**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**<br>*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~~<br>*If "yes" please provide copy of the assessment. This will be linked to the report when published.* |

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

| External Audit | Complete | Update Nov 19 | Not due | Update Nov 19 | In progress | Update Nov 19 | < 3 mths | Update Nov 19 | > 3 mths | Update Nov 19 | +6 mths | Update Nov 19 | + 1 year | Update Nov 19 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Structured Assessment 2018** | 10 | 13 | 3 | 3 | 6 | 6 | | | 5 | 1 | | 2 | 3 | 2 | 27 |
| **Clinical Coding Follow Up** | | 1 | | | | | 1 | | | | | | | | 1 |
| **Discharge Planning** | | 4 | | | | 1 | | | 4 | 3 | 4 | 1 | 2 | 1 | 10 |
| **Primary Care Service** | | 14 | 2 | | | | | | | | 12 | | | | 14 |
| **Review of GP Out of Hours Service** | | 10 | | | | | | | | | | | 10 | | 10 |
| **Review of Medical Equipment** | | | | | | | | | 3 | | 4 | 5 | 1 | 3 | 8 |
| **Total** | **10** | **42** | **5** | **3** | **6** | **7** | **1** | **-** | **12** | **4** | **20** | **8** | **16** | **6** | **70** |

From the above table it can be seen that after tracking these recommendation a further 32 recommendations have been completed which brings the total completed to 60% whereas in September it was at 14%.

| Audit Log Ref No. | Audit Reference | Financial Year Fieldwork Undertaken | Final Report Issued on | Audit Title | Executive Lead for Report | Rec No. | Recommendation Narrative | Management Response | Executive Lead for Recommendation | Agreed Implementation Date | Committee Implementation Monitored by | Recommendation Status [RAG Rating] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WAO 1 | 1025A2019-20 | 2018-19 | Jan-19 | Structured Assessment 2018 | Chief Executive Officer | R1a/11 | R13 [2016] Strengthen tracking arrangements for external audit recommendations by providing more detailed information to the Audit Committee on the extent to which both performance and financial audit recommendations have been completed, and ensure that all action plans are monitored through to completion by he relevant committees of the Board. | There is a tracker for WAO recommendations. The current arrangements don't provide enough clarity around what happens to recommendations where committees other than the audit committee are responsible | Director of Corporate Governance | Dec-16 | Audit and Assurance Committee | Complete |
| WAO 1 | 1025A2019-20 | 2018-19 | Jan-19 | Structured Assessment 2018 | Chief Executive Officer | R1d/11 | R4 [2017] To improve transparency, the Health Board needs to ensure that the Finance Committee papers are made available on its website in a timely manner. | At December 2018, the October 2018 Finance Committee papers were not available on the Health Board's website. | Director of Governance | Dec-16 | Audit and Assurance Committee | Complete |
| WAO 1 | 1025A2019-20 | 2018-19 | Jan-19 | Structured Assessment 2018 | Chief Executive Officer | R1e/11 | R5 [2017] The Health Board needs to strengthen its corporate risk assurance framework (CRAF) by:<br>mapping risks to the Health Board's strategic objectives;<br>reviewing the required assurances;<br>improving clarity of risk descriptors;<br>and clarifying to the reader the date when risks are updated and/or added. | Until recently, the Health Board had made little progress in updating the CRAF. The CRAF was last presented to the Board and committees in November 2017. We recognise the Health Board has recently taken steps to start developing a separate Board Assurance Framework and Corporate Risk Register. The draft BAF was received at both the Audit Committee and Board in November and December respectively. | Director of Governance | Dec-16 | Audit and Assurance Committee | Complete |
| WAO 1 | 1025A2019-20 | 2018-19 | Jan-19 | Structured Assessment 2018 | Chief Executive Officer | R2a/11 | The Health Board should improve its recommendation tracking by:<br>a. addressing our outstanding 2016 structured assessment recommendation to strengthen tracking arrangements for external audit recommendations; | Agreed this will be presented to the next Audit Committee | Director of Corporate Governance | Feb-19 | Audit and Assurance Committee | Complete |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WAO 1 | 1025A2019-20 | 2018-19 | Jan-19 | Structured Assessment 2018 | Chief Executive Officer | R2b/11 | b. including the tracking of internal audit recommendations; and | Agreed | Director of Corporate Governance | Feb-19 | Audit and Assurance Committee | Complete |
| WAO 1 | 1025A2019-20 | 2018-19 | Jan-19 | Structured Assessment 2018 | Chief Executive Officer | R2c/11 | c. completing a review of all outstanding internal and external audit recommendations and reporting the findings to the Audit Committee. | Agreed | Director of Corporate Governance | Feb-19 | Audit and Assurance Committee | Complete |
| WAO 1 | 1025A2019-20 | 2018-19 | Jan-19 | Structured Assessment 2018 | Chief Executive Officer | R3a/11 | The Health Board should:<br>a. Update the Scheme of Delegation to reflect the delegated responsibility for calculating nurse staffing levels for designated acute medical and surgical inpatient wards; | Agreed in progress as result of Internal Audit Report | Director of Corporate Governance | Mar-19 | Audit and Assurance Committee | Complete |
| WAO 1 | 1025A2019-20 | 2018-19 | Jan-19 | Structured Assessment 2018 | Chief Executive Officer | R3c/11 | c. Improve the format of the registers for declarations of interest and gifts, hospitality and sponsorship and clarify the frequency with which the registers are presented to the Audit Committee; | Agreed registers will be improved in format and reported to Audit Committee twice a year | Director of Corporate Governance | Apr-19 | Audit and Assurance Committee | Complete |
| WAO 1 | 1025A2019-20 | 2018-19 | Jan-19 | Structured Assessment 2018 | Chief Executive Officer | R3e/11 | e. Review all committee terms of reference to make sure they are up to date, do not overlap, and are reviewed annually; | Agreed in progress | Director of Corporate Governance | Mar-19 | Audit and Assurance Committee | Complete |
| WAO 1 | 1025A2019-20 | 2018-19 | Jan-19 | Structured Assessment 2018 | Chief Executive Officer | R3f/11 | f. Ensure all committees have an up-to-date work programme, which is linked to the cycle of Board meetings and reviewed annually. | Agreed work plans for each Committee and the Board are in development | Director of Corporate Governance | Mar-19 | Audit and Assurance Committee | Complete |
| WAO 1 | 1025A2019-20 | 2018-19 | Jan-19 | Structured Assessment 2018 | Chief Executive Officer | R5/11 | The Health Board should provide the Finance Committee, or Board, with an update on progress with its testing and delivery of the All Wales Costing System Implementation Project. | The UHB accepts the need to provide an update on progress with this project. As a series of Welsh Costing Returns (WCRs) have now been submitted to Welsh Government using the new system, a comprehensive update on the implementation and future use of the costing development can now be made. It is intended to provide a paper to the Finance Committee following finalisation and publication of WCRs within Wales. | Director of Finance | Apr-19 | Audit and Assurance Committee | Complete |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WAO 1 | 1025A2019-20 | 2018-19 | Jan-19 | Structured Assessment 2018 | Chief Executive Officer | R6/11 | The Health Board should ensure that all recommended matches from the next NFI exercise in January 2019 are reviewed and where necessary investigated in a timely manner. | For the forthcoming NFI exercise, the Health Board will endeavour to increase its compliance in respect of the number of recommended matches checked. A large number of these matches are however in relation to Accounts Payable and this will require further matching and review by the NHS Wales Shared Service Partnership. Consequently this is not wholly within the control of the Health Board. | Director of Finance | Dec-19 | Audit and Assurance Committee | Complete |
| WAO 1 | 1025A2019-20 | 2018-19 | Jan-19 | Structured Assessment 2018 | Chief Executive Officer | R10/11 | The Health Board should complete a review of the structure and governance of its information and information technology functions to support delivery of the strategic digital approach | The newly appointed head of digital and health intelligence is developing a new structure to reflect combined information and IT services with the aim of stablishing functions that can best support the digital transformation agenda. | Director of Transformation and Informatics | Mar-19 | Audit and Assurance Committee | Complete |
| | 333A2017 | 2017-18 | Mar-18 | Review of GP Out-of-Hours Services | Chief Operating Officer | | R1a Develop a process for regularly comparing its out-of-hours expenditure with other health boards, given the GP out-of-hours service's mixed performance. | Historically, the Cardiff and Vale Out of Hours service benchmarked the lowest in Wales in terms of investment per patient; however, due to significant investment, this has increased. C&V will look to review funding per 1000 population, and compare against the Welsh average if this information is available and reliable from other Health Boards. All Wales expenditure to be reviewed through the Out of Hours QSE group, taking into account the difference in Health Board population, and where possible service skill mix. | Chief Operating Officer | Oct-17 | Strategy and Delivery Committee | complete |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 333A2017 | 2017-18 | Mar-18 | Review of GP Out-of-Hours Services | Chief Operating Officer | | R1b Develop a long-term workforce plan aimed at permanently resolving problems with filling GP shifts and improving the timeliness of all aspects of the service. | Workforce and governance reviews currently being undertaken to inform the future workforce development prior to the implementation of 111.<br>111 may have signifant implications for the C&V workforce which will have to be taken into account as and when more information is known.<br>Work has already been undertaken to identify those shifts that are regularly difficult to fill considering alternative clinical cover. It has been acknowledged that the traditional GP OOHs model is not necessarily sustainable in the current climate, with ongoing difficulties in filling core shifts, as such skill mix will be a key factor moving forward.<br>This includes consideration of salaried GPs as well the wider workforce. | Chief Operating Officer | Nov-17 | Strategy and Delivery Committee | complete |
| | 333A2017 | 2017-18 | Mar-18 | Review of GP Out-of-Hours Services | Chief Operating Officer | | R2a Introduce processes for learning from patient feedback to improve GP out-of-hours services. | Develop more patient feedback mechanisms in conjunction with corporate services to for use by OOHs patients. Analysis with themes and trends to be discussed at Out of Hours QSE meeting.<br>Produce information leaflets and posters for patients, along with a section on the service webpage to promote selfcare. | Chief Operating Officer | Sep-17 | Strategy and Delivery Committee | complete |
| | 333A2017 | 2017-18 | Mar-18 | Review of GP Out-of-Hours Services | Chief Operating Officer | | R2b Prioritise clinical audit to ensure all GPs have their out-of-hours clinical contacts regularly reviewed, to meet the national standards. | Agreed audit process in place; feedback to OOHs QSE meeting. | Chief Operating Officer | Sep-17 | Strategy and Delivery Committee | complete |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 333A2017 | 2017-18 | Mar-18 | Review of GP Out-of-Hours Services | Chief Operating Officer | | R2c Check its out-of-hours data relating to the number of call terminations, to ensure the information is accurate | Work is underway to review this information working with the Vale Local Authority who provide some of the telephony statistics.<br>Further work on an All Wales basis is taking place to review OOHs telephony statistics which Cardiff and Vale are leading on. | Chief Operating Officer | Oct-17 | Strategy and Delivery Committee | complete |
| | 333A2017 | 2017-18 | Mar-18 | Review of GP Out-of-Hours Services | Chief Operating Officer | | R3a Improve signposting on its website by including information about GP out-of-hours on the landing page, providing a description of the service, details of the opening hours and locations, and the conditions and circumstances in which patients should use it. | This information has been updated on the intranet for GP OOHs.<br>The internet information is being led by a primary care group, which is also looking at GP OOHs. The refreshed GP OOHs internet site will include all information about the service and advice for the public on self care and other services that can be accessed. | Chief Operating Officer | Dec-17 | Strategy and Delivery Committee | complete |
| | 333A2017 | 2017-18 | Mar-18 | Review of GP Out-of-Hours Services | Chief Operating Officer | | R3b Work with GP practices to ensure all practices have a standard answerphone message that provides appropriate information about the out-of-hours service. | A standardised message was promoted through the primary care access group, of which 27 practices used a standardised message. However, this cannot be enforced with the practices.<br>Work is ongoing with practices to improve the uptake rate to ensure that a consistent message is provided to patients. | Chief Operating Officer | Oct-17 | Strategy and Delivery Committee | complete |
| | 333A2017 | 2017-18 | Mar-18 | Review of GP Out-of-Hours Services | Chief Operating Officer | | R3c As part of the eventual introduction of 111, consider replacing the five different telephone numbers with a single number for accessing GP out-of-hours. | Work towards rationalising the numbers down to one number, impact on stakeholders will need to be assessed during this change process.<br>The Head of OOHs is a member of the Directory of Services group, which is looking at this issue longer term, and will continue to work to ensure a single point of access. | Chief Operating Officer | Nov-17 | Strategy and Delivery Committee | complete |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 333A2017 | 2017-18 | Mar-18 | Review of GP Out-of-Hours Services | Chief Operating Officer | | R4a Share data with all practices showing the variation in use of out-of-hours services between 6.30pm and 7.30pm, with a view to highlighting outliers and resolving issues that are driving out-of-hours demand. | Information included in the desktop assessment of practice sustainability as an additional indicator of performance.<br>Send out monthly to practices and clusters.<br>To be included in the information shared and discussed at annual Practice Development Visits as well as sharing through CD forum. | Chief Operating Officer | Sep-17 | Strategy and Delivery Committee | complete |
| | 333A2017 | 2017-18 | Mar-18 | Review of GP Out-of-Hours Services | Chief Operating Officer | | R4b Identify and address the reasons that are preventing out-of-hours staff from accessing the GP Record. | Ongoing issues with IHR have impacted on the ability for staff working in the Out of Hours service in being able to acess the GP record. This has been raised with NWIS and C&V IT colleagues as a priority area for change. A meeting with the C&V IT dept arranged for August 2017 to review IT related issues and agree actions to address these. | Chief Operating Officer | Aug-17 | Strategy and Delivery Committee | complete |
| WAO 15 | 276A2019-20 | 2018-19 | May-19 | Primary care services | Chief Operating Officer | R1/6 | R1 The Health Board has developed an ambitious plan for primary care, but the plan does not consider the impacts of projected population growth as a result of housing developments in Cardiff. The Health Board should therefore revisit its primary care plan to ensure it includes specific actions to meet the needs of the projected population growth in Cardiff. | The UHB is commissioning an independent assessment of the impact of population growth on the demand for services and to identify opportunities for meeting this increased demand. | Director of Planning | Jan-19 | Strategy and Delivery Committee | Complete |
| WAO 15 | 276A2019-20 | 2018-19 | May-19 | Primary care services | Chief Operating Officer | R2/6 | R2 The Health Board's plans for primary care have been developed with only limited consultation and collaboration with some key groups of stakeholders. The Health Board should therefore develop the necessary consultation and communications plans to ensure meaningful public and stakeholder engagement in any further development / refinement of its primary care plans. | Communication plan to be developed and actions to be carried out this financial year, with the plan to be incorporated as a core part of the 2019-20 Primary and Community Intermediate Care Integrated Medium Term Plan (PCIC IMTP). | Chief Operating Officer | Dec-18 | Strategy and Delivery Committee | Complete |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WAO 15 | 276A2019-20 | 2018-19 | May-19 | Primary care services | Chief Operating Officer | R3a/6 | R3 While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should:<br>a. Calculate a baseline position for its current investment and resource use in primary and community care. | Financial resource shift framework developed and will be used to track investment and resource use from secondary to primary care, starting with the investment in MSK (Musculoskeletal) and MH (Mental Health). | Director of Finance | Oct-18 | Strategy and Delivery Committee | Complete |
| WAO 15 | 276A2019-20 | 2018-19 | May-19 | Primary care services | Chief Operating Officer | R3b/6 | b. Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care. | Build into IMTP annual review process. | Director of Finance | Mar-20 | Strategy and Delivery Committee | Complete |
| WAO 15 | 276A2019-20 | 2018-19 | May-19 | Primary care services | Chief Operating Officer | R4a/6 | R4 Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should:<br>a. Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models.<br>. | Formally evaluate cluster nursing posts and cluster pharmacists.<br>Communicate the evaluation of cluster-based nursing posts and cluster pharmacies, to inform future decision making.<br>Ensure future cluster models (MSK, MH) have robust evaluation built into the process. | Chief Operating Officer | Mar-20 | Strategy and Delivery Committee | Complete |
| WAO 15 | 276A2019-20 | 2018-19 | May-19 | Primary care services | Chief Operating Officer | R4b/6 | b. Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters. | Communicate the evaluation of cluster-based nursing posts and cluster pharmacies at CD (Clinical Directors) forum.<br>Use CD forum to help sharing and learning by publicising the key messages via Cluster Leads. | Chief Operating Officer | Nov-18 | Strategy and Delivery Committee | Complete |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WAO 15 | 276A2019-20 | 2018-19 | May-19 | Primary care services | Chief Operating Officer | R4c/6 | c. Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund. | Many Primary Care funding has now been mainstreamed as core business. Cluster pilots to continue to be evaluated to assess the option of rolling out at scale, starting with MSK and MH. Subject to affordability within the resource available. | Director of Finance | Mar-19 | Strategy and Delivery Committee | Complete |
| WAO 15 | 276A2019-20 | 2018-19 | May-19 | Primary care services | Chief Operating Officer | R4d/6 | d. Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments. | As per R2 – develop Communications Plan.<br>Start communication and engagement by engaging with the UHB Stakeholder Reference Group on new ways of working. | Chief Operating Officer | Dec-18 | Strategy and Delivery Committee | Complete |
| WAO 15 | 276A2019-20 | 2018-19 | May-19 | Primary care services | Chief Operating Officer | R5a/6 | R5 We found variation in the maturity of primary care clusters. The Health Board should:<br>a. Review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary. | Continue to prioritise the OD (Organisational Development) programme for cluster development. | Chief Operating Officer | Mar-19 | Strategy and Delivery Committee | Complete |
| WAO 15 | 276A2019-20 | 2018-19 | May-19 | Primary care services | Chief Operating Officer | R5b/6 | b. Review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups. | Discussion on cluster membership to be built into the cluster OD programme, to include an initial discussion at the CD forum on 31 October 2018. | Chief Operating Officer | Nov-18 | Strategy and Delivery Committee | Complete |
| WAO 15 | 276A2019-20 | 2018-19 | May-19 | Primary care services | Chief Operating Officer | R5c/6 | c. Ensure all cluster leads attend the Confident Primary Care Leaders course | We will ensure lessons are learnt from the current CDs attending the Confident Primary Care Leaders course and encourage this course for new CDs and existing CDs who have not attended. | Chief Operating Officer | Dec-18 | Strategy and Delivery Committee | Complete |
| WAO 15 | 276A2019-20 | 2018-19 | May-19 | Primary care services | Chief Operating Officer | R6a/6 | R6 We found scope to improve the way in which primary care performance is monitored and reported at Board and committee level. The Health Board should:<br>a. Ensure the contents of its Board and committee performance reports adequately cover primary care.<br>. | Review currently being undertaken of Performance reporting to the Board and its Committees. | Director of Transformation and Informatics | Nov-18 | Strategy and Delivery Committee | Complete |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WAO 15 | 276A2019-20 | 2018-19 | May-19 | Primary care services | Chief Operating Officer | R6b/6 | b. Increase the frequency with which Board and committees receive performance reports regarding primary care. | See R6a | Director of Transformation and Informatics | Nov-18 | Strategy and Delivery Committee | Complete |
| WAO 15 | 276A2019-20 | 2018-19 | May-19 | Primary care services | Chief Operating Officer | R6c/6 | c. Ensure that reports to Board and committees provide sufficient commentary on progress in delivering Health Board plans for primary care, and the extent to which those plans are resulting in improved experiences and outcomes for patients | See R6a | Director of Transformation and Informatics | Nov-18 | Strategy and Delivery Committee | Complete |
| WAO * | 166A2017-18 | 2017-18 | Dec-17 | Discharge Planning | Chief Operating Officer | R1a | Develop a system where ward staff are able to access up-to-date information about community health and social care services. | The Integrated Discharge Service is the first point of contact within the Health Board and provide a signposting service for all UHB staff in relation to any queries they may have in relation to community service provision.<br>An Intranet Website is available currently and information on how to access the content is included within training programmes.<br>Website address for DEWIS is also available.<br>First Point of Contact and Single Point of Access, both ICF funded projects, are assisting with the provision of information and advice to patients, their families and to staff as part of the overarching compliance with the Social Services and Wellbeing Act 2014.<br>Additional Discharge Support Officers and IDS team are in place to offer advice and to act as a point of contact.<br>A review of the web site is planned | Chief Operating Officer | Dec-18 | Strategy and Delivery Committee | Complete |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WAO * | 166A2017-18 | 2017-18 | Dec-17 | Discharge Planning | Chief Operating Officer | R1b | Review the range and frequency of data collated about community health and social care services. For example waiting times for some services and the frequency data on services available through other NHS bodies and housing options is collated. | Information relating to how to access community services is available on the UHB intranet site. The UHB is participating in the All Wales development of an integrated Community and Social Care information system which when developed will provide a platform for sharing of information and data.<br>How staff can access the current information on the UHB website and its content will be reinforced during training programmes. | Chief Operating Officer | Dec-18 | Strategy and Delivery Committee | Complete |
| WAO * | 166A2017-18 | 2017-18 | Dec-17 | Discharge Planning | Chief Operating Officer | R2 | The Health Board should seek to involve patients and carers when the next policy revisions are due. | The draft Choice Protocol and Discharge Policy are currently out for consultation.<br>The current draft Discharge Policy and Choice protocol has been provided to South East Wales Carers Trust, Engagement Project for comment. | Chief Operating Officer | Oct-17 | Strategy and Delivery Committee | Complete |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WAO * | 166A2017-18 | 2017-18 | Dec-17 | Discharge Planning | Chief Operating Officer | R3 | The Health Board should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in discharge planning understand how to use it. | There is now a well-developed training and development plan in place.<br>Short-term Plan Discharge Planning<br>Weekly training sessions of 1-1 ½ hrs on both UHW and Llandough<br>Topics: Discharge Policy Choice Protocol simple/supported complex. Integrated discharge Service; Care Homes; CRT; CWS and its use purpose.<br>(20 session completed to date 64 staff attended)<br>"Get me Home"<br>3 monthly workshops have been held which focus on the Home First principles.<br>The HB has also embarked on an organisation wide De-conditioning<br><br>campaign which aims to maintain Patient independence in order to reduce avoidable harm, improve the Patient experience and expedite discharge (two workshops held to dates with two | Chief Operating Officer | Nov-17 | Strategy and Delivery Committee | Complete |
| WAO * | 166A2017-18 | 2017-18 | Dec-17 | Discharge Planning | Chief Operating Officer | R4b | Ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring. | Each Staff member now has the ability to register their own academic achievement and course attendance on ESR, whilst the IDS team are now maintaining a record of all those attending training. Formal workshops are also recorded on the ESR system. | Chief Operating Officer | Dec-18 | Strategy and Delivery Committee | Complete |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WAO * | 1185A2019-20 | 2019-20 | Jun-19 | Clinical Coding Follow-up | Director of Transformation and Informatics | R1 | Clinical Cloding Resources: Resolve the current interim arrangements by agreeing the coding management structure following the directorate reconfiguration, ensuring there is sufficient management and supervisory capacity | The clinical coding teams are included in the restructure of the directorate with the launch taking place on 04/06/19. The new structure will provide adequate management and supervisory capacity | Director of Transformation and Informatics | Sep-19 | Audit and Assurance | Complete |

| | |
|---|---|
| Audit Log Ref No. | (All) |
| Audit Reference | (All) |

| Audit Title | Executive Lead for Report | Rec No. | Recommendation Narrative | Management Response | Status of Report Overall |
|---|---|---|---|---|---|
| Clinical Coding Follow-up | Director of Transformation and Informatics | R1 | Clinical Cloding Resources: Resolve the current interim arrangements by agreeing the coding management structure following the directorate reconfiguration, ensuring there is sufficient management and supervisory capacity | The clinical coding teams are included in the restructure of the directorate with the launch taking place on 04/06/19. The new structure will provide adequate management and supervisory capacity | (blank) |
| | | | **Clinical Cloding Resources: Resolve the current interim arrangements by agreeing the coding management structure following the directorate reconfiguration, ensuring there is sufficient management and supervisory capacity Total** | | |
| | **Director of Transformation and Informatics Total** | | | | |
| Combined follow up of Informatics and Communications Technology audits | Director of Transformation and Informatics | R1/7 | R1 Data quality procedures are inconsistent across the UHB with no routine audit programme in place to monitor compliance. The UHB should establish a data quality policy and document procedures, to set out the ways of working required to comply with the policy. | (blank) | (blank) |
| | | | **R1 Data quality procedures are inconsistent across the UHB with no routine audit programme in place to monitor compliance. The UHB should establish a data quality policy and document procedures, to set out the ways of working required to comply with the policy. Total** | | |
| | | R2/7 | R2 The UHB should identify any material/key clinical systems that have not been tested for disaster recovery and test them appropriately. | (blank) | (blank) |
| | | | **R2 The UHB should identify any material/key clinical systems that have not been tested for disaster recovery and test them appropriately. Total** | | |
| | | R3/7 | R3 There are no documented business continuity plans relating to the Health Edge, Theatreman and Maternity systems. The department responsible for managing these systems should formally document their business continuity plans. | (blank) | (blank) |
| | | | **R3 There are no documented business continuity plans relating to the Health Edge, Theatreman and Maternity systems. The department responsible for managing these systems should formally document their business continuity plans. Total** | | |
| | | R4/7 | R4 Although the ICT department states they review their business continuity plans annually, there is no evidence to support this. The department should incorporate annual review dates into its plan, which should be updated after every review. | (blank) | (blank) |
| | | | **R4 Although the ICT department states they review their business continuity plans annually, there is no evidence to support this. The department should incorporate annual review dates into its plan, which should be updated after every review. Total** | | |
| | | R5/7 | R5 The hosting and backup agreement/SLA for the Artificial Limbs and Appliance Service is out of date and does not accurately reflect the arrangements in place. The UHB should update the agreement and ensure it is signed by the new data owner to reflect staff changes and the end of life server dates removed. | (blank) | (blank) |
| | | | **R5 The hosting and backup agreement/SLA for the Artificial Limbs and Appliance Service is out of date and does not accurately reflect the arrangements in place. The UHB should update the agreement and ensure it is signed by the new data owner to reflect staff changes and the end of life server dates removed. Total** | | |
| | | R6/7 | R6 The draft ICT Strategy has been largely superseded by the UHB's Integrated Medium Term Plan (IMTP) but there remains a need to bring together the strategic intentions for ICT into an updated document. The UHB should clearly document its strategic approach to ICT. | (blank) | (blank) |
| | | | **R6 The draft ICT Strategy has been largely superseded by the UHB's Integrated Medium Term Plan (IMTP) but there remains a need to bring together the strategic intentions for ICT into an updated document. The UHB should clearly document its strategic approach to ICT. Total** | | |
| | | R7/7 | R7 The UHB's overall approach to IM&T is piecemeal with the division of responsibilities between ICT and business departments unclear and inconsistent. Approaches need to be joined up. | (blank) | (blank) |

| | | | | | |
|---|---|---|---|---|---|
| | | | **R7 The UHB's overall approach to IM&T is piecemeal with the division of responsibilities between ICT and business departments unclear and inconsistent. Approaches need to be joined up. Total** | | |
| | **Director of Transformation and Informatics Total** | | | | |
| Diagnostic review of ICT capacity and resources | Director of Transformation and Informatics | R1/6 | R1 To ensure that the totality of ICT resources within the Health Board are used effectively, the Health Board needs to understand the roles and responsibility of ICT staff managed outside of the main department to ensure that these roles are aligned with those within the central managed team and that they are used to their full potential. | (blank) | (blank) |
| | | | **R1 To ensure that the totality of ICT resources within the Health Board are used effectively, the Health Board needs to understand the roles and responsibility of ICT staff managed outside of the main department to ensure that these roles are aligned with those within the central managed team and that they are used to their full potential. Total** | | |
| | | R2/6 | R2 As a result of the high level of one-way links between clinical systems and the main patient administration system, the Health Board needs to consider the potential for strengthening integration between systems, and at the very minimum, ensure that robust mechanisms are in place to make sure that same data items contained on multiple clinical information systems are consistent at all times, for example, patient demographics. | (blank) | (blank) |
| | | | **R2 As a result of the high level of one-way links between clinical systems and the main patient administration system, the Health Board needs to consider the potential for strengthening integration between systems, and at the very minimum, ensure that robust mechanisms are in place to make sure that same data items contained on multiple clinical information systems are consistent at all times, for example, patient demographics. Total** | | |
| | | R3/6 | R3 To ensure that staff remain aware of information governance principles, and to improve the reliability of data contained on the Health Board"s clinical information systems, the Health Board should consider mandating information governance refresher training, which should include data quality, for all staff. | (blank) | (blank) |
| | | | **R3 To ensure that staff remain aware of information governance principles, and to improve the reliability of data contained on the Health Board"s clinical information systems, the Health Board should consider mandating information governance refresher training, which should include data quality, for all staff. Total** | | |
| | | R4/6 | R4 To ensure that staff are proficient in the use of the clinical systems, the Health Board needs to ensure that all temporary staff received appropriate and timely training in order to prevent them from accessing the systems without having the necessary training. | (blank) | (blank) |
| | | | **R4 To ensure that staff are proficient in the use of the clinical systems, the Health Board needs to ensure that all temporary staff received appropriate and timely training in order to prevent them from accessing the systems without having the necessary training. Total** | | |
| | | R5/6 | R5 The Health Board needs to understand and address the negative perceptions from staff in relation to access, reliability and inability to use the clinical information systems that currently exist within the Health Board to ensure that the systems potential is maximised. | (blank) | (blank) |
| | | | **R5 The Health Board needs to understand and address the negative perceptions from staff in relation to access, reliability and inability to use the clinical information systems that currently exist within the Health Board to ensure that the systems potential is maximised. Total** | | |
| | | R6/6 | R6 To minimise the potential to which there is lost time due to system failures, the Health Board needs to ensure that the extent to which ICT equipment is classed as „out-of-life" reduces and that appropriate records are maintained to monitor planned and unplanned downtime. | (blank) | (blank) |

| | | | | | |
|---|---|---|---|---|---|
| | | | **R6 To minimise the potential to which there is lost time due to system failures, the Health Board needs to ensure that the extent to which ICT equipment is classed as „out-of-life" reduces and that appropriate records are maintained to monitor planned and unplanned downtime. Total** | | |
| | **Director of Transformation and Informatics Total** | | | | |
| Discharge Planning | Chief Operating Officer | R1a | Develop a system where ward staff are able to access up-to-date information about community health and social care services. | The Integrated Discharge Service is the first point of contact within the Health Board and provide a signposting service for all UHB staff in relation to any queries they may have in relation to community service provision.<br>An Intranet Website is available currently and information on how to access the content is included within training programmes. Website address for DEWIS is also available.<br>First Point of Contact and Single Point of Access, both ICF funded projects, are assisting with the provision of information and advice to patients, their families and to staff as part of the overarching compliance with the Social Services and Wellbeing Act 2014.<br>Additional Discharge Support Officers and IDS team are in place to offer advice and to act as a point of contact.<br>A review of the web site is planned to ensure that information is current and accessible to all UHB staff.<br>Reinforcement of available information sources will continue to be included in ongoing training programmes. | (blank) |
| | | | **Develop a system where ward staff are able to access up-to-date information about community health and social care services. Total** | | |
| | | R1b | Review the range and frequency of data collated about community health and social care services. For example waiting times for some services and the frequency data on services available through other NHS bodies and housing options is collated. | Information relating to how to access community services is available on the UHB intranet site.<br>The UHB is participating in the All Wales development of an integrated Community and Social Care information system which when developed will provide a platform for sharing of information and data.<br>How staff can access the current information on the UHB website and its content will be reinforced during training programmes. | (blank) |
| | | | **Review the range and frequency of data collated about community health and social care services. For example waiting times for some services and the frequency data on services available through other NHS bodies and housing options is collated. Total** | | |
| | | R2 | The Health Board should seek to involve patients and carers when the next policy revisions are due. | The draft Choice Protocol and Discharge Policy are currently out for consultation.<br>The current draft Discharge Policy and Choice protocol has been provided to South East Wales Carers Trust, Engagement Project for comment. | (blank) |
| | | | **The Health Board should seek to involve patients and carers when the next policy revisions are due. Total** | | |
| | | R3 | The Health Board should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in discharge planning understand how to use it. | development plan in place.<br>Short-term Plan Discharge Planning<br>Weekly training sessions of 1-1 ½ hrs on both UHW and Llandough<br>Topics: Discharge Policy Choice Protocol simple/supported complex. Integrated discharge Service; Care Homes; CRT; CWS and its use purpose.<br>(20 session completed to date<br>64 staff attended)<br>"Get me Home"<br>3 monthly workshops have been held which focus on the Home First principles.<br>The HB has also embarked on an organisation wide De-conditioning<br><br>campaign which aims to maintain Patient independence in order to reduce avoidable harm, improve the Patient experience and expedite discharge (two workshops held to dates with two further dates agreed – 120 staff attended).<br>SNAP Training<br>Daily for 2 weeks – 30min sessions, ward-based<br>Topics: Discharge Policy Choice Protocol simple/supported complex; Integrated discharge Service; Care Homes; CRT; CWS and its use purpose; Fast Track CHC. | (blank) |

| | | | | | |
|---|---|---|---|---|---|
| | | | **The Health Board should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in discharge planning understand how to use it. Total** | | |
| | | 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. | (blank) |
| | | | **Explore developing an e-learning course for discharge planning which ward staff may find more accessible. Total** | | |
| | | R4b | Ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring. | Each Staff member now has the ability to register their own academic achievement and course attendance on ESR, whilst the IDS team are now maintaining a record of all those attending training.<br>Formal workshops are also recorded on the ESR system. | (blank) |
| | | | **Ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring. Total** | | |
| | **Chief Operating Officer Total** | | | | |
| Hospital Catering and Patient Nutrition Follow-up Review | Director of Planning | R 1/9 | R1b We recommend that NHS bodies use the results presented in our local audit reports as a basis for ensuring that they are effectively implementing the all-Wales Nutritional Care Pathway. In particular, ensure that nutritional screening effectively identifies all patients who have nutritional problems, or are at risk of developing them, and that appropriate care plans and monitoring activities are instigated (national). | (blank) | (blank) |
| | | | **R1b We recommend that NHS bodies use the results presented in our local audit reports as a basis for ensuring that they are effectively implementing the all-Wales Nutritional Care Pathway. In particular, ensure that nutritional screening effectively identifies all patients who have nutritional problems, or are at risk of developing them, and that appropriate care plans and monitoring activities are instigated (national). Total** | | |
| | | R 2/9 | R9 Through the fundamentals of care forum monitor the effectiveness of the red tray system approach, its development and the emerging traffic light systems (local 2010). | (blank) | (blank) |
| | | | **R9 Through the fundamentals of care forum monitor the effectiveness of the red tray system approach, its development and the emerging traffic light systems (local 2010). Total** | | |
| | | R 3/9 | R11 Improve the nutritional assessment tool to include an assessment of oral health and the ability to communicate (local 2010) | (blank) | (blank) |
| | | | **R11 Improve the nutritional assessment tool to include an assessment of oral health and the ability to communicate (local 2010) Total** | | |
| | | R 4/9 | R3a We recommend that NHS bodies ensure that their menus provide an appropriate choice of food and that the arrangements for ordering and serving food support adequate patient choice (national). | (blank) | (blank) |
| | | | **R3a We recommend that NHS bodies ensure that their menus provide an appropriate choice of food and that the arrangements for ordering and serving food support adequate patient choice (national). Total** | | |
| | | R 5/9 | R3b We recommend that NHS bodies continue to roll out the protected mealtime policy to as wide a range of wards as possible, communicating its importance to all the relevant staff groups working in the hospital, and regularly reviewing compliance with the policy (national). | (blank) | (blank) |
| | | | **R3b We recommend that NHS bodies continue to roll out the protected mealtime policy to as wide a range of wards as possible, communicating its importance to all the relevant staff groups working in the hospital, and regularly reviewing compliance with the policy (national). Total** | | |
| | | R 6/9 | R4b We recommend that NHS bodies introduce computerised catering information systems, supported by clear cost benefit analysis in comparison to existing manual based information systems (national). | (blank) | (blank) |
| | | | **R4b We recommend that NHS bodies introduce computerised catering information systems, supported by clear cost benefit analysis in comparison to existing manual based information systems (national). Total** | | |
| | | R 7/9 | R7a We recommend that set pricing policies and income generation targets that aim to ensure that non-patient catering services at least break even, or, if they do not, it is the result of a deliberate subsidy policy that is based on a detailed analysis of costs (national). | (blank) | (blank) |

| | | | | | |
|---|---|---|---|---|---|
| | | | **R7a We recommend that set pricing policies and income generation targets that aim to ensure that non-patient catering services at least break even, or, if they do not, it is the result of a deliberate subsidy policy that is based on a detailed analysis of costs (national). Total** | | |
| | | R8/9 | R2 The Restaurant Non-Patient Subsidy Group should reinforce its strong focus on key performance indicators to achieve the target of zero subsidy for non-patient catering services (local 2013). | (blank) | (blank) |
| | | | **R2 The Restaurant Non-Patient Subsidy Group should reinforce its strong focus on key performance indicators to achieve the target of zero subsidy for non-patient catering services (local 2013). Total** | | |
| | | R9/9 | R10b We recommend that NHS bodies systematically collate the information from nutritional screening on the number of patients identified with, or at risk of, nutritional problems to understand the scale of the problem and the likely impact on catering and nutrition services to meet these patients' needs (national). | (blank) | (blank) |
| | | | **R10b We recommend that NHS bodies systematically collate the information from nutritional screening on the number of patients identified with, or at risk of, nutritional problems to understand the scale of the problem and the likely impact on catering and nutrition services to meet these patients' needs (national). Total** | | |
| | **Director of Planning Total** | | | | |
| Primary care services | Chief Operating Officer | R1/6 | R1 The Health Board has developed an ambitious plan for primary care, but the plan does not consider the impacts of projected population growth as a result of housing developments in Cardiff. The Health Board should therefore revisit its primary care plan to ensure it includes specific actions to meet the needs of the projected population growth in Cardiff. | The UHB is commissioning an independent assessment of the impact of population growth on the demand for services and to identify opportunities for meeting this increased demand. | (blank) |
| | | | **R1 The Health Board has developed an ambitious plan for primary care, but the plan does not consider the impacts of projected population growth as a result of housing developments in Cardiff. The Health Board should therefore revisit its primary care plan to ensure it includes specific actions to meet the needs of the projected population growth in Cardiff. Total** | | |
| | | R2/6 | R2 The Health Board's plans for primary care have been developed with only limited consultation and collaboration with some key groups of stakeholders. The Health Board should therefore develop the necessary consultation and communications plans to ensure meaningful public and stakeholder engagement in any further development / refinement of its primary care plans. | Communication plan to be developed and actions to be carried out this financial year, with the plan to be incorporated as a core part of the 2019-20 Primary and Community Intermediate Care Integrated Medium Term Plan (PCIC IMTP). | (blank) |
| | | | **R2 The Health Board's plans for primary care have been developed with only limited consultation and collaboration with some key groups of stakeholders. The Health Board should therefore develop the necessary consultation and communications plans to ensure meaningful public and stakeholder engagement in any further development / refinement of its primary care plans. Total** | | |
| | | R3a/6 | R3 While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should:<br>a. Calculate a baseline position for its current investment and resource use in primary and community care. | Financial resource shift framework developed and will be used to track investment and resource use from secondary to primary care, starting with the investment in MSK (Musculoskeletal) and MH (Mental Health). | (blank) |
| | | | **R3 While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should:<br>a. Calculate a baseline position for its current investment and resource use in primary and community care.<br>Total** | | |
| | | R3b/6 | b. Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care. | Build into IMTP annual review process. | (blank) |
| | | | **b. Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care. Total** | | |

| | | | | |
|---|---|---|---|---|
| | R4a/6 | R4 Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should:<br>a. Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models.<br>. | Formally evaluate cluster nursing posts and cluster pharmacists.<br>Communicate the evaluation of cluster-based nursing posts and cluster pharmacies, to inform future decision making.<br>Ensure future cluster models (MSK, MH) have robust evaluation built into the process. | (blank) |
| | | **R4 Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should:<br>a. Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models.<br>. Total** | | |
| | R4b/6 | b. Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters. | Communicate the evaluation of cluster-based nursing posts and cluster pharmacies at CD (Clinical Directors) forum.<br>Use CD forum to help sharing and learning by publicising the key messages via Cluster Leads. | (blank) |
| | | **b. Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters. Total** | | |
| | R4c/6 | c. Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund. | Many Primary Care funding has now been mainstreamed as core business. Cluster pilots to continue to be evaluated to assess the option of rolling out at scale, starting with MSK and MH. Subject to affordability within the resource available. | (blank) |
| | | **c. Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund. Total** | | |
| | R4d/6 | d. Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments. | As per R2 – develop Communications Plan.<br>Start communication and engagement by engaging with the UHB Stakeholder Reference Group on new ways of working. | (blank) |
| | | **d. Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments. Total** | | |
| | R5a/6 | R5 We found variation in the maturity of primary care clusters. The Health Board should:<br>a. Review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary. | Continue to prioritise the OD (Organisational Development) programme for cluster development. | (blank) |
| | | **R5 We found variation in the maturity of primary care clusters. The Health Board should:<br>a. Review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary.<br><br>Total** | | |
| | R5b/6 | b. Review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups. | Discussion on cluster membership to be built into the cluster OD programme, to include an initial discussion at the CD forum on 31 October 2018. | (blank) |
| | | **b. Review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups. Total** | | |
| | R5c/6 | c. Ensure all cluster leads attend the Confident Primary Care Leaders course | We will ensure lessons are learnt from the current CDs attending the Confident Primary Care Leaders course and encourage this course for new CDs and existing CDs who have not attended. | (blank) |
| | | **c. Ensure all cluster leads attend the Confident Primary Care Leaders course Total** | | |
| | R6a/6 | R6 We found scope to improve the way in which primary care performance is monitored and reported at Board and committee level. The Health Board should:<br>a. Ensure the contents of its Board and committee performance reports adequately cover primary care.<br>. | Review currently being undertaken of Performance reporting to the Board and its Committees. | (blank) |
| | | **R6 We found scope to improve the way in which primary care performance is monitored and reported at Board and committee level. The Health Board should:<br>a. Ensure the contents of its Board and committee performance reports adequately cover primary care.<br><br>. Total** | | |

| | | | | | |
|---|---|---|---|---|---|
| | | R6b/6 | b. Increase the frequency with which Board and committees receive performance reports regarding primary care. | See R6a | (blank) |
| | | | **b. Increase the frequency with which Board and committees receive performance reports regarding primary care. Total** | | |
| | | R6c/6 | c. Ensure that reports to Board and committees provide sufficient commentary on progress in delivering Health Board plans for primary care, and the extent to which those plans are resulting in improved experiences and outcomes for patients | See R6a | (blank) |
| | | | **c. Ensure that reports to Board and committees provide sufficient commentary on progress in delivering Health Board plans for primary care, and the extent to which those plans are resulting in improved experiences and outcomes for patients Total** | | |
| | **Chief Operating Officer Total** | | | | |
| Review of follow-up outpatients – assessment of progress | Chief Operating Officer | (blank) | R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it:<br>• covers a broader range of specialities; and<br>• clearly reports clinical risks associated with delayed follow-up appointments. | had not received information on the volume of delayed follow-up appointments. The People, Planning and Performance Committee (the PPP Committee) is responsible for the oversight of outpatient follow-up care. We found that the PPP Committee had received information about delayed ophthalmology appointments, and updates on the progress of outpatient follow-up waiting list improvement actions. However, the PPP Committee did not receive information about specialties beyond ophthalmology, nor receive adequate assurance on the clinical risks associated with delayed appointments.<br>Since our review, the Board and the PPP Committee have received regular progress reports on the steps taken to validate the outpatient follow-up list and to modernise outpatient services. The PPP Committee has also monitored closely the progress of the Clinical Risk Assessment (see recommendation two). After our report, initially, the PPP Committee were provided with updates on progress with transforming outpatient care every meeting, although the committee members now feel that twice-yearly updates are more appropriate.<br>Performance information reported to the PPP Committee includes the number of patients on | (blank) |
| | | | **R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it:<br>• covers a broader range of specialities; and<br>• clearly reports clinical risks associated with delayed follow-up appointments. Total** | | |
| | | | R2 Implemented | (blank) | (blank) |
| | | | **R2 Implemented Total** | | |
| | | | R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date. | (blank) | (blank) |
| | | | **R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date. Total** | | |
| | | | R4 Develop an outpatient transformation programme to create sustainable, efficient and good-quality services that meet population demand in the long term, considering:<br>• projected demand and capacity for outpatient services;<br>• impacts of local service changes that may result from wider South Wales Programme regional change;<br>• potential for integrated acute, community and primary-level services;<br>• advances in medical practices and potential to utilise technology; and<br>• creation of lean clinical condition pathways. | (blank) | (blank) |
| | | | **R4 Develop an outpatient transformation programme to create sustainable, efficient and good-quality services that meet population demand in the long term, considering:<br>• projected demand and capacity for outpatient services;<br>• impacts of local service changes that may result from wider South Wales Programme regional change;<br>• potential for integrated acute, community and primary-level services;<br>• advances in medical practices and potential to utilise technology; and<br>• creation of lean clinical condition pathways. Total** | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | R5 Identify the change management arrangement needed to accelerate the pace of long-term outpatient transformation. The Health Board should consider:<br>• the clinical resources, including medical, nursing and allied health practitioners, required;<br>• the change capacity and skills required;<br>• internal and external engagement with stakeholders; and<br>• primary and community care capacity to support outpatient modernisation. | (blank) | (blank) |
| | | | **R5 Identify the change management arrangement needed to accelerate the pace of long-term outpatient transformation. The Health Board should consider:<br>• the clinical resources, including medical, nursing and allied health practitioners, required;<br>• the change capacity and skills required;<br>• internal and external engagement with stakeholders; and<br>• primary and community care capacity to support outpatient modernisation. Total** | | |
| | **Chief Operating Officer Total** | | | | |
| Review of GP Out-of-Hours Services | Chief Operating Officer | (blank) | R1a Develop a process for regularly comparing its out-of-hours expenditure with other health boards, given the GP out-of-hours service's mixed performance. | Historically, the Cardiff and Vale Out of Hours service benchmarked the lowest in Wales in terms of investment per patient; however, due to significant investment, this has increased. C&V will look to review funding per 1000 population, and compare against the Welsh average if this information is available and reliable from other Health Boards.<br>All Wales expenditure to be reviewed through the Out of Hours QSE group, taking into account the difference in Health Board population, and where possible service skill mix. | (blank) |
| | | | **R1a Develop a process for regularly comparing its out-of-hours expenditure with other health boards, given the GP out-of-hours service's mixed performance. Total** | | |
| | | | R1b Develop a long-term workforce plan aimed at permanently resolving problems with filling GP shifts and improving the timeliness of all aspects of the service. | Workforce and governance reviews currently being undertaken to inform the future workforce development prior to the implementation of 111. 111 may have signifant implications for the C&V workforce which will have to be taken into account as and when more information is known. Work has already been undertaken to identify those shifts that are regularly difficult to fill considering alternative clinical cover. It has been acknowledged that the traditional GP OOHs model is not necessarily sustainable in the current climate, with ongoing difficulties in filling core shifts, as such skill mix will be a key factor moving forward.<br>This includes consideration of salaried GPs as well the wider workforce. | (blank) |
| | | | **R1b Develop a long-term workforce plan aimed at permanently resolving problems with filling GP shifts and improving the timeliness of all aspects of the service. Total** | | |
| | | | R2a Introduce processes for learning from patient feedback to improve GP out-of-hours services. | Develop more patient feedback mechanisms in conjunction with corporate services to for use by OOHs patients. Analysis with themes and trends to be discussed at Out of Hours QSE meeting. Produce information leaflets and posters for patients, along with a section on the service webpage to promote selfcare. | (blank) |
| | | | **R2a Introduce processes for learning from patient feedback to improve GP out-of-hours services. Total** | | |
| | | | R2b Prioritise clinical audit to ensure all GPs have their out-of-hours clinical contacts regularly reviewed, to meet the national standards. | Agreed audit process in place; feedback to OOHs QSE meeting. | (blank) |
| | | | **R2b Prioritise clinical audit to ensure all GPs have their out-of-hours clinical contacts regularly reviewed, to meet the national standards. Total** | | |
| | | | R2c Check its out-of-hours data relating to the number of call terminations, to ensure the information is accurate | Work is underway to review this information working with the Vale Local Authority who provide some of the telephony statistics.<br>Further work on an All Wales basis is taking place to review OOHs telephony statistics which Cardiff and Vale are leading on. | (blank) |
| | | | **R2c Check its out-of-hours data relating to the number of call terminations, to ensure the information is accurate Total** | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | R3a Improve signposting on its website by including information about GP out-of-hours on the landing page, providing a description of the service, details of the opening hours and locations, and the conditions and circumstances in which patients should use it. | This information has been updated on the intranet for GP OOHs.<br>The internet information is being led by a primary care group, which is also looking at GP OOHs. The refreshed GP OOHs internet site will include all information about the service and advice for the public on self care and other services that can be accessed. | (blank) |
| | | | **R3a Improve signposting on its website by including information about GP out-of-hours on the landing page, providing a description of the service, details of the opening hours and locations, and the conditions and circumstances in which patients should use it. Total** | | |
| | | | R3b Work with GP practices to ensure all practices have a standard answerphone message that provides appropriate information about the out-of-hours service. | A standardised message was promoted through the primary care access group, of which 27 practices used a standardised message. However, this cannot be enforced with the practices.<br>Work is ongoing with practices to improve the uptake rate to ensure that a consistent message is provided to patients. | (blank) |
| | | | **R3b Work with GP practices to ensure all practices have a standard answerphone message that provides appropriate information about the out-of-hours service. Total** | | |
| | | | R3c As part of the eventual introduction of 111, consider replacing the five different telephone numbers with a single number for accessing GP out-of-hours. | Work towards rationalising the numbers down to one number, impact on stakeholders will need to be assessed during this change process.<br>The Head of OOHs is a member of the Directory of Services group, which is looking at this issue longer term, and will continue to work to ensure a single point of access. | (blank) |
| | | | **R3c As part of the eventual introduction of 111, consider replacing the five different telephone numbers with a single number for accessing GP out-of-hours. Total** | | |
| | | | R4a Share data with all practices showing the variation in use of out-of-hours services between 6.30pm and 7.30pm, with a view to highlighting outliers and resolving issues that are driving out-of-hours demand. | Information included in the desktop assessment of practice sustainability as an additional indicator of performance.<br>Send out monthly to practices and clusters.<br>To be included in the information shared and discussed at annual Practice Development Visits as well as sharing through CD forum. | (blank) |
| | | | **R4a Share data with all practices showing the variation in use of out-of-hours services between 6.30pm and 7.30pm, with a view to highlighting outliers and resolving issues that are driving out-of-hours demand. Total** | | |
| | | | R4b Identify and address the reasons that are preventing out-of-hours staff from accessing the GP Record. | Ongoing issues with IHR have impacted on the ability for staff working in the Out of Hours service in being able to acess the GP record. This has been raised with NWIS and C&V IT colleagues as a priority area for change. A meeting with the C&V IT dept arranged for August 2017 to review IT related issues and agree actions to address these. | (blank) |
| | | | **R4b Identify and address the reasons that are preventing out-of-hours staff from accessing the GP Record. Total** | | |
| | **Chief Operating Officer Total** | | | | |
| Review of Medical Equipment: Update on Progress | Director of Therapies & Health Science | R1/8 | R1 Review the effectiveness of the Medical Equipment Group, focusing on:<br>• Membership of the group<br>• Attendance<br>• Executive Support<br>• Reporting lines | Review and Refresh ToR based on recommendations of this report.<br>Set out reporting mechanisms within UHB governance framework and reporting lines. | (blank) |
| | | | **R1 Review the effectiveness of the Medical Equipment Group, focusing on:**<br>**• Membership of the group**<br>**• Attendance**<br>**• Executive Support**<br>**• Reporting lines Total** | | |
| | | R2/8 | R2 Improve the effectiveness of the Medical Device Safety Officer role, by:<br>• providing clarity on the purpose of the role;<br>• ensuring attendance at Medical Equipment Group meetings;<br>• ensuring attendance at Clinical Board Quality, Safety and Experience meetings;<br>• ensuring that MDSOs engage with their respective Clinical Board on medical equipment risks and issues;<br>• ensuring MDSOs have the necessary time and resources to perform the role; and<br>• giving MDSOs access to potential learning and development opportunities. | Fully embed MDSO in CB QSE structures.<br>Review MDSO role profile and resourcing and communicate requirements of the role with Clinical Boards.<br>Develop MDSO dashboard to include:<br>• Attendance at MEG & QSE meetings<br>• QSE Med Equip reports, CB Datix reports,<br>• CB med equipment risks<br>Take learning from comprehensive specialist services' CB compliance audit against the UHB's Medical Equipment Management Policy to all CBs and audit as part of annual self-assessment process. | (blank) |

| | | | | | |
|---|---|---|---|---|---|
| | | | **R2 Improve the effectiveness of the Medical Device Safety Officer role, by:**<br>**• providing clarity on the purpose of the role;**<br>**• ensuring attendance at Medical Equipment Group meetings;**<br>**• ensuring attendance at Clinical Board Quality, Safety and Experience meetings;**<br>**• ensuring that MDSOs engage with their respective Clinical Board on medical equipment risks and issues;**<br>**• ensuring MDSOs have the necessary time and resources to perform the role; and**<br>**• giving MDSOs access to potential learning and development opportunities. Total** | | |
| | | R3/8 | R3 Review medical equipment risk management throughout the organisation, ensuring alignment between the corporate and operational approach. | Ensure CBs capture medical equipment risks as part of their risk management processes. These will be monitored via MEG, and escalated through relevant strategic committees, eg Strategy and Resources/Capital Management/QSE/Management Executive as required. | (blank) |
| | | | **R3 Review medical equipment risk management throughout the organisation, ensuring alignment between the corporate and operational approach. Total** | | |
| | | R4/8 | R4 The Health Board should determine how it can develop an effective medical equipment inventory with available resources. | The MEG will review the WHO good practice guidance and determine what is feasible to introduce, with resources available, to improve medical equipment inventory. | (blank) |
| | | | **R4 The Health Board should determine how it can develop an effective medical equipment inventory with available resources. Total** | | |
| | | R5/8 | R5 The Medical Equipment Group should assure itself that clinical boards operate effective systems and processes for the monitoring, purchase and replacement of medical equipment below £5,000. | Ensure MSDOs include key under £5,000 items on their risk log and escalate replacement needs within the CB.<br>Ensure medical devices procurement officer scrutinises under £5,000 items to identify opportunities for standardisation and efficiency | (blank) |
| | | | **R5 The Medical Equipment Group should assure itself that clinical boards operate effective systems and processes for the monitoring, purchase and replacement of medical equipment below £5,000. Total** | | |
| | | R6/8 | R6 Ensure that Clinical Boards include the Medical Device Safety Officer report as a standing agenda item at the Quality, Safety and Experience meetings to discuss and address any medical equipment risks and incidents that arise. | Develop MDSO metrics for reporting to their CB QSE meetings, and MEG reporting. | (blank) |
| | | | **R6 Ensure that Clinical Boards include the Medical Device Safety Officer report as a standing agenda item at the Quality, Safety and Experience meetings to discuss and address any medical equipment risks and incidents that arise. Total** | | |
| | | R7/8 | R7 Ensure all relevant service areas collaborate, consult and engage on medical equipment issues. It should give particular attention to the arrangements in place for maintenance and replacement of beds and hoists. | Monitor attendance and engagement of CB MSDOs and other members at MEG, escalate non-attendance or lack of engagement.<br><br>Monitor progress of action plan developed by Health and Safety Advisor following the Arjo Proact 2017 survey Health and Safety Committee 18/005 minute (25 January 2018).<br><br>Maintain hoists within the Clinical Engineering Department at the end of external supplier contract.<br>Ensure Clinical Engineering is represented at the Bed Management Group | (blank) |
| | | | **R7 Ensure all relevant service areas collaborate, consult and engage on medical equipment issues. It should give particular attention to the arrangements in place for maintenance and replacement of beds and hoists. Total** | | |
| | | R8/8 | R8 Evaluate the medical equipment arrangements in place within Pathology Services (Laboratory Medicine). | Agree Pathology MDSO role with CD&T with same CB functions at a directorate level reporting through to CB MDSO. | (blank) |
| | | | **R8 Evaluate the medical equipment arrangements in place within Pathology Services (Laboratory Medicine). Total** | | |
| | **Director of Therapies & Health Science Total** | | | | |
| Review of Operating Theatres | Chief Operating Officer | (blank) | R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it:<br>• covers a broader range of specialities; and<br>• clearly reports clinical risks associated with delayed follow-up appointments. | (blank) | (blank) |
| | | | **R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it:**<br>**• covers a broader range of specialities; and**<br>**• clearly reports clinical risks associated with delayed follow-up appointments. Total** | | |
| | | | R2 Identify clinical conditions across all specialties where patients could come to irreversible harm through delays in follow-up appointments. | (blank) | (blank) |

| | | | | | |
|---|---|---|---|---|---|
| | | | **R2 Identify clinical conditions across all specialties where patients could come to irreversible harm through delays in follow-up appointments. Total** | | |
| | | | R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date. | (blank) | (blank) |
| | | | **R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date. Total** | | |
| | **Chief Operating Officer Total** | | | | |
| Structured Assessment 2018 | Chief Executive Officer | R1/11 | The Health Board should complete our 2017 structured assessment recommendations by the end of 2019. | Agreed and these will be monitored to ensure this happens through Management Executives and reported to Audit Committee | (blank) |
| | | | **The Health Board should complete our 2017 structured assessment recommendations by the end of 2019. Total** | | |
| | | R10/11 | The Health Board should complete a review of the structure and governance of its information and information technology functions to support delivery of the strategic digital approach | The newly appointed head of digital and health intelligence is developing a new structure to reflect combined information and IT services with the aim of stablishing functions that can best support the digital transformation agenda. | (blank) |
| | | | **The Health Board should complete a review of the structure and governance of its information and information technology functions to support delivery of the strategic digital approach Total** | | |
| | | 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.<br>A schedule of testing is being developed as part of the technical roadmap work. | (blank) |
| | | | **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 Total** | | |
| | | R1a/11 | R13 [2016] Strengthen tracking arrangements for external audit recommendations by providing more detailed information to the Audit Committee on the extent to which both performance and financial audit recommendations have been completed, and ensure that all action plans are monitored through to completion by he relevant committees of the Board. | There is a tracker for WAO recommendations. The current arrangements don't provide enough clarity around what happens to recommendations where committees other than the audit committee are responsible | (blank) |
| | | | **R13 [2016] Strengthen tracking arrangements for external audit recommendations by providing more detailed information to the Audit Committee on the extent to which both performance and financial audit recommendations have been completed, and ensure that all action plans are monitored through to completion by he relevant committees of the Board. Total** | | |
| | | R1b/11 | R2 [2017] To ensure compliance with the NHS planning framework, the Health Board needs to ensure that the Strategy and Engagement Committee regularly scrutinises progress on delivery of the Annual Operating Plan, and subsequent three year integrated medium term plans. | The new S&D Committee's work plan includes scrutiny of key elements of the Annual Operating Plan, 10-year strategy and transformation programme. The Committee and the Board still need to receive appropriate progress updates against the Annual Operating Plan deliverables to ensure they are on track. | (blank) |
| | | | **R2 [2017] To ensure compliance with the NHS planning framework, the Health Board needs to ensure that the Strategy and Engagement Committee regularly scrutinises progress on delivery of the Annual Operating Plan, and subsequent three year integrated medium term plans. Total** | | |
| | | R1c/11 | R3 [2017] To enable effective scrutiny, the Health Board needs to improve the quality of its papers to Board and Committees by ensuring that the length and content of<br>the papers presented is appropriate and manageable. | The length of Board and committee papers has improved compared to last year, but inconsistencies and variation remain. The Health Board's introduction in September 2018 of a revised cover report template should encourage more succinct reporting | (blank) |
| | | | **R3 [2017] To enable effective scrutiny, the Health Board needs to improve the quality of its papers to Board and Committees by ensuring that the length and content of<br>the papers presented is appropriate and manageable. Total** | | |
| | | R1d/11 | R4 [2017] To improve transparency, the Health Board needs to ensure that the Finance Committee papers are made available on its website in a timely manner. | At December 2018, the October 2018 Finance Committee papers were not available on the Health Board's website. | (blank) |
| | | | **R4 [2017] To improve transparency, the Health Board needs to ensure that the Finance Committee papers are made available on its website in a timely manner. Total** | | |

| | | | | |
|---|---|---|---|---|
| | R1e/11 | R5 [2017] The Health Board needs to strengthen its corporate risk assurance framework (CRAF) by:<br>▪ mapping risks to the Health Board's strategic objectives;<br>▪ reviewing the required assurances;<br>▪ improving clarity of risk descriptors; and clarifying to the reader the date when risks are updated and/or added. | Until recently, the Health Board had made little progress in updating the CRAF. The CRAF was last presented to the Board and committees in November 2017. We recognise the Health Board has recently taken steps to start developing a separate Board Assurance Framework and Corporate Risk Register. The draft BAF was received at both the Audit Committee and Board in November and December respectively. | (blank) |
| | | **R5 [2017] The Health Board needs to strengthen its corporate risk assurance framework (CRAF) by:<br>▪ mapping risks to the Health Board's strategic objectives;<br>▪ reviewing the required assurances;<br>▪ improving clarity of risk descriptors; and clarifying to the reader the date when risks are updated and/or added. Total** | | |
| | R1f/11 | R6 [2017] The Health Board needs to focus its attention on strengthening its information governance arrangements in readiness for the General Data Protection Regulations, which come into force in May 2018. This should include:<br>▪ updating the information governance strategy;<br>▪ putting in place arrangements for monitoring compliance of the primary care information governance toolkit; and<br>▪ developing and completing an Information Asset Register;<br>▪ ensuring that an identified data protection officer is in place; and<br>▪ improving the uptake of information governance training. | ▪ An up-to-date Information Governance strategy does not yet exist. The Health Board has drafted its strategic approach in the Information Governance Policy. The Health Board plans to agree and implement this approach later in 2018.<br>▪ NWIS has developed the information governance toolkit for primary care GP's and intend to monitor compliance at a GP cluster level. These compliance monitoring arrangements for are still being developed. The Primary Care Clinical Board is liaising with the NHS Wales Informatics Service to confirm and agree these arrangements.<br>▪ Information asset registers have been developed within the corporate directorates and clinical boards, but further work is required to fully complete this. The Health Board is planning further work to: identify personal information held; identify information flows; and identify information | (blank) |
| | | **R6 [2017] The Health Board needs to focus its attention on strengthening its information governance arrangements in readiness for the General Data Protection Regulations, which come into force in May 2018. This should include:<br>▪ updating the information governance strategy;<br>▪ putting in place arrangements for monitoring compliance of the primary care information governance toolkit; and<br>▪ developing and completing an Information Asset Register;<br>▪ ensuring that an identified data protection officer is in place; and<br>▪ improving the uptake of information governance training. Total** | | |
| | 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:<br>▪ 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;<br>▪ 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.<br>▪ The S&D Committee continues to receive a high-level performance dashboard, which is less detailed than the performance report received by the Board.<br>▪ Since September 2018, the S&D Committee receives six-monthly updates against the workforce plans, including key workforce metrics. | (blank) |

| | | | | |
|---|---|---|---|---|
| | | **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:**<br>**▪ 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;**<br>**▪ 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. Total** | | |
| | R1h/11 | R9 [2017] To ensure resilience to security issues, such as cyber-attacks, the Health Board should consider identifying a dedicated resource for managing IT security. | In early 2018, the Health Board received an external review of cyber security arrangements. The review recommended improvements to cyber security arrangements. In response the Health Board is developing a formal cyber security improvement action plan. It plans to bring in specialist cyber security skills in early 2019 to address these recommendations and establish a specialist cyber security team. | (blank) |
| | | **R9 [2017] To ensure resilience to security issues, such as cyber-attacks, the Health Board should consider identifying a dedicated resource for managing IT security. Total** | | |
| | R1i/11 | R10 [2017] To improve scrutiny of the Health Board's informatics service, the Health Board should expand the range of key performance indicators relating to informatics to include the cause and impact of informatics incidents. | The Health Board plans to review in early 2019 the structure and governance of its information and information technology functions to deliver the digital strategy. | (blank) |
| | | **R10 [2017] To improve scrutiny of the Health Board's informatics service, the Health Board should expand the range of key performance indicators relating to informatics to include the cause and impact of informatics incidents. Total** | | |
| | R2a/11 | The Health Board should improve its recommendation tracking by:<br>a. addressing our outstanding 2016 structured assessment recommendation to strengthen tracking arrangements for external audit recommendations; | Agreed this will be presented to the next Audit Committee | (blank) |
| | | **The Health Board should improve its recommendation tracking by:**<br>**a. addressing our outstanding 2016 structured assessment recommendation to strengthen tracking arrangements for external audit recommendations;**<br><br>**Total** | | |
| | R2b/11 | b. including the tracking of internal audit recommendations; and | Agreed | (blank) |
| | | **b. including the tracking of internal audit recommendations; and Total** | | |
| | R2c/11 | c. completing a review of all outstanding internal and external audit recommendations and reporting the findings to the Audit Committee. | Agreed | (blank) |
| | | **c. completing a review of all outstanding internal and external audit recommendations and reporting the findings to the Audit Committee. Total** | | |
| | R3a/11 | The Health Board should:<br>a. Update the Scheme of Delegation to reflect the delegated responsibility for calculating nurse staffing levels for designated acute medical and surgical inpatient wards; | Agreed in progress as result of Internal Audit Report | (blank) |
| | | **The Health Board should:**<br>**a. Update the Scheme of Delegation to reflect the delegated responsibility for calculating nurse staffing levels for designated acute medical and surgical inpatient wards;**<br><br>**Total** | | |
| | 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 | (blank) |
| | | **b. Review and update the Standing Orders and Standing Financial Instructions, ensuring these documents are reviewed and approved on an annual basis; Total** | | |

| | | | | |
|---|---|---|---|---|
| | R3c/11 | c. Improve the format of the registers for declarations of interest and gifts, hospitality and sponsorship and clarify the frequency with which the registers are presented to the Audit Committee; | Agreed registers will be improved in format and reported to Audit Committee twice a year | (blank) |
| | | **c. Improve the format of the registers for declarations of interest and gifts, hospitality and sponsorship and clarify the frequency with which the registers are presented to the Audit Committee; Total** | | |
| | R3d/11 | d. Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date; | Agreed | (blank) |
| | | **d. Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date; Total** | | |
| | R3e/11 | e. Review all committee terms of reference to make sure they are up to date, do not overlap, and are reviewed annually; | Agreed in progress | (blank) |
| | | **e. Review all committee terms of reference to make sure they are up to date, do not overlap, and are reviewed annually; Total** | | |
| | R3f/11 | f. Ensure all committees have an up-to-date work programme, which is linked to the cycle of Board meetings and reviewed annually. | Agreed work plans for each Committee and the Board are in development | (blank) |
| | | **f. Ensure all committees have an up-to-date work programme, which is linked to the cycle of Board meetings and reviewed annually. Total** | | |
| | 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. | (blank) |
| | | **The Health Board should update its performance management framework to reflect the organisational changes that have taken place since 2013. Total** | | |
| | R5/11 | The Health Board should provide the Finance Committee, or Board, with an update on progress with its testing and delivery of the All Wales Costing System Implementation Project. | The UHB accepts the need to provide an update on progress with this project. As a series of Welsh Costing Returns (WCRs) have now been submitted to Welsh Government using the new system, a comprehensive update on the implementation and future use of the costing development can now be made. It is intended to provide a paper to the Finance Committee following finalisation and publication of WCRs within Wales. | (blank) |
| | | **The Health Board should provide the Finance Committee, or Board, with an update on progress with its testing and delivery of the All Wales Costing System Implementation Project. Total** | | |
| | R6/11 | The Health Board should ensure that all recommended matches from the next NFI exercise in January 2019 are reviewed and where necessary investigated in a timely manner. | For the forthcoming NFI exercise, the Health Board will endeavour to increase its compliance in respect of the number of recommended matches checked. A large number of these matches are however in relation to Accounts Payable and this will require further matching and review by the NHS Wales Shared Service Partnership. Consequently this is not wholly within the control of the Health Board. | (blank) |
| | | **The Health Board should ensure that all recommended matches from the next NFI exercise in January 2019 are reviewed and where necessary investigated in a timely manner. Total** | | |
| | R7/11 | The Health Board should complete the outstanding actions from the Information Commissioner's Office (ICO) 2016 review of the Health Board's data protection arrangements. | CAV UHB is committed to continually improving mitigation of its risks of non-compliance. We are taking an improvement approach in line with the rest of Wales and in regular discussion with the ICO's office.<br>Progress has been made on the registering of major assets and new flows of information. We intend to progress the assessment of our existing significant flows, adopting a risk based approach. | (blank) |
| | | **The Health Board should complete the outstanding actions from the Information Commissioner's Office (ICO) 2016 review of the Health Board's data protection arrangements. Total** | | |
| | R8/11 | The Health Board should achieve full compliance with the General Data Protection Requirement by May 2019. | Delivery of the CAV UHB's updated action plan will reduce the risks we carry in relation to noncompliance with GDPR.<br>Prioritisation of risks and mitigating actions are part of our continuous improvement plan, aimed at achieving full GDPR compliance during 2019. | (blank) |
| | | **The Health Board should achieve full compliance with the General Data Protection Requirement by May 2019. Total** | | |
| | R9/11 | The Health Board should improve its response times to requests for information from Freedom of Information Act and Data Protection Subject Access Requests. | CAV UHB has recently appointed additional staff resulting in a positive impact on response times for FOI and Subject Access Requests.<br>This will be monitored as we continue to move towards achieving fully compliant response times. | (blank) |

| | | | | | |
|---|---|---|---|---|---|
| | | | **The Health Board should improve its response times to requests for information from Freedom of Information Act and Data Protection Subject Access Requests. Total** | | |
| | **Chief Executive Officer Total** | | | | |
| (blank) | (blank) | (blank) | (blank) | (blank) | (blank) |
| | | | **(blank) Total** | | |
| | **(blank) Total** | | | | |

**Grand Total**

| Audit Reference | (All) |
|---|---|

| Audit Title | Executive Lead for Report | Status of Report Overall | Age Group |
|---|---|---|---|
| **Clinical Coding Follow-up** | **Director of Transformation and Informatics** | (blank) | Less Than 3 Months |
| **Combined follow up of Informatics and Communications Technology audits** | **Director of Transformation and Informatics** | (blank) | Date not Specified |
| **Diagnostic review of ICT capacity andresources** | **Director of Transformation and Informatics** | (blank) | Date not Specified |
| **Discharge Planning** | **Chief Operating Officer** | (blank) | Over 6 Months |
| | | | Over One Year |
| **Hospital Catering and Patient Nutrition Follow-up Review** | **Director of Planning** | (blank) | Date not Specified |
| **Primary care services** | **Chief Operating Officer** | (blank) | Due Date Not Reached |
| | | | Over 6 Months |
| **Review of follow-up outpatients – assessment of progress** | **Chief Operating Officer** | (blank) | Date not Specified |
| | | | Over One Year |
| **Review of GP Out-of-Hours Services** | **Chief Operating Officer** | (blank) | Over One Year |
| **Review of Medical Equipment: Update on Progress** | **Director of Therapies & Health Science** | (blank) | Over 3 Months |
| | | | Over 6 Months |
| | | | Over One Year |
| **Review of Operating Theatres** | **Chief Operating Officer** | (blank) | Date not Specified |
| **Structured Assessment 2018** | **Chief Executive Officer** | (blank) | Due Date Not Reached |
| | | | Over 3 Months |
| | | | Over 6 Months |
| | | | Over One Year |
| **(blank)** | **(blank)** | (blank) | Date not Specified |
| | | | (blank) |
| **Grand Total** | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Report Title:** | Report of the Losses and Special Payments Panel | | | | | | | | |
| **Meeting:** | Audit and Assurance Committee | | | | | | **Meeting Date:** | 3.12.2019 | |
| **Status:** | **For Discussion** | | **For Assurance** | | **For Approval** | | **x** | **For Information** | |
| **Lead Executive:** | Executive Director of Finance | | | | | | | | |
| **Report Author (Title):** | Head of Financial Accounting and Services | | | | | | | | |

**SITUATION**

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

The work of the panel supports the UHB's sustainability and ensures that we make the best use of the resources that we have.

**BACKGROUND**

The Losses and Special Payments Panel last met on 22nd November 2019 to consider the 6 month period April 1st 2019 to September 30th 2019. This report informs the Audit and Assurance Committee of the items considered at this meeting and the recommendations made for formal Audit and Assurance Committee approval. The minutes of the last meeting of the Losses and Special Payments Panel are attached as Appendix 1. These minutes give more detail about the issues discussed at the meeting, including those items that have been recommended to the audit committee for approval.

**ASSESSMENT**

The following losses have been identified for write off:

- Clinical negligence claims of £9.397m and personal injury claims of £0.280m for the period 1st April 2019 to 30th September 2019. For noting the income & expenditure charge suffered by the UHB in respect of such incidents was £0.873m;

- £5,425 in respect of bad debt write offs for the period 1st April 2019 to 30th September 2019;

- £231,235 in respect of one permanent injury case concluded during the six months to 30th September 2019.

- Small Claims Panel Losses of £14,393 for the period 1st April 2019 to 30th September 2019;

- £657,864 in respect of Ex Gratia & Fruitless Payments made during the period 1st April 2019 to 30th September 2019;

- £35,500 regarding Employment Tribunals settled between 1st April 2019 and 30th September 2019.

**ASSURANCE** is provided by:

- The detailed minutes of the Panel meeting attached at Appendix 1.

**RECOMMENDATION**

The Audit and Assurance Committee is asked to:

- **APPROVE** the write offs outlined in the Assessment Section of this report.

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

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

**MINUTES OF THE MEETING OF THE LOSSES AND SPECIAL PAYMENTS PANEL HELD ON 22nd NOVEMBER 2019**

**PRESENT:** Mr R Mahoney – Asst. Finance Director (Acting Chair)
Mr A Crook – Head of Workforce Governance
Mr S Monk – Losses & Taxation Accountant
Mr A Williams – Head of Financial Services
Mrs S Wicks – Clinical Negligence & Personal Injury Claims Manager
Mrs H Lawrence – Senior Finance Business Partner
Mr R Hurton – Head of Financial Accounting & Services

**APOLOGIES:** Mr C Greenstock – Counter Fraud Manager
Mr C Lewis – Deputy Finance Director (Chair)
Mr R Cockayne – Assistant Security Manager

**1. Minutes of Last Meeting**

The minutes of the last meeting were reviewed for accuracy and the group endorsed the minutes as an accurate record. There were no matters arising which were not covered elsewhere on the agenda.

**2. Clinical Negligence and Personal Injury Losses**

Mr Monk presented the financial report on Clinical Negligence and Personal Injury losses for the six month period ending 30th September 2019.

The income and expenditure effect for the period was described as shown below: For comparison, the figures for the same period in 2018/2019 were also discussed.

SUMMARY OF LOSSES

| | 2019/2020 £'000 | 2018/2019 £'000 |
|---|---|---|
| Clinical Negligence | 26,233 | -641 |
| Personal Injury | 238 | 11 |
| Total Loss | 26,471 | -630 |
| Less WRP Receipts Due | -25,598 | 1,482 |
| Total Net Cost to the UHB | 873 | 852 |

With respect to clinical negligence claims, Mr Monk advised that there had been an increase in gross expenditure in comparison to the previous year (before reimbursal from the Risk Pool) of £26.874m. This movement was largely as a result of some large cases which had previously been assessed as having a possible or remote chance of success being reassessed as certain or probable by Welsh Health Legal Services. In addition during 2018/19 two large cases were reclassified as possible/remote from their previous assessment of probable. No such adjustment had been required in 2019/20. Mrs Wicks noted that the discount rate that is used to estimate the future liabilities has changed again in 2019/20. The result of this is expected to be a reduction in the gross value of existing claims over the last six months of 2019/20. Mr Hurton noted that more and more claimants were opting to take a higher percentage of their settlement as an up-front sum. This was causing the Risk Pool to exceed their annual funding from WG and were having to pass this overspend on to the LHB's under the risk sharing agreement. Unless WG would fund this, it would be a significant cost pressure for the Health Board.

The impact of all recorded Personal Injury claims had been a gross I&E charge of £0.238m. This was £0.227m higher than in 2018/19. The biggest factor being the increase in expected settlement values in regards of existing claims.

**Recommendation**

**The Panel recommended that the Audit and Assurance Committee note that following expected reimbursement from the WRP, the net expenditure incurred by the UHB on these Clinical Negligence and Personal Injury claims was £0.873m for the period 1st April 2019 to 30th September 2019.**

**Finalised Clinical Negligence (including Redress) Claims**

During the six months ending 30th September 2019, there were 47 claims (where liability had been conceded and settlements paid) which had concluded at a total settlement cost of £9.397m (which are treated as a loss). The UHB also incurred £0.316m in legal fees re these cases and was successful in recovering £8.850m from the Welsh Risk Pool and Welsh Government for these claims, resulting in a net cost to the UHB of £0.863m.

**Finalised Personal Injury Claims**

During the six months ending 30th September 2019, 12 claims where liability had been conceded and settlements paid have concluded at a total settlement cost of £0.280m (which are treated as a loss). The UHB had also incurred

£0.028m in defence fees and was successful in recovering £0.197m from the WRP for these claims, resulting in a net cost to the UHB of £0.111m.

Mr Monk reminded the group that expenditure on defence fees was not treated as a loss and also that it should be remembered that the net loss is accrued over the lifetime of a claim which can span many years.

Mr Hurton said that the amounts settled over any six month period could be volatile, being influenced by both the change in the discount rate applied and by the existence of any abnormally large cases (which usually were in respect of infants). For comparison the amounts recommended for write off in previous panel meetings had been:

May 2019 Clinical Negligence £19.851m, Personal Injury £0.321m

November 2018 Clinical Negligence £11.777m, Personal Injury £0.292m

May 2018 Clinical Negligence £4.457m, Personal Injury £0.636m

November 2017 Clinical Negligence £2.983m, Personal Injury £0.260m

May 2017 Clinical Negligence £15.380m, Personal Injury £0.470m

**Recommendation**

**The Panel recommended that the Audit and Assurance Committee approve the write off of the settlement costs of claims finalised in the period 1st April 2019 – 30th September 2019. The value of these claims finalised was - Clinical Negligence - £9.397m. Personal Injury - £0.280m.**

### 3. Debt Write-Offs

Mr Williams presented a report on proposed invoice write-offs for the period 1st April 2019 to 30th September 2019.

These were as follows:

| Category of Debt | Value | Number |
|---|---|---|
| Dental | 70 | 5 |
| Payroll | 2,035 | 7 |
| Private Patients | 776 | 8 |
| O/Seas Patients | 66 | 1 |
| Misc | 2,478 | 17 |
| **Total** | **5,425** | **38** |
| | | |

The total value of write-offs actioned for the first six months of this financial year had been £5,425.

Mr Williams stated that the number of write-offs actioned in the first six months of this financial year was low compared to previous years. This will increase in the second half of the year as a number of potential write-offs have already been identified for action in the last six months of the year. Even so, there had still been a reduction in the number of debts being put forward for write-off in the year to date.

As in previous years the overpayment of salary for those employees who have terminated continue to prove difficult collect with all debts being referred to CCI Legal Services if we have been unable to collect.

Included in the miscellaneous category are 4 invoices totalling £1,430 relating to crèche fees. These all related to non UHB employees. Mr Williams had spoken to the manager of the crèche in respect of these and a watching brief was being kept around similar customers to assess if the risk of non-payment warranted a change in how payment is received from this group.

The below gives a comparison to amounts written off in previous years.

| | 2014/15 | | 2015/16 | | 2016/17 | | 2017/18 | | 2018/19 | | 2019/20 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Value | No | Value | No | Value | No | Value | No | Value | No | Value | No |
| Accommodation | 0 | 0 | 8 | 1 | 1,049 | 8 | 0 | 0 | 260 | 1 | 0 | 0 |
| Dental | 90 | 7 | 130 | 10 | 81 | 6 | 148 | 11 | 289 | 8 | 70 | 5 |
| Medical Records | 1,182 | 48 | 360 | 22 | 650 | 35 | 207 | 10 | 200 | 18 | 0 | 0 |
| Payroll | 15,229 | 18 | 2,004 | 7 | 20,025 | 53 | 6,857 | 11 | 3,243 | 5 | 2,035 | 7 |
| Private Patients | 4,573 | 18 | 4,578 | 32 | 24,325 | 28 | 13,976 | 23 | 0 | 0 | 776 | 8 |
| O/Seas Patients | 24,761 | 38 | 53,011 | 48 | 16,475 | 10 | 47,306 | 29 | 6,809 | 6 | 66 | 1 |
| IVF Wales | 0 | 0 | 0 | 0 | 31,026 | 24 | 0 | 0 | 0 | 0 | 0 | 0 |
| Misc | 122,466 | 68 | 17,787 | 50 | 78,685 | 61 | 22,835 | 25 | 42,806 | 480 | 2,478 | 17 |
| | **168,301** | **197** | **77,877** | **170** | **172,315** | **225** | **91,330** | **109** | **53,607** | **518** | **5,425** | **38** |

**Recommendation**

**The Panel recommended that the Audit and Assurance Committee approve the write off of £5,425 in respect of Bad Debts for the period 1st April 2019 to 30th September 2019.**

**4. Permanent Injury Losses**

Mr Monk presented a report on permanent injury costs for the first six months of the financial year 2019-20. He explained that permanent injury allowances were approved by the NHS Pensions Agency and the long term costs were picked up by the UHB. The costs must be treated as losses and should be noted by the Panel. The UHB made payments on a quarterly basis to the Pensions Agency based on bills received from them.

One case had been closed during the period as a result of the death of the beneficiary. This had led to an income & expenditure benefit of £0.277m as the relevant provision had been released. In addition there were a total of 26 cases ongoing, which in expenditure terms had resulted in a net cost over the six month period to the UHB of £0.117m.There were payments made in the same period of £0.112m.

Mr Monk stated that as the one case had concluded then the total payments made in respect of it would now be recognised as a loss. The total payments incurred over the life of the case were £231,234.63.

**Recommendation**

**The Panel recommended that the Audit and Assurance Committee approve the write off of £231,235 in respect of Permanent Injury for the period 1st April 2019 to 30th September 2019.**

**5. Employment Tribunal Costs**

Mr Crook presented a paper outlining the claims and costs for the period 1st April 2019 to 30th September 2019.

During the period, Cardiff and Vale University Health Board had been involved with fourteen Employment Tribunal claims.

Ten of these cases were still live as at March 31st 2019. Two cases had been won during the period & settlements of £35,500 had been made in respect of the final two.

**Recommendation**

**The Panel recommended that the Audit and Assurance Committee approve the write off of £35,500 in respect of Employment Tribunal Settlements for the period 1st April 2019 to 30th September 2019.**

**6. Ex Gratia Payments and Other Losses**

Mr Monk presented a report on relevant costs for the period 1st April 2019 to 30th September 2019. Mr Monk noted that there were 20 ex-gratia losses totalling £657,864 made in the six months under consideration.

Nine of the cases (£7,125) were the result of the independent review / ombudsman process. Six of the cases involved the receipt by UHB departments of counterfeit bank notes (£140). In respect of these incidents Mr Mahoney requested that Mr Williams contact the relevant department to see if they have determined if buying the relevant equipment to detect forgeries was a cost efficient solution to preventing such instances reoccurring. (**Action: Mr Williams)**

Two cases (£376.27) related to interest levied by the NHS Pension's Agency re the late payment of Final Pension Control Invoices raised by the same body. Mr Hurton briefed the group that payment of the invoice had been withheld as the UHB had believed that it would be able to appeal against these assessments, however this had subsequently been found to be incorrect.

The UHB in line with other Welsh LHB's had made payment of £215,790.47 re unpaid tax and employees national insurance contributions in respect of GP's who provided the UHB's out of hours payments for the period April to November 2017. Mr Hurton briefed the group that the payment arose as a result of HMRC challenging the previously accepted position that the GP's provided this service on a self-employed basis. The UHB also had to pay a £14,289.79 interest charge on this payment. Due to the high profile nature of this case, approval to write off the loss from the Director of Finance for NHS Wales had already been obtained prior to these payments being made. Mr Hurton briefed the group that as the potential liability had been provided for in both the 2017/18 & 2018/19 Annual Accounts, the audit committee had previously received a briefing of the incident via the Major Judgements & estimates paper that is prepared for them each year to accompany the Accounts.

The UHB had been fined £416,015.90 by the Health & Safety Executive for a number of compliance failures which had contributed to a serious accident by a contractor engaged in window cleaning at the UHW site in September 2016.

Mr Hurton briefed the group that as the potential liability had been provided for in both the 2017/18 & 2018/19 Annual Accounts, the audit committee had previously received a briefing of the incident via the Major Judgements & estimates paper that is prepared for them each year to accompany the Accounts.

The UHB had been directed to pay court costs awarded due to the failure to provide the requested medical records (£4,126.20). Mr Hurton described that there had been an investigation as to why this had occurred; but had failed to locate the records in question. It seemed that due process had been followed as the records had been appropriately tracked on leaving the medical records department to the requesting department and the requesting department operates within a secure environment. Hence the failure was apparently down to human error. As a lesson to be learned, Mrs Wicks stated that often if the facts around such incidents are communicated to the court on a timely basis they will choose not to levy such costs.

**Recommendation**

**The Panel recommended that the Audit and Assurance Committee approve the write off of £657,863.63 in respect of Ex-gratia and fruitless payments for the period 1st April 2019 to 30th September 2019, whilst noting that £230,080.26 has already been approved by the Welsh Government.**

**7. Small Claims Panel Losses**

Mr Monk presented a report on costs for the period 1st April 2019 to 30th September 2019. During that period 25 claims had been settled at a total cost of £14,393. (2018/19 £4,875 paid re 16 claims).

Mrs Wicks outlined the process under which such claims are considered. Small claims are investigated by the Clinical Board and signed off by the Directorate Manager, the claim is then reviewed by the Small Claims Manager and Assistant Director of Patient Experience

Four payments were greater than £1,000, three of these being for loss of jewellery and one for the loss of a hearing aid.

**Recommendation**

**The Panel recommended that the Audit and Assurance Committee approve the write off of the £14,393 in respect of compensation payments which had been paid during the first six months of the Financial Year 2019/20.**

## 8. Voluntary Early Release Payments

Mr Crook reminded the Panel that payments under a Voluntary Early Release Scheme were classified as "ex-gratia" payments and were managed in accordance with the Losses and Special Payments procedure. All such payments would require the approval of the Remuneration and Terms of Service Committee.

Where any compensatory payments were over £50,000, under the terms of the scheme, the Welsh Assembly Government would be required to provide approval for such payments to be made.

The Panel was asked to note the total payments figure. However no recommendation for approval was required, since these have been approved by the appropriate committee.

**The panel noted that there had been 2 payments during the first 6 months of the year totalling £0.148m.**

## 9. Any Other Business

Mr Hurton advised the panel that no reports had been received from the Counter Fraud or Security teams, hence a full year report would be required from each when the panel meets again in May. However, it was noted that Mr Greenstock regularly updates the audit committee on the activities of the Counter Fraud Team outside of the panel.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Report Title:** | **Approval of Counter Fraud and Corruption Policy** | | | | | | | | |
| **Meeting:** | **Audit Committee** | | | | | | **Meeting Date:** | **3.12.19** | |
| **Status:** | **For Discussion** | **x** | **For Assurance** | | **For Approval** | **x** | **For Information** | | |
| **Lead Executive:** | **Finance Director** | | | | | | | | |
| **Report Author (Title):** | **Counter Fraud Manager** | | | | | | | | |

**SITUATION**

The Cardiff and Vale University Health Board is committed to reducing the level of fraud and/or corruption within the NHS to an absolute minimum and keeping it at that level, thereby this will free up public money that can be put to providing better patient care. One of the basic principles of public sector organisations is the proper use of public funds. As result, the UHB must, therefore, ensure that it's employees, patients, members of the general public and external contractors act with absolute, integrity and honesty at all times and as expected.

**REPORT**

To facilitate this approach, the UHB must have a policy which sets out the Codes of Conduct that must be followed in addition to the four (4) standards required as part of Countering Fraud in the NHS.

The policy must also ensure clarity about the responsibilities at each stage of the process.

The purpose of this report is to present the Policy for approval to the Audit Committee.

**BACKGROUND**

The UHB must demonstrate that it is committed to Countering Fraud in the NHS and in order to do so must have a robust policy in place, which documents how this process is to be achieved.

**OBJECTIVES**

The objectives of the Policy (Appendix 1) are to define the arrangements and procedures that are required to be in place for the implementation of Counter Fraud within the NHS and primarily within the UHB and to establish the following:

- Codes of Conduct
- Four (4) Standards
- Definition of Fraud and Corruption (Fraud Act 2006)
- Bribery Act 2010
- Common types of Fraud
- Counter Fraud Strategy
- Roles and Responsibilities
- The UHB Fraud Response Plan
- The Recovery of Losses to Fraud and/or Corruption

**SCOPE**

This Policy is applicable across the whole of the UHB and it should be referred to at all times where any fraud and/or corruption is alleged and/or identified with the UHB.

**STYLE FORMAT and CONTENT**

The Policy has been developed using the agreed UHB template for policies, procedures and written control documents. As part of this process, all UHB staff were given the opportunity to be involved in quality assuring and/or agreeing the content of the Policy.

The Roles and Responsibilities have been arrived at having considered the management arrangements within the UHB in conjunction with external third parties (e.g. CFS Wales, SW Police, HMRC, DWP and/or UKBA).

An Equality and Health Impact Assessment (EHIA) (see Appendix 2) has been undertaken, which identifies that there is no possible or actual impact on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh Language, religion or belief, transgender, age or other protected characteristics.

**CONCLUSION**

The Audit Committee is responsible together with the Finance Director for providing assurance to the Board and NHS CFS (Wales) that Countering Fraud in the NHS is being effectively managed within the UHB. The approval of the Policy will ensure that this responsibility is discharged and that employees within the UHB have clear guidance as to the role that they have to play by reporting any fraudulent activity and by doing so, protecting the assets of the UHB at all times.

**RECOMMENDATION**

The Committee is asked to:

- **RECEIVE**, **CONSIDER and APPROVE** the Counter Fraud and Corruption Policy

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

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

| | |
|---|---|
| **Reference Number:** UHB054<br>**Version Number:** 2 | **Date of Next Review:**<br>**Previous Reference Number:** T/129 |

# Counter Fraud and Corruption Policy

## Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will be committed to reducing the level of fraud and/or corruption within the NHS to an absolute minimum and keeping it at that level, thereby this will free up public money that can be put to providing better patient care. As one of the basic principles of Public Sector organisations is the proper use of public funds, the Health Board must ensure that its employees act with absolute integrity and honesty as expected and detailed under the various Codes of Conduct.

## Objectives

The objective of the Counter Fraud and Corruption Policy is to ensure that all assets and public funds entrusted to the Health Board are protected against Fraud and/or Loss.

The supporting Counter Fraud and Corruption procedure describes the mechanisms and process that the Health Board will implement and then use to develop an Anti Fraud Culture in accordance with the NHS Counter Fraud Authority's four (4) required standards of Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account.

## Supporting Procedures and Written Control Documents

This Policy should be read in conjunction with the supporting Counter Fraud and Corruption Procedure, the All Wales Raising Concerns Policy and the All Wales Disciplinary Policy.

## Scope

This policy applies to all of our staff in all locations including those with honorary contracts

| | |
|---|---|
| **Equality and Health Impact Assessment** | An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact. This policy relies on the generic EHIA for admin type policies. |
| **Policy Approved by** | Audit Committee |
| **Group with authority to approve procedures written to explain how this policy will be implemented** | Audit Committee |
| **Accountable Executive or Clinical Board Director** | Executive Director of Finance |

**Disclaimer**

**If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**

| Summary of reviews/amendments | | | |
|---|---|---|---|
| **Version Number** | **Date Review Approved** | **Date Published** | **Summary of Amendments** |
| 1 | 24th May 2011 | 24th May 2011 | None |
| 2 | | | |
| | | | |
| | | | |

| | |
|---|---|
| **Reference Number:** UHB054<br>**Version Number:** 2 | **Date of Next Review:**<br>**Previous Reference Number:** T/129 |

# Counter Fraud and Corruption Procedure

## Introduction and Aim

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will be committed to reducing the level of fraud and/or corruption within the NHS to an absolute minimum and keeping it at that level, thereby this will free up public money that can be put to providing better patient care. As one of the basic principles of Public Sector organisations is the proper use of public funds, the Health Board must ensure that its employees act with absolute integrity and honesty as expected and detailed under the various Codes of Conduct.

## Objectives

The objective is to ensure that all assets and public funds entrusted to the Health Board are protected against Fraud and/or Loss.

The Counter Fraud and Corruption Procedure describes the mechanisms and process that the Health Board will implement and then use to develop an Anti Fraud Culture in accordance with the NHS Counter Fraud Authority's four (4) required standards of Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account.

## Scope

This procedure applies to all of our staff in all locations including those with honorary contracts

| | |
|---|---|
| **Equality and Health Impact Assessment** | An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact. This procedure relies on the generic EHIA for admin type policies. |
| **Documents to read alongside this Procedure** | This procedure should be read in conjunction with the UHB Counter Fraud and Corruption Policy, the All Wales Raising Concerns Policy and the All Wales Disciplinary Policy. |
| **Approved by** | Audit Committee |
| **Accountable Executive or Clinical Board Director** | Executive Director of Finance |
| **Author(s)** | Counter Fraud Manager |

**Disclaimer**

**If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**

| Summary of reviews/amendments | | | |
|---|---|---|---|
| **Version Number** | **Date of Review Approved** | **Date Published** | **Summary of Amendments** |
| 1 | 24th May 2011 | 24th May 2011 | None |
| 2 | | | |
| | | | |
| | | | |

| CONTENTS | | Page |
|---|---|---|

## 1. OPENING STATEMENT

The Cardiff and Vale University Health Board (UHB) is committed to reducing the level of fraud and/or corruption within the NHS to an absolute minimum and keeping it at that level, thereby this will free up public money that can be put to providing better patient care. As one of the basic principles of public sector organisations is the proper use of public funds, the UHB must ensure that its employees act with absolute, integrity and honesty as expected and detailed under the various Codes of Conduct.

## 2. CODES OF CONDUCT

Accountability is one of the crucial public service values, which under-pins the work not only of the UHB, but of the NHS as a whole. The NHS, like all organisations which receive public funds, is required to demonstrate a high standard of conduct in the way it carries out its work. If the UHB is to succeed it needs the co-operation of its Independent Members and Employees. They must ensure that at all times that they have high standards of corporate and personal conduct, based on the recognition that the needs of patients must come first. The fundamental values for working within the Public Sector, including the NHS, are set out in the Nolan Principles and cover codes of conduct for NHS staff and all Public Sector work. These are:

*Selflessness*

Individuals should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

*Integrity*

Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

*Objectivity*

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for awards or benefits. Individuals should make choices on merit.

*Accountability*

Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

*Openness*

Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.

*Honesty*

Individuals have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising, in a way that protects the public interest.

*Leadership*

Individuals should promote and support these principles by leadership and example.

## 3. INTRODUCTION

The majority of people who work in the NHS are honest and professional and agree that fraud committed by a minority is wholly unacceptable as it ultimately leads to a reduction in the resources available for patient care. It is important, therefore, that all UHB employees are aware of the risk of fraud and the means of enforcing the rules against any acts involving dishonesty (e.g. claiming for hours not worked), theft and/or corruption.

This procedure has been produced by the Nominated Lead Local Counter Fraud Specialist (LCFS) and it is intended as a guide for all employees on the counter fraud work that is undertaken within the UHB. All genuine suspicions of fraud and corruption can be reported to the LCFS on **02921 836265** or through the NHS Fraud and Corruption Reporting Line (FCRL) on Free Phone **0800 028 40 60**.

The NHS Counter Fraud Service (NHS CFS) is part of the NHS Counter Fraud Authority (formerly known as NHS Protect) and was established, in November 2017, as an independent Special Health Authority. It has responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud and corruption. In England, it is also responsible for the management of security. All instances where fraud is suspected are properly investigated until their conclusion by staff who have been trained by the NHS Counter Fraud Authority. Any investigations will be handled in accordance with the *NHS Counter Fraud and Corruption Manual*.

Within each NHS body, there is a Nominated Lead LCFS, who is trained and accredited to investigate all cases of fraud within his/her NHS body and up to a limit of £15,000. Any investigation involving allegations over this amount has to be referred to the relevant Operational Fraud Manager, who works as part of NHS Counter Fraud Authority and whose key objective is to combat fraud and/or corruption in the NHS and will liaise with the UHB LCFS providing ongoing advice and support.

The LCFS can also be supported by other LCFS', who have also been trained by NHS Counter Fraud Authority to undertake investigations into allegations of Fraud and/or Corruption against the NHS and primarily within their own NHS body.

The UHB currently has four (4) LCFS' and is totally committed to the NHS initiative on Countering Fraud and Corruption within the NHS. This includes procedures covering the four (4) Standards for Fraud, Bribery and Corruption as follows:

1. **Strategic Governance**

This section sets out the standards in relation to the Health Body's Strategic Governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the Health Body.

2. **Inform and Involve**

This section sets out the requirements in relation to raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of crime against the NHS.

3. **Prevent and Deter**

This section sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS and ensuring that opportunities for crime to occur are minimised.

4. **Hold to Account**

This section sets out the requirements in relation to detecting and investigating crime, prosecuting those who have committed crime and seeking redress.

In relation to these, the Audit Committee will review the adequacy of the UHB policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's Directions on Countering Fraud in the NHS and as required, by the NHS Counter Fraud Authority.

## 4. DEFINITIONS OF FRAUD AND CORRUPTION

**Fraud**

***"The deliberate alteration of any financial statements or other records by persons, internal and/or external to the organisation, which is carried out in order to conceal the misappropriation of assets or otherwise for gain"***

On 15th January 2007, the Fraud Act 2006 was introduced. This Act represents an entirely new way of investigating fraud since it is no longer necessary to prove that a person has been deceived. The focus is now on the dishonest behaviour of the suspect and their intent to make a gain or cause a loss.

The new offence of Fraud can be committed in three (3) separate ways:

1) **Fraud by False Representation** (s.2) – lying about something using any means, e.g. by words or actions

2) **Fraud by Failing to Disclose** (s.3) – not saying something when you have a legal duty to do so

3) **Fraud by Abuse of a Position of Trust** (s.4) – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation.

It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed dishonestly and with intent to cause gain or loss. The gain or loss does not have to succeed, so long as the intent is there.

**Corruption**

***"The giving, offering, soliciting and/or acceptance of an inducement or reward, which may then influence the action of any person."***

**Bribery Act 2010**

The Bribery Act 2010 received Royal Assent on 8th April 2010 and became operative on 1st July 2011.

The Bribery Act 2010 abolished all existing UK Anti-Bribery Laws and replaced them with a suite of new offences markedly different to what has gone before. The Bribery Act 2010 makes it a criminal offence to "***give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad"***. It will increase the maximum penalty for bribery to 10 years imprisonment, with an unlimited fine.

In addition, the Act introduces a 'corporate offence' of failing to prevent bribery by the organisation not having adequate preventative procedures in place. An organisation may avoid conviction if it can show that it had such procedures and protocols in place to prevent bribery. The 'corporate offence' is not a stand alone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

**Common types of NHS fraud:**

Some of the most common types of fraud which have been seen by the NHS Counter Fraud Service are as follows:

- Overstated times on timesheets for hours not worked
- Staff working elsewhere despite having reported to be on sickness absence
- Non Declaration of previous criminal convictions on CV's or Application Forms
- Overstated qualifications and previous employment history on Application Forms or CV's
- Claiming for journeys not undertaken or expenses not incurred (e.g. taxi fares)
- Using NHS revenue funds to purchase assets for own personal gain
- Sale of NHS equipment on Internet websites (e.g. Ebay) for own personal gain

## 5. COUNTER FRAUD STRATEGY

### 1. Inform and Involve

The UHB will use appropriate counter fraud publicity material that is "in the public domain" to persuade those staff, who work in the UHB, that fraud and/or corruption is serious and takes away resources from important services (e.g. patient care).
In order to do this, any criminal prosecution fraud cases which are reported on and appear in the public domain (i.e. local or national press), will appear on the UHB intranet site.

In addition, regular fraud awareness sessions will also be carried out by the LCFS', with the various staff groups. This is to ensure that the fraud work that is being undertaken within the UHB is made known to staff at all levels, together with examples of any recent NHS fraud investigations. The staff will also be made aware of what to do when there is any suspicion that a fraud is being or has been committed and who to report the matter to.

The LCFS will also produce a quarterly newsletter to be posted on the UHB intranet site, which will include up to date information on the counter fraud work currently being undertaken within the UHB.

### 2. Prevent and Deter

Deterrence is about increasing the expectation that someone will be caught if they attempt to defraud the NHS and this is more than just tough sanctions. The UHB will introduce such measures to minimise the occurrence of fraud and/or corruption, which will include, as and when required, the "fraud proofing", in conjunction with Internal Audit, of any policy or procedure to ensure that any apparent system weaknesses are identified and then rectified at an early stage and before the policy or procedure is given final approval.

The LCFS will also ensure, in conjunction with Internal and External Audit, that any areas where "Best Practice" is identified elsewhere within the UHB will be shared with relevant staff to ensure that a consistent approach is taken (e.g. timesheets, time off in lieu, annual leave, staff sickness recording).

The UHB also has policies and procedures in place to reduce the likelihood of fraud and/or corruption occurring. These include regulatory checks, which are periodically carried out by Internal and External Audit to ensure that the UHB has a System of Internal Control, Standing Financial Instructions and documented procedures, which involve physical and supervisory checks, financial reconciliations and segregation of duties are in place and there are clear and well defined statements of individual roles and responsibilities when dealing with such matters. However, where fraud and/or corruption is then subsequently found to have occurred, the UHB will ensure that any necessary changes to it's systems and procedures take place immediately, in order to prevent similar incidents from happening in the future.

### 3. Hold to Account

The UHB will develop and maintain controls to try to prevent fraud and/or corruption from occurring in the first instance and to also ensure that there are systems in place that should a fraud take place, it can be promptly detected and then immediately referred to the Nominated Lead LCFS for further investigation.

The Nominated Lead LCFS and any supporting LCFS' will be professionally trained and accredited to carry out investigations into suspicions of fraud and/or corruption to the highest standards. In liaison with the NHS Counter Fraud Authority, the LCFS' will professionally investigate all suspicions of fraud and/or corruption in order to identify any evidence that would either prove or disprove the allegation.

Following the conclusion of an investigation, if there is sufficient evidence that a fraud against the NHS had been committed, then all available sanctions will be considered in accordance with the guidance issued by the NHS Counter Fraud Authority - 'Applying Appropriate Sanctions Consistently'. This may include criminal prosecution, civil proceedings and/or disciplinary action (e.g. dismissal) being taken as well as a referral being made to the individual's professional or regulatory body.

Recovery of any losses incurred by the NHS will also be sought through civil proceedings, if appropriate, to ensure that any losses suffered by the UHB and/or the NHS are then returned by the perpetrator for their proper use (i.e. patient care).

## 6. ROLES AND RESPONSIBILITIES

### Role of the Cardiff and Vale University Health Board (UHB)

The UHB, like all other Health Bodies in Wales, has to comply with Directions issued to NHS Bodies 2005, by the National Assembly for Wales on Counter Fraud Measures, which came into force in 1st July 2005 and should be read in conjunction with the NHS Counter Fraud and Corruption Manual.

It is the responsibility of the UHB, through the UHB Director of Finance, in conjunction with the Nominated Lead Local Counter Fraud Specialist (LCFS), to ensure the creation of an Anti-Fraud Culture. This must be done by publicising the work of the LCFS and ensuring awareness that fraud and/or corruption will not be tolerated and appropriate action will be taken against those who are found to have perpetrated any deliberate acts of fraud against the NHS.

The UHB has a duty to ensure employees who are involved in or who are managing Internal Control systems receive adequate training and support in order to carry out their responsibilities However, responsibility for the operation and maintenance of controls falls directly to Line Managers and requires the involvement of all UHB employees.

The UHB also has a duty to ensure that it provides a secure environment in which to work, and one where people are confident to raise concerns without worrying that it will reflect badly on them. This extends to ensuring that staff feel protected when carrying out their official duties and are not placed in a vulnerable position. If staff do have concerns, about any procedures or processes that they are asked to be involved in, the UHB has a duty to ensure that those concerns are listened to and addressed. The individual staff groups will also be regularly updated, via ongoing fraud awareness sessions provided by the LCFS', as to what types of fraud could be perpetrated in the NHS. As part of the training, the staff will be given examples of fraud cases, which are already in the public domain.

**Audit Committee**

In compliance with the Secretary of State for Health Directions on Countering Fraud in the NHS, members of the Audit Committee have a duty to receive regular progress update reports, which should outline the current standing of any Counter Fraud and/or Corruption work that has been carried out within the Health Body as at the date of the meeting.

It is also the responsibility of the Audit Committee to approve this procedure and subsequent changes and also, once agreed between the UHB Director of Finance and LCFS, to approve the Counter Fraud Annual Work-plan and the Self Risk Tool (SRT) which is required to be submitted annually to NHS Counter Fraud Authority as part of the Quality Assurance process.

**Chief Executive**

The Chief Executive is liable to be called to account for specific failures in the UHB system of Internal Controls and therefore, all employees, who are involved in or who are managing Internal Control systems, should receive adequate training and support in order to carry out their responsibilities and the Chief Executive must ensure compliance.

**Director of Finance**

The Director of Finance, in conjunction with the Chief Executive, monitors and ensures compliance with Secretary of State Directions regarding countering fraud and corruption in the NHS.

The Director of Finance will, depending on the outcome of investigations (whether on an interim/ongoing or concluding basis) and/or the potential significance of suspicions that have been raised, inform the relevant senior management accordingly.
The LCFS shall be responsible, in discussion with the Director of Finance, for involving third parties, such as External Audit and/or the police at the earliest opportunity, as circumstances dictate.

The Director of Finance will inform and consult the Chief Executive in cases where the loss may be above the £15k limit or where the incident may lead to adverse publicity.

The Director of Finance will inform the Head of Internal Audit of any possible system weakness at the first opportunity. If an investigation is deemed to be appropriate, the Director of Finance will delegate the responsibility for this to the LCFS to carry out the investigation.

**Managers**

Managers must be vigilant and ensure that procedures to guard against fraud and/or corruption are followed. They should be alert to the possibility that unusual events or transactions could be symptoms of fraud and/or corruption. If they have any doubts, they must seek advice from the Nominated Lead LCFS.

Managers must instil and try to encourage an Anti-Fraud Culture within their team and ensure that information on UHB procedures and policies is made available to all employees.

All instances of actual or suspected fraud and/or corruption, which come to the attention of a Line Manager, must be reported immediately to the LCFS. It is appreciated that some employees will initially raise concerns with their manager. However, in such cases, managers must not attempt to investigate the allegation themselves; they have clear responsibility to refer the concerns to the LCFS as soon as possible.

Line Managers at all levels have a responsibility to ensure that an adequate system of Internal Control exists within their areas of responsibility and that controls operate effectively. The responsibility for the prevention and detection of fraud and/or corruption therefore primarily rests with managers, but still requires the co-operation of all employees.

As part of that responsibility, Line Managers need to:

- inform staff of the standards of behaviour expected, as part of their induction process, paying particular attention to the need for accurate completion of personal records and forms
- ensure that all employees, for whom they are accountable, are made aware of the requirements of UHB policies and procedures and have access to them
- assess the types of risk involved in the operations for which they are responsible
- ensure that adequate control measures are put in place to minimise the risks. This must include clear roles and responsibilities, supervisory checks, staff rotation (particularly in key posts), separation of duties (wherever possible), so that control of a key function is not vested in one individual, and regular reviews, reconciliations and test checks to ensure that control measures continue to operate effectively
- ensure that any use of computers by employees is linked to the performance of their duties within the UHB and not for private use other than in accordance with relevant policies
- be aware of the UHB Counter Fraud and Corruption Procedure and the rules and guidance covering the control of specific items of expenditure and receipts
- identify financially sensitive posts
- ensure that controls are being complied with
- contribute to the risk assessment of the risks and controls within their business area, which feeds into the UHB and the Welsh Assembly Government Accounting Officer's overall Statement of Accountability and Internal Control.

**Employees**

The UHB Standing Orders, Standing Financial Instructions, Policies and Procedures place an obligation on all employees, Honorary contract holders and Independent Members to act in accordance with best practice.

Employees are expected to act in accordance with the standards laid down by their professional institutes, where applicable, and have a personal responsibility to ensure that they are familiar with them.

Employees also have a duty to protect the assets of the UHB, including information, goodwill and property.

In addition, all employees have a responsibility to comply with all applicable laws and regulations relating to ethical business behaviour, procurement, personal expenses, conflicts of interest, confidentiality and the acceptance of gifts, hospitality and sponsorship.

This means, in addition to maintaining the normal standards of personal honesty and integrity, all employees should always:

- avoid acting in any way that might cause others to allege, or suspect them of, dishonesty
- behave in a way that would not give cause for others to doubt that UHB employees deal fairly and impartially with official matters
- be alert to the possibility that others might be attempting to deceive.

All employees have a duty to ensure that public funds are safeguarded, whether or not they are involved with cash or payment systems, receipts or dealing with contractors or suppliers.

If an employee suspects that there has been a fraud and/or corruption committed, or has seen any suspicious acts or events, they must report the matter to the nominated LCFS (*see LCFS heading below).* Employees should also be aware of the existence of the UHB Raising Concerns Policy, which will ensure that if a genuine concern is raised, staff will not be at risk of losing their job or suffering any form of retribution or detriment as a result.

Notwithstanding this, all employees need to be aware of their professional responsibilities and/or professional codes of conduct. The fact that an employee has raised a matter under the Raising Concerns Policy does not automatically bring exemption from further investigation under the UHB Disciplinary Policy or a simultaneous Counter Fraud investigation, into allegations of potential breaches of professional codes, serious professional misconduct and/or alleged fraudulent acts.

However, the assurance offered by the Raising Concerns Policy will not be extended to someone, who maliciously raises a matter they know to be untrue.

**Nomination of Lead Local Counter Fraud Specialist (LCFS)**

It is a requirement of the Secretary of State Directions on Countering Fraud in the NHS that each Health Body has to appoint and then nominate an individual LCFS. The LCFS' role is to ensure that all cases of actual or suspected fraud and/or corruption are notified to the Director of Finance and reported accordingly.

Where there is a need to replace an LCFS, then the NHS Counter Fraud Authority and NHS CFS (Wales) shall be notified of a suitable replacement within three (3) months of the replacement being made and in accordance with the nomination process.

**Role of the LCFS**

The NHS Counter Fraud Manual is provided to both Directors of Finance and the LCFS' and this details how counter fraud work should be delivered in order to comply with the requirements of the Directions.

The LCFS is responsible for the implementation of the National NHS Counter Fraud Strategy at a local level and the LCFS will undertake a range of activities in each of the four (4) Standards for Fraud, Bribery and Corruption (see page 5 of this pocedure).

The LCFS will:

- investigate all cases of fraud
- regularly report to the Director of Finance on the progress of any investigation
- ensure that the Director of Finance is informed about all referrals/cases
- be responsible for the day-to-day implementation of the four (4) standards relating to counter fraud and/or corruption activity and, in particular, the investigation of all suspicions of fraud
- in consultation with the Director of Finance, report any case to the relevant Operational Fraud Manager (OFM) based at NHS CFS (Wales) as agreed and in accordance with the *NHS Counter Fraud and Corruption Manual*
- report any case and the outcome of the investigation through the NHS Counter Fraud Authority case management system (FIRST)
- ensure that other relevant parties are informed, where necessary, e.g. Human Resources (HR) will be informed if an employee is the subject of a referral
- ensure that any system weaknesses, identified as part of an investigation, are followed up with management and reported to Internal Audit
- adhere to the Counter Fraud Professional Accreditation Board (CFPAB)'s Principles of Professional Conduct as set out in the *NHS Counter Fraud and Corruption Manual*
- not have responsibility for or be in any way engaged in the management of security for any NHS body
- ensure that the Director of Finance is informed of any NHS CFS (Wales) investigation, that involves the UHB, including any progress updates.
- provide a quarterly update, to the UHB Audit Committee, on any significant case progress and performance against the UHB Annual Counter Fraud Plan.
- provide the UHB Audit Committee with an Annual Report detailing the counter fraud work undertaken during the period in question
- be required to complete a Self Risk Tool (SRT) as part of the Annual Qualitative Assessment process, which can then be used by the NHS Counter Fraud Authority to determine at what level the UHB is performing in relation to its counter fraud work when this is compared to other NHS bodies in England and Wales
- proactively assist the encouragement of an Anti-Fraud Culture by undertaking work to raise fraud awareness amongst staff within the UHB.
- under delegated responsibility from the Director of Finance and in conjunction with the agreed protocol, liaise with the Director of Workforce and Organisational Development or nominated Human Resources (HR) Officer, prior to any member of staff being interviewed under caution and should it be decided that there is a need for the individual to also be subject to a disciplinary investigation. Neither the Director of Finance nor the LCFS will conduct a disciplinary investigation, but this separate investigation is to be managed by the nominated HR officer and regular meetings should then take place between the LCFS and HR to agree a suitable way forward on a case by case basis.

**Operational Fraud Managers (OFMs)**

Each regionally based Operational Fraud Manager works as part of the NHS Counter Fraud Authority, whose key objective is to combat fraud and/or corruption in the National Health Service.

**Workforce & OD**

Workforce & OD staff will liaise closely with relevant Clinical Board and Departmental Managers and the LCFS from the outset, if an employee is suspected of being involved in fraud and/or corruption, in accordance with agreed liaison protocols. Workforce and OD staff will be responsible for ensuring the appropriate use of the UHB Disciplinary Policy. The HR department will advise those, involved in the investigation on matters of employment law and other procedural matters, such as disciplinary and complaints procedures, as requested. Close liaison between the LCFS and HR staff will be essential to ensure that any parallel sanctions (i.e. criminal, civil and/or disciplinary sanctions) are applied effectively and in a co-ordinated manner.

HR staff will take steps as part of the recruitment process, in conjunction and discussion with Line Managers, to establish, as far as possible, the previous record of potential employees, as well as the veracity of required qualifications and memberships of professional bodies, in terms of their propriety and integrity.
In this regard, temporary and/or fixed-term contract employees are treated in the same manner as permanent employees.

**Information Technology (IT) Security**

The UHB IT Security Manager (or equivalent) will contact the LCFS immediately in all cases where there is suspicion that IT is being used for fraudulent purposes. HR staff will also be informed if there is a suspicion that an employee is involved.

**Internal and External Audit**

Any incident or suspicion that comes to Internal or External Audit's attention will be passed immediately to the nominated LCFS. The outcome of the investigation may necessitate further work by Internal and/or External Audit to review systems.

## 7. THE RESPONSE PLAN

**Reporting Fraud and/or Corruption**

This section outlines the action to be taken if fraud and/or corruption is discovered or suspected.

If an employee has any of the concerns mentioned in this document, they must inform the nominated LCFS and/or the Director of Finance immediately, unless of course, the Director of Finance and/or LCFS is implicated.

If that is the case, they should report the matter to the UHB Chairman or Chief Executive, who will decide on the action to be taken.

***Form 1*** provides a reminder of the key contacts and a checklist of the actions to follow if fraud and/or corruption, or other illegal acts, are discovered or suspected. Managers are encouraged to copy this to staff and to place it on staff notice boards in their department.

An employee can contact any Executive Director or Independent Member of the UHB to discuss their concerns if they feel unable, for any reason, to report the matter to the LCFS or Director of Finance. Employees can also call the NHS Fraud and Corruption Reporting Line on Free-phone 0800 028 40 60. This provides an easily accessible route for the reporting of genuine suspicions of fraud within or affecting the NHS. It allows NHS staff, who may be unsure of internal reporting procedures, to report their concerns in the strictest confidence. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

Anonymous letters, telephone calls, etc are occasionally received from individuals who wish to raise matters of concern, but not through official channels. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously.
The LCFS will make sufficient enquiries to establish whether or not there is any foundation to the suspicion that has been raised. If the allegations are found to be malicious, they will also be considered for further investigation to establish their source.

Staff should always be encouraged to report reasonably held suspicions directly to the LCFS. Staff can do this by filling in the appropriate NHS Fraud and Corruption Referral Form (***Form 2***) or by contacting the LCFS by telephone or email using the contact details supplied on ***Form 1***.

The UHB wants all it's employees to feel confident that they can expose any wrongdoing without any risk to themselves. In accordance with the provisions of the Public Interest Disclosure Act 1998, the UHB has produced a Raising Concerns Policy. This procedure is intended to complement the UHB Counter Fraud and Corruption Policy and Code of Business Conduct and ensures there is full provision for staff to raise any concerns with others if they do not feel able to raise them with their Line Manager.

**Disciplinary Action**

The UHB Disciplinary Policy must be followed if an employee is suspected of being involved in a fraudulent or otherwise illegal act.

It should be noted, however, that the duty to follow disciplinary procedures will not override the need for legal action to be taken (e.g. consideration of criminal action). In the event of doubt, legal statute will prevail.

## Police involvement

In accordance with the *NHS Counter Fraud and Corruption Manual*, the Director of Finance, in conjunction with the LCFS, will decide whether or not a case should be referred to the police. Any referral to the police will not prohibit action being taken under the local disciplinary procedures of the UHB.

## Managing the investigation

The LCFS, in consultation with the UHB Director of Finance, will investigate an allegation in accordance with procedures documented in the *NHS Counter Fraud and Corruption Manual* issued by the NHS Counter Fraud Authority.

All employees who are under investigation have a right to be represented at internal disciplinary interviews by a Trade Union Representative or accompanied by a friend, colleague or any other person of their choice, not acting in a legal capacity in connection with the case. Therefore, any members of staff who are under investigation which could lead to disciplinary action, do have the right to be represented at all stages. The UHB will follow its own Disciplinary Policy in association with the procedures documented in the *NHS Counter Fraud and Corruption Manual.*
In certain circumstances, evidence may best be protected if the staff member is placed on suspension. The relevant manager will decide the most appropriate course of action based on HR advice whilst the investigation into the allegation(s) takes place.

The UHB will continue to follow its own Disciplinary Policy, once it has been proven that there is evidence that an employee has committed an act of fraud and/or corruption.

## Gathering evidence

The LCFS will take control of any physical evidence, and record this in accordance with the procedures outlined in the *NHS Counter Fraud and Corruption Manual*. If evidence consists of several items, such as many documents, LCFS' should record each one with a separate reference number corresponding to the written record. Note that in criminal actions, evidence on or obtained from electronic media needs a document confirming its accuracy.

Interviews under caution or to gather evidence will only be carried out by the LCFS and if it is decided, by the LCFS, that such an interview is appropriate, then this will be carried out in accordance with the Police and Criminal Evidence Act 1984 (PACE). The LCFS will also take written statements where necessary.

All employees have a right to be represented at internal disciplinary interviews by a Trade Union Representative or accompanied by a friend, colleague or any other person of their choice, not acting in a legal capacity in connection with the case.

## 8. Recovery of losses incurred as a result of Fraud and/or Corruption

The seeking of financial redress or recovery of losses should always be considered in cases of fraud and/or corruption that are investigated by either the LCFS or NHS CFS (Wales) where a loss is identified. As a general rule, recovery of the loss caused by the perpetrator should always be sought. The decisions must be taken in the light of the particular circumstances of each case.

Redress allows resources that are lost to fraud and/or corruption to be returned to the NHS for use as intended, for provision of high-quality patient care and services.

### Reporting the results of the investigation

The investigation process requires the LCFS to review the systems in operation to determine whether there are any inherent weaknesses. Any such weaknesses identified should be corrected immediately.

If fraud and/or corruption is found to have occurred, the LCFS should prepare a report for the Director of Finance and update the UHB Audit Committee, setting out the following details:

- the circumstances
- the investigation process
- the estimated loss
- the steps taken to prevent a recurrence
- the steps taken to recover the loss.

### Action to be taken

Sections 10 and 11 of the *NHS Counter Fraud and Corruption Manual* provide in-depth details of how sanctions can be applied where fraud and/or corruption is then subsequently proven and how redress can be sought.

Actions which may be taken when considering seeking redress include:

- no further action
- criminal investigation
- civil recovery
- disciplinary action
- confiscation order under Proceeds of Crime Act (POCA) 2002
- recovery from ongoing salary payments.

To summarise, local action can be taken to recover money by using the administrative procedures of the UHB or the Civil Law.

In cases of serious fraud and/or corruption, it is recommended that parallel sanctions are applied. For example: disciplinary action relating to the status of the employee in the NHS; use of civil law to recover lost funds; and use of criminal law to apply an appropriate criminal penalty upon the individual(s), and/or a possible referral of information and evidence to external bodies – for example, professional bodies – if appropriate.

Criminal investigations are primarily used for dealing with any criminal activity. The main purpose is to determine if activity was undertaken with criminal intent. Following such an investigation, it may be necessary to bring this activity to the attention of the criminal courts (Magistrates' Court and Crown Court). Depending on the extent of the loss and the proceedings in the case, it may be suitable for the recovery of losses to be considered under POCA.

The NHS CFS (Wales) can also apply to the courts, on behalf of the Health Body, to make a restraining order or confiscation order under POCA. This means that a person's money is taken away from them if it is believed that the person benefited from the crime. It could also include restraining assets during the course of the investigation.

In some cases (taking into consideration all the facts of a case), it may be that the UHB, under guidance from the LCFS and with the approval of the Director of Finance, decides that no further recovery action is taken.

The civil recovery route is also available to the UHB if this is cost-effective and desirable for deterrence purposes. This could involve a number of options such as applying through the Small Claims Court and/or recovery through debt collection agencies. Each case needs to be discussed with the Director of Finance to determine the most appropriate action.

The appropriate Senior Manager, in conjunction with the HR department, will be responsible for initiating any necessary Disciplinary Action. Arrangements may be made to recover losses via payroll if the subject is still employed by the UHB. In all cases, current legislation must be complied with.

**Timescales**

Action to recover losses should be commenced as soon as practicable after the loss has been identified. Given the various options open to the Health Body, it may be necessary for various departments to liaise about the most appropriate option.

**Recording**

In order to provide assurance that policies were adhered to, the Director of Finance will maintain a record highlighting when recovery action was required and when the action was taken. This will be reviewed and updated on a regular basis.

## Implementation and Staff Awareness

Any newly employed UHB member of staff must be made aware, during induction, of the existence of the UHB Fraud and Corruption Procedure and their responsibilities under it, and must also have access to this document. If required, the UHB Counter Fraud staff will provide this information. It is also the Line Manager's role to ensure that all existing UHB staff be made aware that a copy of the procedure is available on the UHB intranet site and that further advice will be also disseminated to existing staff as a result of the UHB Counter Fraud staff providing regular fraud awareness sessions.

## Equality Health Impact Assessment (EHIA)

The UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups. We have undertaken an EHIA and received feedback on this procedure and the way it operates. We wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The assessment found that there was no adverse impact to the equality groups mentioned. Where appropriate we have taken the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities and human rights legislation.

## Resources and Funding

There will be no additional costs incurred by the implementation of this procedure, since there is already time accounted for and allocated within the UHB Annual Counter Fraud Work-Plan for such matters which has been agreed between the LCFS and the UHB Finance Director.

A copy of the procedure will be held on the UHB Intranet website and its contents will be brought to the attention of UHB staff as part of regular Fraud Awareness training sessions.

## Audit of the Procedure

Compliance with this procedure is to be audited by members of the UHB Counter Fraud Team when undertaking evaluation questionnaires, which are to be completed by those who attend, at the conclusion of individual Fraud Awareness sessions. In addition to this, monitoring the effectiveness of the procedure will be undertaken firstly, by members of the UHB Audit Committee, when monitoring the amount of Counter Fraud work being carried out by means of the regular progress reports submitted by the Nominated Lead LCFS; secondly as part of the Self Review Tool declarations submitted, by the Nominated Lead LCFS to the NHS Counter Fraud Authority as part of the Qualitative Assessment process and finally by the actual number of days of counter fraud work carried out within the UHB being compared, to the total number of days agreed in the UHB Annual Counter Fraud Work-Plan.

**Review of the Procedure**

It is the responsibility of the Nominated Lead LCFS of the UHB to review and update the procedure taking into account new guidelines, changes in the law, and/or recommendations arising from any subsequent audit and/or the implementation of the procedure. This will occur three (3) years from the date of final approval, but more frequently if needed.

**FORM 1**

*NHS Fraud and Corruption: dos and don'ts*
*A desktop guide for Cardiff and Vale University Health Board*

***FRAUD*** **is the deliberate or reckless intent to permanently deprive an employer of money or goods through false representation, failing to disclose information or abuse of position.**
***CORRUPTION*** **is the deliberate use of bribery or payment of benefit-in-kind to influence an individual to use their position in an unreasonable way to help gain advantage for another.**

## *DO*

- **note your concerns**

**Record details such as your concerns, names, dates, times, details of conversations and possible witnesses. Time, date and sign your notes.**

- **retain evidence**

**Retain any evidence that may be destroyed, or make a note and advise your LCFS.**

- **report your suspicion** **Confidentiality will be respected – delays may lead to further financial loss.**

**Complete a fraud report and submit in a sealed envelope marked 'Restricted – Management' and 'Confidential' for the personal attention of the LCFS.**

## *DO NOT*

- **confront the suspect or convey concerns to anyone other than those authorised, as listed below**

**Never attempt to question a suspect yourself; this could alert a fraudster or accuse an innocent person.**

- **try to investigate, or contact the police directly**

**Never attempt to gather evidence yourself unless it is about to be destroyed; gathering evidence must take into account legal procedures in order for it to be useful. Your LCFS can conduct an investigation in accordance with legislation.**

- **be afraid of raising your concerns**

**The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.**

**If you suspect that fraud against the NHS has taken place, you must report it immediately, by:**

- **directly contacting the Local Counter Fraud Specialist, or**
- **telephoning the freephone NHS Fraud and Corruption Reporting Line, or**
- **contacting the Director of Finance.**

## *Do you have concerns about a fraud taking place in the NHS?*

**If so, any information can be passed to the**

**NHS Fraud and Corruption Reporting Line: 0800 028 40 60**

**All calls will be treated in confidence and investigated by professionally trained staff**

**Your Nominated Lead Local Counter Fraud Specialist is CRAIG GREENSTOCK, who can be contacted by telephoning 02921 836265, or emailing craig.greenstock@wales.nhs.uk**

**If you would like further information about the NHS Counter Fraud Service, please visit www.nhsbsa.nhs.uk/fraud**

***Protecting your NHS***

**FORM 2**

**NHS Fraud and Corruption Referral Form**

**Under no circumstances should this report, which contains personal details, be transmitted electronically.**

*All referrals will be treated in confidence and investigated by professionally trained staff*

**Note:** ***Referrals should only be made when you can substantiate your suspicions with one or more reliable pieces of information. Anonymous applications are accepted but may delay any investigation.***

1. ***Date***

2. ***Anonymous application <Delete as appropriate>***
   *Yes (If 'Yes' go to section 6) or No (If 'No' complete sections 3–5)*

3. ***Your name***

4. ***Your organisation/profession***

5. ***Your contact details***

6. ***Suspicion***

7. ***Please provide details including the name, address and date of birth (if known) of the person to whom the allegation relates.***

8. ***Possible useful contacts***

9. **Please attach any available additional information.**

Submit the completed form (in a sealed envelope marked 'Restricted – Management' and 'Confidential') for the personal attention of **CRAIG GREENSTOCK**, the nominated LCFS for **CARDIFF AND VALE UNIVERSITY HEALTH BOARD**.

# Equality & Health Impact Assessment for

# Generic EHIA for Administrative Type Policies

| | | |
|---|---|---|
| **1.** | For service change, provide the title of the Project Outline Document or Business Case and Reference Number | This EHIA has been designed for administrative type policies only. |
| **2.** | Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details | Executives - Finance<br><br>Craig Greenstock 02921 836265 |
| **3.** | Objectives of strategy/ policy/ plan/ procedure/ service | As stated in the individual policies |
| **4.** | Evidence and background information considered. For example<br>• population data<br>• staff and service users data, as applicable<br>• needs assessment<br>• engagement and involvement findings<br>• research<br>• good practice guidelines<br>• participant knowledge<br>• list of stakeholders and how stakeholders have engaged in the | • Not applicable<br>• See Addendum 1 for staffing profile<br>• As an Administration Policy as opposed to a clinical policy, it was unnecessary to undertake a needs assessment.<br>• It is good practice for staff to consider similar policies from other organizations.<br>• Many admin and governance type policies are based on model policies and guidance.<br>• Stakeholders were not engaged in the EHIA and/or policy development but have previously been consulted in order to |

| | | |
|---|---|---|
| | development stages<br>• comments from those involved in the designing and development stages<br><br>Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2]. | share views. |
| **5.** | Who will be affected by the strategy/ policy/ plan/ procedure/ service | Staff, Patients, NHS Contractors, members of the public and other external contractors who provide goods and services to the UHB. |

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

## 6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

| **How will the strategy, policy, plan, procedure and/or service impact on:-** | **Potential positive and/or negative impacts** | **Recommendations for improvement/ mitigation** | **Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| **6.1 Age**<br>For most purposes, the main categories are:<br>• under 18;<br>• between 18 and 65; and<br>• over 65 | There does not appear to be any impact. | n/a | n/a |
| **6.2 Persons with a disability as defined in the Equality Act 2010**<br>Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes | The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy would be made accessible to all staff | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate.<br>Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| **6.3 People of different genders:**<br>Consider men, women, people undergoing gender reassignment<br><br>**NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender | There appears not to be any impact on staff regarding gender. | | |
| **6.4 People who are married or who have a civil partner.** | There appears not to be any impact. . | | |
| **6.5 Women who are expecting a baby, who are** | There appears not to be any impact on staff. | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate.<br>Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| **on a break from work after having a baby, or who are breastfeeding.** They are protected for 26 weeks after having a baby whether or not they are on maternity leave. | | | |
| **6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers** | There appears not to be any impact on staff regarding race, nationality, colour, culture or ethnic origin. | Whilst there doesn't appear to be any impact, if a member of staff was known to have difficulties with the written word, good management would dictate that alternative arrangements be made, such as individual meetings. | All departments to be aware of their staff profiles. |
| **6.7 People with a religion or belief or with no religion or belief**.<br>The term 'religion' includes a | It is unlikely to be any impact on staff regarding their religion. | Staff are able to raise any issues with their line manager/Human | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate.<br>Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| religious or philosophical belief | | Resources. | |
| **6.8 People who are attracted to other people of**:<br>• the opposite sex (heterosexual);<br>• the same sex (lesbian or gay);<br>• both sexes (bisexual) | There appears not to be any impact on staff. | | |
| **6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design**<br><br>Well-being Goal – A Wales of vibrant culture and thriving Welsh language | | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate.<br>Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| **6.10 People according to their income related group:** Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health | There appears not to be any impact on staff. | | |
| **6.11 People according to where they live:** Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities | There appears not to be any impact on staff. | | |
| **6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service** | There are no other groups including Carers or risk factors to take into account with regard to this Policy. | | |

**7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?**

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

| **How will the strategy, policy, plan, procedure and/or service impact on:-** | **Potential positive and/or negative impacts and any particular groups affected** | **Recommendations for improvement/ mitigation** | **Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| **7.1 People being able to access the service offered:** Consider access for those living in areas of deprivation and/or those experiencing health inequalities<br><br>Well-being Goal - A more equal Wales | As an administrative Policy, there will be no impact. | | |
| **7.2 People being able to improve /maintain healthy lifestyles:** Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking | As an administrative Policy, there will be no impact. | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts and any particular groups affected | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate<br>Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc<br><br>Well-being Goal – A healthier Wales | | | |
| **7.3 People in terms of their income and employment status:**<br>Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions | As an administrative Policy, there will be no impact. | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts and any particular groups affected | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate<br>Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| Well-being Goal – A prosperous Wales | | | |
| **7.4 People in terms of their use of the physical environment:**<br>Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces<br><br>Well-being Goal – A resilient Wales | As an administrative Policy, there will be no impact. | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts and any particular groups affected | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate<br>Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| **7.5 People in terms of social and community influences on their health:**<br>Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos<br><br>Well-being Goal – A Wales of cohesive communities | As an administrative Policy, there will be no impact. | | |
| **7.6 People in terms of macro-economic, environmental and sustainability factors:**<br>Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate<br>Well-being Goal – A globally responsible Wales | As an administrative Policy, there will be no impact. | | |

**Please answer question 8.1 following the completion of the EHIA and complete the action plan**

| | |
|---|---|
| **8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service** | Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of administrative type policies. |

## Action Plan for Mitigation / Improvement and Implementation

| | Action | Lead | Timescale | Action taken by Clinical Board / Corporate Directorate |
|---|---|---|---|---|
| **8.2 What are the key actions identified as a result of completing the EHIA?** | If a member of staff was known to have difficulties with the written word, good management would dictate that alternative arrangements be made, such as individual meetings.<br>Staff are able to raise any issues with their line manager/Human Resources. | Line Manager as applicable | Depending on individual need | Action in accordance with UHB Employment Policies and Procedures such as the Dignity at Work Policy and to follow advice from Human Resources |
| **8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required?**<br><br>This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required? | As there has been potentially very limited impact identified, it it is unnecessary to undertake a more detailed assessment and formal consultation is not required. | | | |

| | Action | Lead | Timescale | Action taken by Clinical Board / Corporate Directorate |
|---|---|---|---|---|
| **8.4 What are the next steps?**<br><br>Some suggestions:-<br>• Decide whether the strategy, policy, plan, procedure and/or servi proposal:<br>○ continues unchanged as there are no significant negative impacts<br>○ adjusts to account for the negative impacts<br>○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)<br>○ stops.<br>• Have your strategy, policy, plan, procedure and/or service proposal approved<br>• Publish your report of this impact assessment<br>• Monitor and review | The Policy remains unchanged. T EHIA has been consulted upon internally as a generic document to support a variety of administrative-type policies and procedures.<br>When an administrative-type policy is developed or reviewed, tl EHIA will form part of that consultation exercise and publication. This EHIA will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required. The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement). | | | |

# Mental Health Clinical Board – Third Sector Contracts

## Final Internal Audit Report

## Cardiff and Vale University Health Board

## 2019/20

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



| | |
|---|---|
| **Review reference:** | C&V1920-29 |
| **Report status:** | Final Internal Audit Report |
| **Fieldwork commencement:** | 7th August 2019 |
| **Fieldwork completion:** | 23rd September 2019 |
| **Draft report issued:** | 2nd October 2019 |
| **Management response received:** | 22nd October 2019 |
| **Final report issued:** | 31st October 2019 |
| **Auditors:** | Ian Virgill, Stuart Bodman |
| **Executive sign off:** | Steve Curry, Chief Operating Officer |
| **Distribution:** | Ian Wile, Director of Operations |
| | Tracey Porter, Service Development Manager |
| **Committee:** | Audit Committee |

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

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

**Disclaimer notice - Please note:**

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

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

## 1. Introduction and Background

The review of third sector contracts within the Mental Health Clinical Board was completed in line with the 2019/20 Internal Audit Plan for Cardiff and Vale University Health Board.

Fundamental to the delivery of the Health Board's 'Shaping Our Future Wellbeing Strategy' is the principle of co-production and working more collaboratively with communities and partners, including the third sector.

The Mental Health Clinical Board contracts with a number of third sector organisations working in the field of mental health, to deliver services on its behalf.

The relevant lead Executive Director for this review is the Chief Operating Officer.

## 2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Mental Health Clinical Board for the management of third sector contracts, in order to provide reasonable assurance to the Health Board's Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review was to establish if appropriate processes are in place to ensure that all third sector contracts are appropriately awarded and performance is managed.

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

- The Clinical Board has appropriate policies and procedures in place for the management of third sector contracts;
- Appropriate specifications are produced prior to contracting for the provision of services by the third sector;
- Effective stakeholder engagement and consultation is undertaken as part of the process for developing specifications;
- All third sector contracts are awarded on the basis of a robust quotation/competitive tendering exercise in accordance with the Health Board's Standing Financial Instructions (SFIs); and
- Robust performance management arrangements are in place for all awarded contracts to ensure contracts to ensure that the third sector providers are delivering to the required level and quality.

Six third sector contractors were sampled from the Mental Health Clinical Board 3rd Sector Organisation Commissioning spreadsheet for 2019, namely;

- Ace - Tier Zero Cardiff East, West, North and Southwest
- Cardiff MIND - Community Opportunity Services

- Mind in the Vale (MITV) - Tier Zero Vale Locality
- Gofal - Crisis House
- 4 Winds - Drop In/Resource Centre
- Alzheimer's Society - Carers Support & Dementia Training

### 3. Associated Risks

- Contracts are put in place that do not meet the needs of the Health Board or service users;
- Non-compliance with SFI's; and
- Services are not delivered to the required level and/or quality.

## 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 Clinical Board – Third Sector Contracts is **Substantial assurance**.

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

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

In summary, Third Sector contracts are being managed effectively and in accordance with the Clinical Board's policies and procedures and the Health Board's Standing Orders and SFIs.

The Clinical Board's framework and guidance in respect of the management and oversight of Third Sector contracts is current, but does

require revision to include escalation processes in the event that contractual service delivery issues cannot be resolved at a local level.

Appropriate contract specification documents are produced prior to the completion of competitive tendering and contract awarding processes, both of which are undertaken in compliance with the UHB SFIs.

Testing also identified that bi-annual performance management monitoring and annual governance monitoring is being undertaken on third sector contracts, in accordance with the Clinical Board's procedures and framework.

One additional issue that requires management action was identified relating to an absence of evidence to comprehensively support stakeholder's involvement in the drafting of third sector service specifications.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | Policies & Procedures | | | ✓ | |
| **2** | Prior to contract specifications | | | | ✓ |
| **3** | Stakeholder Engagement & Consultation | | | | ✓ |
| **4** | Quotations & Tendering | | | | ✓ |
| **5** | Performance Management of Contracts | | | | ✓ |

** 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 Mental Health Clinical Board – Third Sector Contracts.

### Operation of System/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the operation of the designed system/control for Mental Health Clinical Board – Third Sector Contracts.

## 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 Clinical Board has appropriate policies and procedures in place for the management of third sector contracts.**

The following area of good practice was noted:

- The Mental Health Clinical Board has current guidance in place for the management of third sector contracts that covers all stages from contract specification through to delivery and performance management.

The following findings was noted:

- No processes are stated within the 'Third Sector Mental Health Providers – Contracting and Performance Management Arrangements' document or the 'Mental Health Third Sector Commissioning Guide' in respect of escalation of issues in the event of non-compliance.

**Objective 2: Appropriate specifications are produced prior to contracting for the provision of services by the third sector.**

The following area of good practice was noted:

- All six sampled contracts held appropriate specifications which were produced prior to contracting for the provision of services by the third sector.

We did not identify any findings under this objective.

**Objective 3: Effective stakeholder engagement and consultation is undertaken as part of the process for developing specifications.**

The following area of good practice was noted:

- Processes are in place to allow for engagement with key stakeholders prior to the production of specifications for third sector contracts.

The following finding was noted:

- There is an absence of evidence to confirm that detailed and comprehensive stakeholder engagement and input into the development of contract specifications was undertaken for the sampled contracts.

**Objective 4: All third sector contracts are awarded on the basis of a robust quotation / competitive tendering exercise in accordance with the Health Board's Standing Financial Instructions (SFIs).**

The following area of good practice was noted:

- All six sampled contracts were supported by a competitive tendering, evaluation and contract awarding exercise that had been undertaken in accordance with the UHB SFIs.

We did not identify any findings under this objective.

**Objective 5: Robust performance management arrangements are in place for all awarded contracts to ensure that the third sector providers are delivering to the required level and quality.**

The following areas of good practice were noted:

- All six sampled contracts were subject to effective bi-annual performance management monitoring and annual governance monitoring, in accordance with the Clinical Board's procedures.

We did not identify any findings under this objective.

## 7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

| Priority | H | M | L | Total |
|---|---|---|---|---|
| **Number of recommendations** | **0** | **1** | **1** | **2** |

| Finding 1 - Escalation of performance and/or service delivery issues. (Control design) | Risk |
|---|---|
| Whilst the Clinical Board has comprehensive procedures in place that cover all stages relating to commissioning, contracting and performance management arrangements in respect of Third Sector contracts, these omit processes that relate to the escalation of unresolved performance and/or service delivery issues in the event of non-compliance of terms stated within the provider contacts. | Contracts are put in place that do not meet the needs of the Health Board or service users. |
| **Recommendation** | **Priority level** |
| 'Third Sector Mental Health Providers – Contracting and Performance Management Arrangements' document and 'Mental Health Third Sector Commissioning Guide' should be revised to state the processes in place in respect of escalation of unresolved performance and/or service delivery issues in the event of non-compliance of terms stated within provider contacts. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Third Sector Commissioning Guide and Framework (revised) to reflect recommendation<br>(Attached with this report) | Tracey Porter - Completed |

| Finding 2 - Retention of Stakeholder engagement and consultation documentation (Operating effectiveness) | Risk |
|---|---|
| Whilst all six sampled contracts are supported by some evidence of stakeholder consultation and engagement during the initial development of contract specifications that go back to the legacy Local Health Board arrangements, any recent changes to the service specifications cannot be fully evidenced due to damage to the previous Service Development Manager's computer hard drive which resulted in the loss of evidence that would fully support this. | Contracts are put in place that do not meet the needs of the Health Board or service users. |
| **Recommendation** | **Priority level** |
| All future stakeholder engagement and consultation documentation should be retained and held with the contract specification documentation. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| A new cycle of commissioning will begin in 2020 and the recommendation is noted and will be included in all future commissioning/tender processes. | Tracey Porter<br>Commissioning/Tender Process<br>June 2020 |

## Appendix B - Assurance opinion and action plan risk rating

### Audit Assurance Ratings

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

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

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

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

### Prioritisation of Recommendations

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

| Priority Level | Explanation | Management action |
|---|---|---|
| **High** | Poor key control design OR widespread non-compliance with key controls.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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

# Claims Reimbursement

## Final Internal Audit Report

## Cardiff and Vale UHB

## November 2019/20

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



**Review reference:** C&V-1920-02

**Report status:** Final
**Fieldwork commencement:** 13th November 2019
**Fieldwork completion:** 14th November 2019
**Draft report issued:** 22nd November 2019
**Management response received:** 24th November 2019
**Final report issued:** 25th November 2019

**Auditor/s:** Cara Vernon, Internal Auditor

**Executive sign off:** Ruth Walker, Executive Nurse Director

**Distribution:** Angela Hughes, Assistant Director of Nursing
Suzanne Wicks, Claims Manager
Karen Lewis, Claims Manager

**Committee:** Audit Committee

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

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

## 1. Introduction and Background

The review of the claims reimbursement process was completed in line with the Internal Audit Plan. The review sought to provide the Health Board with assurance on compliance with Area for Assessment 23 of the Welsh Risk Pool (WRP) Concerns and Compensation Claims Management Standard.

The current review covered claims that have been submitted from April to 30th September 2019, prior to the introduction of changes to the WRP reimbursement process on 1st October 2019.

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

## 2. Scope and Objectives

The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of claims reimbursement, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review was to provide assurance to the Audit Committee that the claims reimbursement process is in compliance with the requirements of the Welsh Risk Pool Standard.

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

- Appropriate and accurate completion and authorisation of Appendix V Cost Schedules by the Claims Manager.
- Appendix T Checklists are completed by the Claims Manager and signed by the Chief Executive and Nurse Director (or a delegated person); and forwarded to the Welsh Risk Pool.
- All claims submitted are accurately entered onto the DATIX Risk Management Database.

## 3. Associated Risks

The potential risk considered in this review is as follows:

- Claims costs reimbursed from the Welsh Risk Pool are inaccurately recorded and are not appropriately authorised by Health Board senior management.

## OPINION AND KEY FINDINGS

## 4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Claims Reimbursement is **Substantial Assurance**.

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

The audit identified that the Health Board's claims reimbursement process is undertaken in compliance with Assessment Area 23 of the Welsh Risk Pool (WRP) Concerns and Compensation Claims Management Standard and the Organisational Claims Handling Policy and Procedure.

For the sample of reimbursed claims reviewed audit found that the above guidance and procedure had been followed.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | Appendix U Cost Schedules | | | | ✓ |
| **2** | Appendix S Checklists | | | | ✓ |
| **3** | Datix Risk Management | | | | ✓ |

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

### Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the system control/design for Claims Reimbursement.

### 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 Claims Reimbursement.

## 6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork.

**Objective 1: Appropriate and accurate completion and authorisation of Appendix U Cost Schedules by the Claims Manager.**

We note the following areas of good practice:

- For the claims reviewed, audit found that the Appendix U Cost schedules had been accurately completed and authorised by either Cardiff and Vale's Claims Manager or Redress Lead.

There were no significant findings identified.

**Objective 2: Appendix S Checklists are completed by the Claims Manager and signed by the Chief Executive and Nurse Director (or a delegated person); and forwarded to the Welsh Risk Pool**

The following area of good practice was noted:

- For the claims reviewed audit found that the Appendix S checklists had been fully and correctly completed. The checklists were signed and appropriately authorised.

There were no significant findings identified.

**Objective 3: All claims submitted are accurately entered onto the DATIX Risk Management Database**

The following area of good practice was noted:

- All claims reviewed were accurately recorded on the Datix risk management database.
- Audit was able to evidence confirmation of the reimbursement to the Health Board by the Welsh Risk Pool
- Relevant documentation had been electronically filed onto Datix

There were no significant findings identified.

## 7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

| Priority | H | M | L | Total |
|---|---|---|---|---|
| **Number of recommendations** | **0** | **0** | **0** | **0** |

# 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.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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

# Cardiff & Vale University Health Board

# Private and Overseas Patients

# Final Internal Audit Report

# 2019/20

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



| | |
|---|---|
| **Review reference:** | C&V-1920-17 |
| **Report status:** | Final Internal Audit Report |
| **Fieldwork commencement:** | 26th July 2019 |
| **Fieldwork completion:** | 13th September 2019 |
| **Draft report issued:** | 24th September 2019 |
| **Management response received:** | 14th October 2019 |
| **Final report issued:** | 21st October 2019 |
| **Auditors:** | Ian Virgill, Stuart Bodman |
| **Executive sign off:** | Dr. Stuart Walker, Medical Director |
| **Distribution:** | Bob Chadwick, Director of Finance |
| | Paul Emmerson, Finance Manager - Resource Management |
| | Kathryn Thomas, Income Control Accountant |
| **Committee:** | Audit Committee |

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

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

**Disclaimer notice - Please note:**

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

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

## 1. Introduction and Background

The review of the Cardiff and Vale University Health Board (the UHB or the 'Health Board') Private and Overseas Patients processes was completed in line with the 2019/20 Internal Audit Plan.

The NHS provides free healthcare services to people who live in the UK. On occasions patients may be treated who do not normally live in this country and are therefore not eligible to free healthcare services. In addition, consultants may choose to undertake private work and in doing so, use NHS services and accommodation.

The relevant lead Executive Director for this review is the Medical Director.

## 2. Scope and Objectives

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

The scope of the audit was to establish if the Health Board has effective processes in place to ensure that all private and overseas patients are identified and required charges are made in order to recover relevant costs incurred.

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

- There are relevant and current policies and procedures in place setting out the processes involved in relation to private and overseas patients.
- Roles and responsibilities for the management of private and overseas patients are clearly defined.
- Information regarding potential fees are made available to patients.
- Tariffs are reviewed on a periodic basis to ensure they cover the cost of service delivery and any increases are approved.
- There are processes in place in order to identify private and overseas patients prior to being treated, and notifications and agreements of charges are in place for relevant patients.
- Overseas patients are treated in accordance with Welsh Government guidelines for EEA and non-EEA residents.
- Monitoring arrangements are in place to ensure all private and overseas patients have been identified.

Testing of processes relating to the management and application of private and overseas patients were undertaken at the following departments;

- Emergency Unit, University Hospital of Wales (UHW).
- Dermatology Directorate, UHW.

- Maternity Unit, UHW.
- Oral Surgery, University Dental Hospital (UDH).

## 3. Associated Risks

- Potential loss of income if patients are not identified as being from overseas or are privately treated.
- Non-compliance with legislation or corporate and operational policies.
- Under-recovery of costs due to incorrect tariffs.

## 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 Private and Overseas Patients is **Reasonable assurance**.

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

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

The UHB has sound structures in place that provide effective governance and oversight of the management of private and overseas patients and there are current policies and procedures posted on its intranet and internet sites. The Private and Overseas Patient Office has a formal structure, reporting and lines of accountability and the Finance Department has procedures in place that govern the management and oversight of private patients. The UHB is currently liaising with Welsh Government in

preparation for changes in overseas patient's processes arising from the UK withdrawal from the European Union.

Patient fee information and points of contacts for private and overseas patients are also stated on the UHB internet site. Testing undertaken within the sampled departments established that those patients that were charged for treatment at the point of care were done so in accordance with the appropriate 2019/20 Directorate tariff.

However, the testing of existing processes in place identified a number of areas where controls are inadequate or are not being applied consistently. Two of the four sampled departments did not hold documented procedures/staff guidance in respect of local management of overseas patients, and they also had no awareness of the UHB private and overseas patient's intranet and internet pages or the procedures and fee charges detailed within them.

Additionally, the UHB Private Patient Tariffs posted on the internet site currently state 2018/19 prices and not 2019/20 prices and there has not been a UHB wide review of overseas and private patient costs/tariffs in recent years.

The current processes in place within the Private and Overseas Patients Office for monitoring and following-up on evidence of patient's entitlement to treatment, need to be formalised and built into a regular timetable.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | Policies and Procedures | | | ✓ | |
| **2** | Roles and Responsibilities | | | | ✓ |
| **3** | Fee Information for Patients | | | ✓ | |
| **4** | Review of Tariffs and Service Delivery Costs | | | ✓ | |
| **5** | Identification and Applicability for Treatment | | ✓ | | |

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **6** | Identification and Monitoring of Charges Raised | | | ✓ | |
| **7** | Overseas Patients treated in accordance with WG Guidelines | | | | ✓ |

** 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 two issues that are classified as weaknesses in the system control/design for Private and Overseas patients.

### Operation of System/Controls

The findings from the review have highlighted five issues that are classified as weaknesses in the operation of the designed system/control for Private and Overseas patients.

## 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 relevant and current policies and procedures in place setting out the processes involved in relevant in relation to private and overseas patients.**

The following areas of good practice were noted:

- The UHB has current policies and procedures relating to private and overseas patients posted in its intranet and internet sites.
- The Finance Department has procedures in place that govern the management and oversight of private patients.
- The UHB is liaising with Welsh Government in preparation to changes in overseas patient's processes arising from the UK withdrawal from the European Union.

The following significant findings were noted:

- Only two of the four sampled areas for testing held documented procedures in respect of local management of overseas patients i.e. Emergency Oral Surgery, Dental Hospital and the Emergency Unit, UHW.
- Two of the four sampled departments had no awareness of the UHB private and overseas patients Intranet and Internet pages or the procedures in place held within them.

**Objective 2: Roles and responsibilities for the management of private and overseas patients are clearly defined.**

The following areas of good practice were noted:

- Private and Overseas Patient Office has a formal structure, reporting and lines of accountability.
- Private and overseas patient activity is reported to the UHB Finance Committee on a monthly basis.
- Cardiff and Vale UHB contributes into the Private Healthcare Information Network (PHIN).

We did not identify any findings under this objective.

**Objective 3: Information regarding potential fees is made available to patients.**

The following areas of good practice were noted:

- The Health Board has a public facing internet page for private and overseas patients which includes fee types and points of contact for enquiries.
- Private Patient 2019/20 Tariffs and current forms are available on the UHB intranet site.
- The Emergency Dental Clinic provides clearly visible and readily accessible information stating its overseas patient treatment fees.

The following significant findings were noted:

- Neither the Dermatology Directorate or the Obstetrics and Gynaecology Directorate had awareness of fee charges in place in respect of their private or overseas patients.

**Objective 4: Tariffs are reviewed on a periodic basis to ensure they cover the cost of service delivery and any increases are approved.**

The following areas of good practice were noted:

- Tariffs are reviewed annually with an inflationary uplift and agreed with insurance companies prior to publication.

The following significant findings were noted:

- The UHB Private Patient Tariffs posted on the internet site state 2018/19 prices and not 2019/20 prices.
- A UHB wide review of overseas and private patient costs/tariffs has not been undertaken in recent years.

**Objective 5: There are processes in place in order to identify private and overseas patients prior to being treated, and notifications and agreements of charges are in place for relevant patients.**

The following areas of good practice were noted:

- Good practice is noted that the Private & Overseas Patients intranet site provides baseline questions for staff to ask overseas patients so as to confirm their eligibility status.
- The A & E Department populates an Accident & Emergency Module for each patient on PMS which asks the following 2 questions "have you lived in the UK for the past 12 months" & "do you have an EHIC or PRC card?"
- Patients that were charged for treatment at the point of care were done so in accordance with the appropriate 2019/20 Directorate tariff.

The following significant findings were noted:

- Only one of the four sampled areas (Dermatology Directorate) currently does not have processes in place for overseas patients to confirm their eligibility to access healthcare when they present themselves for treatment - although it is noted that no overseas patients have been treated in 2018/19 or 2019/20.
- Private Patient Agreement and Charging Forms submitted by Consultants to the Private and Overseas Patients Office are not always the current iterations and do not reflect 2019/20 tariffs and as such there is undercharging of patients for treatments provided.
- Absence of a completed and signed Overseas Patients Notification Form submitted by a Consultant to the Private and Overseas Patients Office.
- The current processes undertaken by the Private and Overseas Patients Office in respect of letters sent to patients that have been treated but

failed to evidence their entitlement to treatment, need to be formalised and built into a regular timetable.

**Objective 6: Monitoring arrangements are in place to ensure all private and overseas patients have been identified.**

The following areas of good practice were noted:

- The Private and Overseas Patients Office has documented processes in place for the monitoring and chasing up of outstanding debtors invoices.
- Recovery measures are in place supported by reporting of aged debts to UK Borders Agency when appropriate.
- Private and overseas income is reported to the UHB Finance Committee on a monthly basis.

The following significant findings were noted:

- There is currently a lack of evidence to confirm that a quarterly reconciliation exercise is being undertaken by the Private and Overseas Patients Office in respect of private patients MS Access database to PMS and the debtors ledger.
- There is no formal, regular and routine reconciliations of the database to activity data or review of aged debt statements.

**Objective 7: Overseas patients are treated in accordance with Welsh Government guidelines for EEA and non-EEA residents.**

The following areas of good practice were noted:

- The Private and Overseas Patients Office are following Welsh Government Guidelines.

We did not identify any findings under this objective.

## 7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

| Priority | H | M | L | Total |
|---|---|---|---|---|
| **Number of recommendations** | **1** | **6** | **0** | **7** |

| Finding 1 - Private Patient Agreement and Charging Forms (Operating effectiveness) | Risk |
|---|---|
| Testing was undertaken on a sample of private patients across the three sampled Directorates to ascertain whether the current Private Patient Agreement and Charging Forms that include 2019/20 tariffs were in use, and each were accurately invoiced.<br><br><u>Dermatology</u><br><br>8 of 10 sampled Private Patient Agreement and Charging Forms used by Consultant Dermatologists and submitted to the Private and Overseas Patients Office were not in the 2019/20 format as posted on the intranet site and of these 8 forms, 6 of the charges levied were understated by a total of £38 due to the use of out of date tariffs.<br><br><u>Obstetrics & Gynaecology</u><br><br>The sole Obstetrics and Gynaecology Private Patient Agreement and Charging Form submitted to the Private and Overseas Patients Office was not in the 2019/20 format as posted on the intranet site.<br><br>The clinical procedure undertaken and charge levied was not stated on the Directorate's Tariff list so it could not be determined whether the charge was correct.<br><br><u>Oral Surgery, UDH</u><br><br>7 of 10 sampled Private Patient Agreement and Charging Forms used by Consultant Oral Surgeons and submitted to the Private and Overseas Patients Office were not in the 2019/20 format as posted on the intranet site, 2 of the charges levied were understated by a total £3 due to the use of out of date tariffs. | Potential loss of income if patients are not identified as being from overseas or are privately treated. |

| | |
|---|---|
| It is however noted that of the total sample of 21 forms, all were supported by invoices sent to the patients/insurance companies. | |
| **Recommendation** | **Priority level** |
| All Directorates should be informed of the current Private Patient Agreement and Charging Forms that include 2019/20 tariffs and ensure that their respective Consultants who undertake private work should be using these forms and not those that relate to previous financial years so as to ensure accurate billing and recovery of Directorate costs incurred. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| The UHB updates the private patient tariffs and agreement forms on its intranet and internet sites on an annual basis. Past changes to private patient requirements have been communicated through the UHB News Service and the Medical Directors Bulletin. The UHB's internet page has recently been updated to include the 2019/20 Private Patient Tariff.<br><br>Moving forwards all Directorates will be notified of the current Private Patient Agreement and Charging Forms that include up to date tariffs on an annual basis to ensure that their respective Consultants who undertake private work are using the correct forms and not those that relate to previous financial years.<br><br>A note will be relayed to all Directorates and the UHB News Service by the end of December 2019 to confirm where the relevant private patient forms and tariffs for 2019/20 can be found. | Paul Emmerson/ Kathryn Thomas<br><br>December 2019 |

| Finding 2 - Absence of awareness of Private and Overseas Patients Policies and Procedures (Operating effectiveness) | Risk |
|---|---|
| Only two of the four sampled areas for testing held documented procedures in respect of local management of overseas patients i.e. Emergency Oral Surgery, Dental Hospital and the Emergency Unit, UHW.<br>Two of the four sampled departments (Maternity, UHW and Dermatology Directorate) had no awareness of the UHB private and overseas patients Intranet and Internet pages or the procedures in place held within them. | Non-compliance with legislation or corporate and operational policies. |
| **Recommendation** | **Priority level** |
| The Private and Overseas Patients Office should promote and increase awareness relating to the existence of its intranet and internet web pages if it is to ensure that all UHB Directorates/Departments are conversant with the contents of its policy, procedures and their supporting documentation. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| The Private and Overseas Patients Office will promote the existence of its intranet and internet web pages directly to Directorates by the end of November 2019 and annually thereafter.<br>In addition a short note providing an overview of policy and procedures will be produced by the end of 2019/20 for distribution to Directorates on an annual basis. | Paul Emmerson/ Kathryn Thomas<br>November 2019 |

| Finding 3 - Tariffs and Service Delivery Costs (Control design) | Risk |
|---|---|
| Whilst it is noted that private and overseas patient tariffs are reviewed annually, uplifted for inflation and then agreed with insurance companies prior to publication; there has been no UHB wide costing exercise undertaken in recent years to ensure that private and overseas patient costs/tariffs are fully current and accurately reflect service delivery costs.<br><br>Additionally, Private Patient tariffs currently posted on the internet site state 2018/19 prices and have not been updated to reflect 2019/20 prices.<br><br>It is noted, however, that 2019/20 tariffs are posted on the intranet site. | Under-recovery of costs due to incorrect tariffs. |
| **Recommendation** | **Priority level** |
| The UHB Overseas and Private Patient internet pages should be updated to include the 2019/20 Private Patient Tariffs. ~~and~~<br><br>Given that a review of overseas and private patient tariffs has not been completed for a number of years, it is advisable that the UHB's Costing Team and Clinical Boards should liaise to undertake this exercise as soon as is practicable so as to ensure that service delivery costs are fully recovered. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| The UHB Overseas and Private Patient internet page has now been updated to include the 2019/20 Private Patient Tariffs.<br><br>The UHB's Costing Team and Clinical Boards should will be engaged so that a | Kathryn Thomas - Completed<br><br>Paul Emmerson - March 2020 |

| | |
|---|---|
| scope for the review of all tariffs can be agreed by the end 2019/20 with the aim of implementing the reviewed tariffs at the beginning of 2020/21. | |

| **Finding 4 - Availability and Access to Fee Information by Staff and Patients (Operating effectiveness)** | **Risk** |
|---|---|
| Two of the four sampled departments (Dermatology and Obstetrics & Gynaecology) had no awareness of the existence of the patient fee information or the Trust Private and Overseas Patient internet and intranet pages.<br><br>Testing identified that whilst the Emergency Dental Clinic overseas patients' charges are current per Welsh Government Guidelines and are made accessible to all patients at the Reception Desk, the private outpatient charging forms used by Consultants are dated 2015 and the costs stated on these forms are four years out of date. As such, the department has been under-recovering its costs for the past three years. The results of our sample testing would however indicate that the level of under charging is not significant.<br><br>It is unclear why these forms were not updated to reflect the uplift in costs over the previous three year period. | Under-recovery of costs due to incorrect tariffs. |
| **Recommendation** | **Priority level** |
| Private and Overseas Patients Office should ensure that fee information is made known to Directorates/Department at the commencement of each new financial year so as to maximise an increased awareness of its existence and use when required. | **Medium** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| Moving forwards all Directorates will be notified of the current Private Patient Agreement and Charging Forms that include up to date tariffs on an annual basis ensure that their respective Consultants who undertake private work are using the correct forms and not those that relate to previous financial years.<br>In addition a general notice will be published via the UHB news service. | Paul Emmerson<br>December 2019 |

| Finding 5 - Dermatology Directorate : Management of Overseas Patients (Control design) | Risk |
|---|---|
| The Dermatology Directorate currently has no formal processes in place for staff to follow to ascertain and confirm overseas patient eligibility to access healthcare when they present themselves for treatment.<br>It is noted that no charges have been identified for the treatment of any overseas patients by the Directorate during 2018/19 or 2019/20, | Potential loss of income if patients are not identified as being from overseas or are privately treated. |
| **Recommendation** | **Priority level** |
| The Private patient office should ensure that the Dermatology Directorate introduce formal processes to identify, ascertain and confirm overseas patient eligibility to access healthcare if they attend the clinics. | **Medium** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| The Private Patient and Overseas Office will advise the Dermatology Directorate of the formal processes to identify, ascertain and confirm overseas patient eligibility to access healthcare provided by the UHB by the end of November 2019.<br><br>In addition the Office will offer to meet the Directorate and provide staff training if required. | Paul Emmerson - November 2019 |

| Finding 6 - Directorate management of Overseas Patients legitimacy to access treatment. (Operating effectiveness) | Risk |
|---|---|
| Testing was undertaken to ascertain whether appropriate residency checks were undertaken in each of the three sampled Directorates to confirm that overseas patients were entitled to access treatment between April and August 2019, and where appropriate charging was undertaken for those who are not entitled to free NHS care.<br><br><u>Dermatology</u><br><br>It is noted that no overseas patients have been submitted to Private Patients Office as at August 2019, nor have any been recorded on PMS which corroborates with the conversations held with Dermatology Directorate Management.<br><br><u>Obstetrics & Gynaecology</u><br><br>Good practice is noted that all 10 sampled Obstetrics & Gynaecology patients were supported by a completed and signed Overseas Patients Notification Form submitted by the Consultant | Potential loss of income if patients are not identified as being from overseas or are privately treated. |

| | |
|---|---|
| However, 4 of the 10 sampled patients could not provide evidence of their residency entitlement to access treatment. All of these were written to by the Private Patients Office but no replies have been forthcoming since letters were sent in May and June 2019.<br><br><u>Oral Surgery, UDH</u><br><br>9 of the 10 sampled Oral Surgery patients were supported by a completed and signed Overseas Patients Notification Form submitted by the Consultant Oral Surgeon. 1 patient file could not be located for review.<br><br>However, 1 of the 9 patients could not provide evidence of their residency entitlement to access treatment and this patient was written to on 12th August 2019, but no reply was provided to Private and Overseas Patients Office at the time of the Audit.<br><br>Review of the processes within the Private and Overseas Patients Office identified that they are not routinely and regularly monitoring and following upon the letters sent to those overseas patients that have received treatment and have not provided appropriate residency documentation to evidence their entitlement to free NHS care and have not replied.<br><br>The Private and Overseas Patients Office have processes in place for monitoring and following up on the letters sent to those overseas patients that have received treatment and have not provided appropriate residency documentation to evidence their entitlement to free NHS care and have not replied. However the processes are currently ad hoc and are not formalised or scheduled into a regular timetable.<br><br>Without a regular and formalised process the UHB may not be complying with the requirements of the Welsh Government 'Implementing the Overseas Visitors | |

| | |
|---|---|
| Hospital Charging Regulations' and may be failing to recover treatment costs incurred in respect of those patients. | |
| **Recommendation** | **Priority level** |
| The Private and Overseas Patients Office should remind Directorates that an Overseas Patients Notification Form must be completed by the Consultant and submitted to the Private and Overseas Patients Office for each overseas patient seen, supported with documentary evidence of their residency entitlement to access free NHS treatment.<br><br>The Private and Overseas Patients Office should formalise and regularly timetable the current processes to monitor and follow up on letters sent to those overseas patients that have received treatment and have not provided appropriate residency documentation to evidence their entitlement to free NHS care. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| The Private and Overseas Patients Office will write to remind all Directorates that an Overseas Patients Notification Form along with any documentary evidence of their residency entitlement or insurance details must be completed by the Care Team and submitted to the Private and Overseas Patients Office for each overseas patient seen.<br><br>The Private and Overseas Patients Office will formalise and regularly timetable the current processes to monitor and follow up on letters sent to those overseas patients that have received treatment and have not provided appropriate residency documentation to evidence their entitlement to free NHS care. | Paul Emmerson December 2019 |

| Finding 7 - Private Patient Income Reconciliation Exercises (Operating effectiveness) | Risk |
|---|---|
| Good practice is noted that the Private and Overseas Patients Office has documented processes in place for the monitoring and chasing up of outstanding debtors invoices and recovery measures are in place supported by reporting of aged debts to UK Borders Agency when appropriate.<br><br>However, testing identified that there is insufficient documentary evidence to verify that reconciliation exercises are being undertaken as stated in Section 5.2 of the Private Patients Procedure whereby;<br><br>• 'All private patients invoices are logged on an MS Access database which is reconciled quarterly to PMS and the financials debtors ledger'; and<br><br>• 'Reconciliations of the database to activity data and review of aged debt statements are undertaken periodically'. | Potential loss of income if patients are not identified as being from overseas or are privately treated. |
| **Recommendation** | **Priority level** |
| The Private and Overseas Patients Office should implement and evidence documented quarterly reconciliation exercises in respect of its MS Access database to PMS and the debtors' ledger and of the database to activity data or review of aged debt statements as per the stated requirements of the Private Patients Procedure. | **Medium** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| The Private and Overseas Patients Office will implement a Control Pack that evidences: quarterly reconciliation exercises in respect of the MS Access database; PMS and the debtors' ledger; the database to activity data; and a review of aged debt statements. | Paul Emmerson December 2019 |

# 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.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

## Cardiff and Vale University Health Board

# Surgery Clinical Board – Medical Finance Governance Follow-Up

## Final Internal Audit Report

## 2019/20

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



| | |
|---|---|
| **Review reference:** | C&V-1920-37 |
| **Report status:** | Final Internal Audit Report |
| **Fieldwork commencement:** | 3rd September 2019 |
| **Fieldwork completion:** | 23rd September 2019 |
| **Draft report issued:** | 1st October 2019 |
| **Management response received:** | 22nd October 2019 |
| **Final report issued:** | 31st October 2019 |
| **Auditor/s:** | Ian Virgill, Lucy Jugessur |
| **Executive sign off:** | Steve Curry, Chief Operating Officer |
| **Distribution:** | Mike Bond, Director of Operations<br>Tina Bayliss, Deputy Director of Operations<br>Emma Wilkins, Interim Service Manager |
| **Committee:** | Audit Committee |

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

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

## 1. Introduction and Background

The follow-up review of Surgery Clinical Board Medical Finance Governance was completed in line with the 2019/20 Internal Audit Plan.

The relevant lead Executive for the assignment is the Chief Operating Officer.

The original Surgery Clinical Board Medical Finance Governance report was finalised in February 2019 and highlighted a total of 6 issues which resulted in an overall assurance rating of limited assurance.

## 2. Scope and Objectives

The objective of the original review was to evaluate and determine the adequacy of the systems and controls in place within the Surgery Clinical Board for the management of Medical Finance governance, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The purpose of the follow up review was to establish if the previously agreed management actions have been implemented, in order to ensure that the Health Board has appropriate processes in place within the Clinical Board to ensure that Medical staff time and costs are appropriately monitored and controlled.

As per the original audit, the follow-up review focussed on the Ophthalmology and General Surgery Directorates.

In following up the agreed actions the main areas that the review sought to provide assurance on were:

- There are appropriate local procedures and processes in place for the management of medical staff time that are in line with the relevant Health Board policies and procedures and Welsh Government (WG) guidance;
- Consultant staff are appropriately working the required core contracted hours as stated within their current job plans and flexible sessions are appropriately managed;
- Additional sessions worked by consultants and other medical staff are justified, subject to appropriate authorisation and are worked in addition to their core contracted hours;
- Requests for locum medical staff are made following an effective assessment of need and are appropriately authorised and correctly paid; and
- Previous Internal Audit recommendations have been appropriately actioned.

## 3. Associated Risks

The potential risks considered in this review are as follows:

- Delays in patient treatment / non-achievement of objectives or targets;
- Inappropriate / ineffective medical staff activity; and
- Unnecessary / inappropriate expenditure.

## 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.

| | | |
|---|---|---|
| **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. |

It is evident that the Clinical Board has made progress towards implementing the agreed management actions from the original review. However, there are still actions that require completion.

There is an appropriate process in place for obtaining staff and Locums now which has been documented in a Standard Operating Procedure for Scrutiny of Posts in General Surgery. In addition, the Directorates are utilising the Health Board Medical Staff Claim forms for Waiting List Initiative.

As detailed within section 5 below, the follow-up has concluded that three of the management responses have been fully actioned (1 high & 2 medium), 2 have been partially actioned (2 High) and 1 has not been actioned (medium).

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Surgery Clinical Board – Medical Finance Governance has improved to **Reasonable Assurance**.

Management will however need to ensure that the outstanding actions are fully implemented and that job plans are completed for General Surgery and that Colorectal Consultants cover each other's sessions when unavailable.

## 5. Summary of Audit Findings

Follow up work was undertaken to confirm the progress that the Health Board has made against the agreed management responses from the original audit, as detailed within Appendix A.

In summary, progress against the four agreed recommendations that required implementation is as follows:

| Priority rating | No of management responses to be implemented | Fully actioned | Partially actioned | Not actioned | Not Applicable |
|---|---|---|---|---|---|
| High | 3 | 1 | 2 | 0 | 0 |
| Medium | 3 | 2 | 0 | 1 | 0 |
| Low | 0 | 0 | 0 | 0 | 0 |
| **Total** | **6** | **3** | **2** | **1** | **0** |

In summary, the progress made against the six management responses that required implementation is as follows:

- There is now a process in place for managing all annual, special, sick and study leave. Spreadsheets are in place for cancelled theatres. In addition, there is a spreadsheet maintained of all Colorectal Consultants and the theatre sessions that they work. The Interim Service Manager has produced a tracker of all dates for the current job plans and when the current job plan is due to be reviewed;
- Ophthalmology are utilising the Health Board Medical Staff Claim form for Waiting List Initiative and General Surgery are in the process of rolling out the form for it to be in place for the 1st October. Timetables are work in progress within the General Surgery Directorate;
- Each of the Service Groups within Surgery have to review all vacant posts prior to consideration of locum requests by the Clinical Board Scrutiny Panel. A SOP for Scrutiny of posts in Surgery Clinical Board has been produced;
- A standard Operating Procedure has been produced for General Surgery and Ophthalmology titled 'Locum Claims' which covers Consultant Extra Duty Claims and how to claim them;
- The Director of Operations and Clinical Board Director for Surgery have arranged to meet the Colorectal Consultants on two occasions to discuss the job plans but the meetings have been cancelled. The Interim Service Manager has produced a tracker of all dates for the current job plans and when the current job plans are due to be reviewed; and

- Standard Operating Procedure for Scrutiny of posts in the Surgery Clinical Board has been produced outlining the process to follow for new staff.

| Original Finding 1 – General Surgery Consultants working required hours (Operating effectiveness) | Risk |
|---|---|
| Audit reviewed a sample of 10 General Surgery Consultants to establish if they were working the required Direct Clinical Care Sessions. The following findings were noted from the testing of sessions worked during May 2018:<br>• One Consultant only undertook 1 of the 4 clinics that he was due to carry out during May, with 2 being cancelled due to meetings. The same Consultant was due to undertake 8 theatre sessions but 4 were cancelled. However, there was no evidence or reason provided for the cancellations. This point was discussed with the Clinical Director for General Surgery and he confirmed that this Consultant is a mentor. Audit were advised that the Consultant was mentoring on these dates and the theatre sessions were undertaken by the mentee. However, it was not recorded on Theatreman that the Consultant was mentoring for those theatre sessions;<br>• Three of the Consultants reviewed were Colorectal Consultants. There are 8 Colorectal Consultants who undertake theatre lists over the 5 days and therefore if a Consultant is unable to carry out a session they should ensure that there is cover for that session. However the following was noted:<br>  • It was identified that 1 of the Consultants was on leave for 1 session, study leave for 1 session and on call for 1 session during May and none of the other Colorectal Consultants undertook the theatre lists. In addition, the Consultant was due to do a theatre list on the 23 May 2018 but it was cancelled and there was no reason provided.<br>  • Another of the Consultants had 2 theatre sessions cancelled due to the Consultant having study leave for 1 session and annual leave for 1 session, again none of the other Colorectal Consultants undertook the theatre lists. | Inappropriate / ineffective medical staff activity. |

| | |
|---|---|
| A 3rd Consultant had 2 theatre sessions cancelled due to the Consultant being on military leave and none of the other Colorectal Consultants undertook the theatre list. | |
| **Original Recommendation** | **Priority level** |
| The Directorate should ensure that consultants carry out all planned sessions wherever possible and appropriate reasons are recorded for the cancellation of clinics and theatres.<br>Colorectal Consultants should ensure that they cover and backfill the other Consultants lists if they are unable to carry out the planned session. | **High** |
| **Original Management Response** | **Responsible Officer/ Deadline** |
| • A new system to accurately record consultant activity in theatre is being developed with a clear desktop procedure.<br>• Through job planning each consultants expected activity will be agreed in weeks and monitored accordingly by the Directorate<br>• Expectation around backfill sessions will be agreed and signed by consultants and a system to monitor this will be managed by the Directorate team<br>• Systems will be put in place by end of March 2019 | Directorate/Speciality Manager for General Surgery in conjunction with Clinical Director<br>End March 2019 |

## Current Position

**Action Part Complete**

There is now a process in place for managing all annual, special, sick and study leave and this is recorded on a spreadsheet so that the Directorate team can verify that all shifts are being worked. In addition, the Support Manager is checking the information against the Intrepid system to ensure that they both match.

There is a spreadsheet maintained of all cancelled theatre sessions. There is a spreadsheet maintained of all the Colorectal Consultants and the days of their theatre sessions.

The Director of Operations and Clinical Board Director for Surgery have arranged to meet the Colorectal Consultants to discuss the job plans to ensure that they are all consistent but both meetings have had to be cancelled due to work priorities. The Interim Service Manager has produced a tracker of all the dates for the current job plans and when the current plan is due to be reviewed.

Colorectal Consultants now work in partners so that they can cover each other. Testing of theatre sessions during May 2019 identified the following:

- Within the Main theatres there were eight sessions that could not be undertaken by the identified consultant. However only one session was not covered as the Consultant was on annual leave and his partner was on call so could not cover. The other Colorectal Consultants were unable to cover the Consultant due to other priorities. Therefore, only one session was not covered by the other Colorectal Consultants within Main Theatres.
- There were nine SSSU theatre sessions that could not be undertaken by the identified consultant. Four sessions were covered by either other Colorectal Consultants or GI Consultants. There were five sessions that were not covered

Overall for the 34 sessions within July for the main theatre and SSSU theatre there were only five sessions not covered by Colorectal Consultants. This represents an improved position from the time of the original review.

| Updated Management Response | Updated Responsible Officer / Deadline |
|---|---|
| Colorectal job planning to be completed. | Mike Bond/Alan Tomkinson 30th November 2019 |

| Original Finding 2 – Additional Sessions (Operating effectiveness) | Risk |
|---|---|
| The Waiting List Initiative Policy confirms that "WLI work may be accommodated through the temporary displacement of SPA job plan commitments…The nature of the displaced SPA activity and when this will be rescheduled must be agreed and recorded on the WLI claim form."<br><br>The Waiting List Initiative Forms for Ophthalmology in May were reviewed and all had been authorised by the Directorate Manager. It was however identified that six of the eight Waiting List Initiative additional sessions were undertaken when the Consultant was timetabled to do an SPA session. It was evident from reviewing the WLI claim forms that there was no record confirming if the SPAs had been displaced and rescheduled and therefore no record of agreement.<br><br>There were only 2 instances of additional sessions worked by General Surgery Consultants in May. The job plan of the Consultant that undertook the extra sessions confirmed that they were planned to do a pre-op ward round and multi-disciplinary team at the time of the additional sessions. There was no recorded detail or agreement to confirm that these sessions were rescheduled. | Unnecessary / inappropriate expenditure. |

| Original Recommendation | Priority level |
|---|---|
| The Directorates should ensure that any displaced SPA sessions are appropriately recorded and agreed on the WLI form, in accordance with the policy. | **High** |
| **Original Management Response** | **Responsible Officer/ Deadline** |
| • Systems will be put in place to ensure that the governance for displaced SPA will be aligned to health board policy and audited within Directorates.<br>• Job plans will have clear timetables to ensure it is simple to follow WLI against working week<br>• Key responsible officers will be allocated to this task | Directorate/Speciality Managers in conjunction with Clinical Directors |
| **Current Position** | |
| **<u>Action Part Complete</u>**<br>Ophthalmology are utilising the Health Board Medical Staff Claim forms for Waiting List Initiative and they request the Consultant to confirm whether a WLI session was undertaken during SPA time. Audit reviewed a sample of Waiting Initiative Forms within Ophthalmology for June and July and the section on the form had been completed confirming whether a WLI session had been undertaken during SPA time.<br>Within the General Surgery Directorate they have produced their own claim form. We met with General Surgery Directorate on the 16th September 2019 and were advised that they are in the process of rolling out the form that is being utilised within Ophthalmology and it should be in place for the 1st October 2019.<br>Timetables are a work in progress and they are hoping to produce a new timetable for each Consultant within General Surgery including a section on activity | |

| Updated Management Response | Updated Responsible Officer / Deadline |
|---|---|
| WLI Forms rolled out and in use demonstrating SPA displacement<br>As part of demand and capacity planning the directorate will develop and activity monitoring tool to be shared with clinicians on a quarterly basis | Laura jones 1st October 2019<br>Emma Wilkins January 2020 |

| Original Finding 3 – Requests for General Surgery Locum Consultants (Operating effectiveness) | Risk |
|---|---|
| During the period of review there had only been 2 occasions where Locum Consultants were required within General Surgery. It was identified that the request for the locum cover was made via an Email to Medacs from the Directorate Administrator.<br>Audit was advised that the CV of the Locum would have been reviewed by the Clinical Director and the Professional Clinical Lead.<br>However, there was no paperwork in place within the Directorate to authorise the request for the Locum Consultant or any documentation approving the Locum Consultant provided by Medacs.<br>The Medical Personnel department have confirmed that whilst it is adequate for Locum Consultants to be requested via Email, the actual approval process should have been performed within the Directorate and evidence of the approval should be maintained there. | Unnecessary / inappropriate expenditure. |

| Original Recommendation | Priority level |
|---|---|
| General Surgery should ensure that they follow the correct procedure for recruiting and authorising Locum Consultants. | **High** |
| **Original Management Response** | **Responsible Officer/ Deadline** |
| • Ensure CD signs off paperwork for locum highlighting rationale for locum<br>• Create SOP/DTP so all staff can follow clear process<br>• Review paperwork to ensure it is up to date<br>These actions will be put in place by end of March 2019 | Directorate/Speciality Manager in conjunction with CD<br>End March 2019 |
| **Current Position** | |
| **<u>Action Complete</u>**<br>Each of the Service Groups within Surgery have to scrutinise all vacant posts prior to submitting any requests for locums to the bi-weekly Clinical Board Scrutiny Panel. The General Manager is responsible for scrutinising vacant posts with the manager requesting the locum. All posts submitted to the Clinical Board Scrutiny Panel must include relevant paperwork.<br>A SOP for Scrutiny of posts in Surgery Clinical Board has been produced detailing the process to follow and including the Scrutiny Form that requires completion. | |

| Original Finding 4 – Desk top procedures (Control design) | Risk |
|---|---|
| There are processes in place for managing Consultant medical staff time and costs within both of the Directorates reviewed. However, the processes are not recorded on any local documented procedure notes within either of the Directorates.<br>The lack of documented procedure notes creates the risk that the processes may not be consistently carried out or may not be completed at all during periods of staff absence or turnover. | Delays in patient treatment / non-achievement of objectives or targets |
| **Original Recommendation** | **Priority level** |
| Management should produce desk top procedures to ensure that Consultants medical staff time and costs are being managed appropriately and consistently. | **Medium** |
| **Original Management Response** | **Responsible Officer/ Deadline** |
| • Standardised procedure notes to be created and shared with key personnel (March 2019) | Directorate/Speciality Manager<br>End March 2019 |
| **Current Position** | |
| **Action Complete**<br>Standard Operating Procedure has been produced for General Surgery titled Locum Claims which covers Consultant Extra Duty Claims and how to claim them, Specialist Trainees and Junior Doctors extra duty claim and copy of the claim forms are within the procedure. | |

| |
|---|
| At the time of commencing the follow-up review there was not a Standard Operating Procedure in place for Ophthalmology. However they produced one before the end of the review which is in the format of the General Surgery SOP and it was approved by the Surgery Clinical Board Director of Operations. |

| **Original Finding 5 – Job Plans for General Surgery Consultants (Operating effectiveness)** | **Risk** |
|---|---|
| Audit tested a sample of 10 General Surgery Consultants to establish if they were appropriately working their contracted sessions in clinics and theatres as recorded on their individual job plans.<br><br>It was identified that the job plans for five of the Consultants were out of date as their recorded working patterns for theatres were not in line with the actual theatre sessions that they were required to deliver.<br><br>In addition, there was another of the Consultants who had no job plan in place at all.<br><br>The issue of out of date and / or missing job plans has been previously raised as part of a specific Internal Audit review of Consultant job planning that was completed in May 2018. Actions to address the findings from the previous review are currently being progressed via the Medical Director's office and Clinical Boards.<br><br>The issue has been raised here due to the impact it had on Audit's ability to test if the sampled consultants were working the correct sessions. The difficulty created by the lack of up to date job plans was partly mitigated by the information on current consultant clinical and theatre sessions held by the Directorate team. This is reflected in the current priority rating for this finding. | Inappropriate / ineffective medical staff activity. |

| Original Recommendation | Priority level |
|---|---|
| In conjunction with the actions already being taken following the Consultant Job Planning Audit, the Directorate should ensure that all consultants have an up to date, agreed job plan in place that accurately reflects the current required sessions | **Medium** |
| **Original Management Response** | **Responsible Officer/ Deadline** |
| • All job plans will be completed and recorded appropriately (March 2019) | Clinical Director<br>End March 2019 |
| **Current Position** | |
| **<u>Action Not Complete</u>**<br>The Director of Operations and Clinical Board Director for Surgery have arranged to meet the Colorectal Consultants to discuss the job plans to ensure that they are all consistent but both meetings have had to be cancelled due to work priorities. The Interim Service Manager has produced a tracker of all the dates for the current job plans and when the current plan is due to be reviewed. It was identified that from the 25 General Surgery job plans that 18 were out of date and for two Consultants there were no job plans. | |
| **Updated Management Response** | **Updated Responsible Officer / Deadline** |
| Job plans complete | Emma Wilkins/Guy Blackshaw 31st December 2019 |

| Original Finding 6 – Ophthalmology Locum cover (Operating effectiveness) | Risk |
|---|---|
| There were 2 Ophthalmology Locum covers during the period Audit reviewed. An extension of one of the Locum Consultants was required. The extension was for the period 2 April - 13 July 2018, however, the Locum request document was dated the 2 July 2018. The request form should be completed prior to an extension for the locum cover.<br><br>This point was discussed with the Directorate and Audit were advised that there had been a verbal approval of the extension but there was a delay in the paperwork being processed to Medacs. | Unnecessary / inappropriate expenditure |
| **Original Recommendation** | **Priority level** |
| Management should ensure that request for Locum cover documentation is fully completed prior to the cover required. | **Medium** |
| **Original Management Response** | **Responsible Officer/ Deadline** |
| **Clinical Board Response**<br>• SOP/DTP will be developed and standardised for all Directorates to record adherence to agree protocols (March 2019) | Directorate Manager/Deputy Director of Operations<br><br>End March 2019 |
| **Current Position** | |
| **<u>Action Complete</u>**<br>Standard Operating Procedure for Scrutiny of posts in Surgery Clinical Board has been produced and the Ophthalmology Directorate are utilising. | |

## Appendix B - Assurance opinion and action plan risk rating

### Audit Assurance Ratings

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

**Follow up -** All recommendations implemented and operating as expected.

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

**Follow up** - All high level recommendations implemented and progress on the medium and low level recommendations.

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

**Follow up -** No high level recommendations implemented but progress on a majority of the medium and low recommendations.

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

**Follow up -** No action taken to implement recommendations.

## Prioritisation of Recommendations

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

| Priority Level | Explanation | Management action |
|---|---|---|
| **High** | Poor key control design OR widespread non-compliance with key controls.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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

# Deprivation of Liberties Safeguards (DoLS)

## Final Internal Audit Report

## Cardiff and Vale UHB

## 2019/20

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



| | |
|---|---|
| **Review reference:** | C&V-1920-19 |
| **Report status:** | Final Internal Audit Report |
| **Fieldwork commencement:** | 7th August 2019 |
| **Fieldwork completion:** | 3rd October 2019 |
| **Draft report issued:** | 4th October 2019 |
| **Management response received:** | 21st November 2019 |
| **Final report issued:** | 21st November 2019 |
| **Auditor/s:** | Lucy Jugessur, Cara Vernon |
| **Executive sign off:** | Stuart Walker, Medical Director |
| **Distribution:** | Jason Roberts, Deputy Executive Nurse Director<br>Julia Barrell, Mental Capacity Act Manager<br>Susan Broad, MCA / DoLS Co-ordinator |
| **Committee:** | Audit Committee |

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

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

**Disclaimer notice - Please note:**

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

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

## 1. Introduction and Background

The review of the Deprivation of Liberties Safeguards (DoLS) has been completed in line with the 2019/20 Internal Audit plan for Cardiff and Vale University Health Board.

The relevant lead Executive Director for this review is the Medical Director.

The Deprivation of Liberty Safeguards were introduced to prevent breaches of the European Convention of Human Rights (ECHR), Article 50 Right to Liberty and security of Person. The safeguards were introduced as an amendment to the Mental Capacity Act 2005 and came into force on the 1st April 2009. Thus, a legal framework now exists to provide authorisation to deprive vulnerable adults of their liberty in a care home or hospital setting. The safeguards are for adults aged 18 years and over who have a mental disorder and who lack capacity to decide where they need to reside to receive treatment and/or care.

If a hospital or care home, referred to as a Managing Authority, needs to deprive a person of their liberty, in their best interests, to keep them safe from harm, then the Managing Authority needs to apply for a DoLS authorisation (i.e. permission) through the DoLS team. Following assessment by a Best Interests assessor and a Doctor, if appropriate/needed the Supervisory Body (Local Authority or Health Board) gives permission to deprive a person of their liberty by granting a DoLS Authorisation.

DoLS is governed by law, Regulations and a Code of Practice that has statutory force- i.e. it must be followed, unless there is good reason not to. There is also a considerable body of case law on deprivation of liberty and DoLS.

In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards. This is due to come into force on 1st October 2020.

The DoLS process within the Health Board was previously subject to Internal Audit review in 2015/16. The resultant limited assurance report was subject to detailed follow-up in early 2018 when it was identified that a number of issues were still outstanding. Given the time elapsed since the original review, it has been decided that the DoLS process will now be subject to a new full review.

## 2. Scope and Objectives

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

The purpose of the review was to establish if adequate procedures are in place within the Health Board to ensure that DoLS are consistently complied with and authorisations are obtained for all relevant patients.

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

- The Health Board has appropriate processes and guidance in place to ensure compliance with DoLS in order to avoid unlawful deprivations of liberty;
- Adequate training on DoLS (based on the guidance) is provided to all relevant staff and systems are in place to raise awareness of the UHB processes;
- Requests for urgent and / or standard DoLS authorisations are made for all relevant patients within the required timescales;
- All requests for urgent DoLS authorisations are appropriately assessed within the statutory timescales;
- All requests for standard DoLS authorisations are appropriately assessed within a reasonable timescale and the level of risk is assessed and managed where the statutory timescales are not met;
- All DoLS authorisations are correctly signed by the Supervisory Body;
- Processes are in place for monitoring and reporting compliance with DoLS and any issues are appropriately escalated and addressed: and
- The Health Board has appropriate plans in place to manage the transition to the new Liberty Protection Safeguards.

## 3. Associated Risks

The potential risks considered in this review are as follows:

- Non-compliance with DoLS due to lack of processes / awareness;
- Patients may be unlawfully deprived of their liberties; and
- The Health Board is unaware of issues relating to DoLS compliance.

# OPINION AND KEY FINDINGS

## 4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls within the Deprivation of Liberties Safeguards (DoLS) is **Reasonable assurance**.

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

The Audit was assessed as reasonable assurance as there have been improvements made since the previous Internal Audit review in early 2018. There has been a decrease overall in the number of DoLS standard and further requests being submitted and it was identified that they were being completed in a timelier manner. In addition, the review highlighted that the DoLS assessments were being authorised on a timely basis as the Health Board have identified additional staff members to undertake signing off the DoLS assessments.

There are still some issues identified as part of the review as there has been a vast increase in the number of urgent DoLS requests and staff are not able to always complete them within the required seven days as documented within the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards. Whilst this is a serious issue that the Health Board will need to seek to address, it is noted that all the sampled urgent DoLS requests have been completed but not in line with the stipulated time limits.

It was evident from our review that there has been a significant increase in awareness of DoLS as identified from our discussions with ward staff and having a specific Nurse managing the process within the Stroke unit. However, there has only been one DoLS training session carried out this year as the others have been cancelled due to the lack of numbers of staff attending.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | Processes and Guidance | | | | ✓ |
| **2** | Training & Awareness | | | ✓ | |
| **3** | Raising DoLS requests | | | | ✓ |
| **4** | Assessment of Urgent requests | | ✓ | | |
| **5** | Assessment of Standard requests | | | ✓ | |
| **6** | Authorisations | | | | ✓ |
| **7** | Monitoring and Reporting | | | | ✓ |
| **8** | Liberty Protection Safeguards | | | ✓ | |

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

### Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the system control/design for Deprivation of Liberties Safeguards (DoLS).

### Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weaknesses in the operation of the designed system/control for Deprivation of Liberties Safeguards (DoLS).

## 6. Summary of Audit Findings

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

**Objective 1: The Health Board has appropriate processes and guidance in place to ensure compliance with DoLS in order to avoid unlawful deprivations of liberty**

We note the following areas of good practice:

- There is a section on the Cardiff and Vale UHB Intranet for DoLS and available on there is documentation relating to DoLS such as the Law Societies document on "Identifying a deprivation of liberty: a practical guide" and the Department of Health document titled "Mental Capacity Act 2005 Deprivation of Liberty Safeguards".
- The UHB utilises and complies with the DoLS Code of Practice.
- A proforma has been developed within the Health Board to assess whether the ward should apply for a DoLS authorisation assessment for a patient.
- Audit selected a sample of wards to establish whether ward staff were able to identify patients that required DoLS. It was evident from discussions that ward staff were able to identify patients that require a DoLS and the forms that required completion.

We did not identify any findings under this objective.

**Objective 2: Adequate training on DoLS (based on the guidance) is provided to all relevant staff and systems are in place to raise awareness of the UHB processes**

We note the following areas of good practice:

- It was evident that the awareness of DoLS has increased within the Health Board based on discussions with ward staff. In addition, there has been an increase in the DoLS requests made to the DoLS team which shows an awareness of DoLS.

We identified the following findings:

- There are only 33 staff who have undertaken the statutory and mandatory training on DoLS.
- Audit was advised that a number of planned DoLS training sessions have had to be cancelled due to the number of employees that have been unable to attend. It was reported in the DoLS Annual Report that only one monthly training session has taken place so far this year and all others have been cancelled due to non-attendance.

**Objective 3: Requests for urgent and / or standard DoLS authorisations are made for all relevant patients within the required timescales**

We note the following areas of good practice:

- Audit visited a sample of four wards and the requests for urgent and / or standard DoLS authorisations were undertaken in a timely fashion. It was identified during the review that all DoLS documentation was available on the patients' files.

We did not identify any findings under this objective.

**Objective 4: All requests for urgent DoLS authorisations are appropriately assessed within the statutory timescales**

We note the following areas of good practice:

- All sampled urgent requests had been appropriately assessed and outcomes determined.

We identified the following findings:

- Audit reviewed a sample of 25 urgent requests to establish if they had been completed in line with the required statutory timescales and 22 urgent requests had failed to be completed within the seven days.

**Objective 5: All requests for standard DoLS authorisations are appropriately assessed within a reasonable timescale and the level of risk is assessed and managed where the statutory timescales are not met**

We note the following areas of good practice:

- It was identified from review of standard and further DoLS authorisations that they were adequately assessed and outcomes reached.

We identified the following finding:

- Audit selected a sample of 5 standard and further DoLS authorisations and two of the five had been completed within the 21 days. It was evident that there had been a vast improvement in the time taken to complete the standard and further authorisations.

**Objective 6: All DoLS authorisations are correctly signed by the Supervisory Body**

We note the following areas of good practice:

- It was identified in the previous Internal Audit review that there was a delay in the authorising of DoLS requests. As part of the current review Audit selected a sample of 30 DoLS requests and all had been authorised in a timely manner. The Health Board has increased the number of senior staff that are authorised to approve DoLS requests.

We did not identify any findings under this objective.

**Objective 7: Processes are in place for monitoring and reporting compliance with DOLs and any issues are appropriately escalated and addressed**

We note the following areas of good practice:

- The MCA / DOLs Coordinator provides a report to the quarterly Partnership Board which includes the Health Board, Cardiff Council and Vale Council on number of DOLs requests. This is broken down by the type of requests, withdrawn applications and applications completed and outstanding.
- There is a Health Board Safeguarding Steering Group which meets every two months and the DOLs information is reported into this group.

We did not identify any findings under this objective.

**Objective 8: The Health Board has appropriate plans in place to manage the transition to the new Liberty Protection Safeguards**

We note the following areas of good practice:

- The Health Board is aware that DoLS are being replaced by Liberty Protection Safeguards (LPS). The law is in place and the Standards come into force in October 2020. The associated Code of Practice has not been produced yet detailing the process to follow.

We identified the following finding:

- Currently, there is no plan in place within the Health Board for implementing the LPS as they are awaiting the Code of Practice to be produced.

## 7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

| Priority | H | M | L | Total |
|---|---|---|---|---|
| **Number of recommendations** | **1** | **1** | **2** | **4** |

| Finding 1 - Timescales for undertaking DOLs Urgent Authorisations (Operating effectiveness) | Risk |
|---|---|
| Audit obtained a report of all DoLS authorisation requests from January to July 2019 which included 230 urgent requests. A sample of 25 urgent requests was reviewed to establish if they had been completed in line with the required statutory timescales.<br>Below are our findings:<br>• 22 of the urgent requests had failed to be completed within the required 7 days.<br>• The longest time it took to complete an urgent request was 26 days. For those 22 urgent requests not completed within 7 days it took on average 15 days to complete the urgent requests. | Patients may be unlawfully deprived of their liberties |
| **Recommendation** | **Priority level** |
| Staff should attempt to ensure that all Urgent assessments are undertaken within the stipulated seven days as detailed in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| All attempts are made to ensure the DoLs assessments are carried out within the specified timeframes, however this remains a challenge with the current resource. Only 1.5 wte (out of 6 wte) staff are funded by health with the remaining staff funded by LA. This means that resource is shared between LA assessments also. This position will be reviewed in 2020 with introduction of LPS. | To be confirmed / October 2020 |

| Finding 2 - DOLs Training (Operating effectiveness) | Risk |
|---|---|
| Audit were advised that July 2019 was the first month that any DoLS training has been carried out formally as there had not been the numbers previously. Six staff are required to undertake the training session for it to be feasible and they were not receiving the numbers so subsequently the training was cancelled.<br><br>In addition, the DOLs Annual Report submitted to the Safeguarding meeting on the 25 July 2019 confirmed that only one monthly training session took place this year and all others have been cancelled.<br><br>Audit was provided with DOLs training figures from Workforce and there had been 33 staff who had carried out the statutory and mandatory training on DOLs.<br><br>Despite the low level of training undertaken, it is noted that the staff members on the wards visited as part of the review, demonstrated a good level of awareness of DoLS requirements and the associated processes. | Non- compliance with DOLs due to lack of processes / awareness |
| **Recommendation** | **Priority level** |
| The Health Board should ensure that staff are provided with appropriate DoLS training and where areas have low compliance these areas should be targeted. | **Medium** |

| Management Response | Responsible Officer/ Deadline |
|---|---|
| DoLs training has remained challenging, as it is directly related to the ability of clinical areas to release staff. The inability to release staff for Mandatory and Statutory training remains high on the UHB risk register. Formal monthly training continues to be supported by staff, although attendance poor. Bespoke training (one hour) drop in sessions are now being provided. Training is also incorporated into the general Safeguarding Training to continue to raise awareness of DoLs, however these results are captured in the safeguarding training numbers and not a formal record of DoLs training. | To be confirmed / October 2020 |

| Finding 3 - Completion of standard and further authorisations (Operating effectiveness) | Risk |
|---|---|
| There were only 27 standard and further DoLS authorisation requests between January - July 2019 and therefore Audit reviewed three standard and two further DOLs authorisation requests to establish if they had been completed in line with the required statutory timescales of 21 days.<br>For the three standard DOLs authorisation requests the following was noted:<br>• One had been completed on the day it was received;<br>• One had been completed in 26 days whilst the third had been completed in 85 days.<br>• The average time taken was therefore 37 days.<br>For the two further DoLS authorisation requests the following was noted: | Patients may be unlawfully deprived of their liberties |

| | |
|---|---|
| • One further DOLs authorisation request was completed in 21 days<br>• The other request was completed in 24 days, just marginally over the required timescales for completion.<br>There has however been an improvement in the number of days taken for the completion of standard and further DoLS authorisation requests as it took on average 80 days to undertake a standard and further DoLS assessment when we carried out the previous review. | |
| **Recommendation** | **Priority level** |
| Staff should attempt to ensure that all Standard and Further assessments are undertaken within the stipulated 21 days as set out in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| All assessments that are deemed as a priority have to be undertaken before the Standard and further assessments as outlined in line with WG priority tool. | To be confirmed / October 2020 |

| Finding 4 - Liberty Protection Safeguards (Operating effectiveness) | Risk |
|---|---|
| The new Liberty Protection Safeguards (LPS) are coming into force in October 2020. The law is already in place but the Code of Practice has not been produced yet detailing the process to follow.<br>DoLS will be running alongside LPS for a year from October 2020 – October 2021.<br>Currently, there is no plan in place within the Health Board for implementing the LPS as they are awaiting the Code of Practice being produced. | The Health Board is unaware of issues relating to DOLs compliance |
| **Recommendation** | **Priority level** |
| The Health Board need to ensure that they produce a plan for implementing Liberty Protection Safeguards following the production of the Code of Practice. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Whilst LPS will come into force in October 2020, we are unable to formulate a plan without the implementation of the code. Scoping meeting planned for 12th December 2019 to develop framework and code and produce work plan across wales for 2020. | To be confirmed / October 2020 |

## Appendix B - Assurance opinion and action plan risk rating

### Audit Assurance Ratings

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

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

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

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

### Prioritisation of Recommendations

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

| Priority Level | Explanation | Management action |
|---|---|---|
| **High** | Poor key control design OR widespread non-compliance with key controls.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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

# Cardiff and Vale University Health Board

# Charitable Funds

# Final Internal Audit Report

# 2019/20

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



| | |
|---|---|
| **Review reference:** | C&V-1920-15 |
| **Report status:** | Final Internal Audit Report |
| **Fieldwork commencement:** | 19th August 2019 |
| **Fieldwork completion:** | 26th September 2019 |
| **Draft report issued:** | 30th September 2019 |
| **Management response received:** | 17th October 2019 |
| **Final report issued:** | 17th October 2019 |

| | |
|---|---|
| **Auditor/s:** | Olubanke Ajayi Olaoye, Senior Internal Auditor |
| | Ian Virgill, Acting Head of Internal Audit |
| **Executive sign off:** | Bob Chadwick – Director of Finance. |
| **Distribution:** | Chris Lewis, Deputy Director of Finance |
| | Alun Williams, Financial Services Manager |
| | Andrew Turton, Senior Charitable Funds Officer |
| | Lucie Barrett, Fundraising Officer |
| **Committee:** | Audit Committee |

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

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

**Disclaimer notice - Please note:**

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

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

## 1. Introduction and Background

The review of Charitable Funds was completed in line with the 2019/20 Internal Audit plan for Cardiff and Vale University Health Board.

The Cardiff and Vale University Health Board General Purpose Charitable Fund is a registered charity that is governed by the Trust Deed. Under the terms of this deed the Charitable Fund is administered by the Trustees, the Cardiff and Vale University Health Board as a body corporate. The fund is an umbrella charity with a number of subsidiary charities registered therein and also managed by the Health Board.

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

## 2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for the management of the Charitable Funds, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The purpose of the review was to establish if the Health Board has appropriate processes in place to ensure that the Charitable Funds were appropriately managed and administered in accordance with relevant legislation and Charity Commission guidance.

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

- Up to date policy and procedures are in place for the appropriate management of the charitable funds;
- All charitable funds income received is appropriate and accounted for correctly (including gift aid);
- All charitable funds expenditure is appropriate, authorised and within the terms of the relevant fund;
- Effective governance arrangements are in place for the charitable funds; and
- Funds held in Trust are appropriately monitored, managed and invested.

## 3. Associated Risks

The potential risks considered for the review were as follows:

- Charitable funds income isn't maximised;
- Charitable funds income may be incorrectly recorded and or accounted for;

- Charitable funds expenditure may be inappropriate, excessive or may be incorrectly recorded; and
- Non-compliance with legislation and Charity Commission guidelines.

## OPINION AND KEY FINDINGS

### 4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls within the Charitable Funds is **reasonable assurance**.

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

Overall the controls in place to manage the risks associated with the systems and processes tested within the review are of a reasonable standard.

Elements of good practice were observed within all the areas covered as documented in section 6 of this report.

The governance arrangements in place for the administration of the charitable funds within the Charitable Funds Committee was good.

However, the review identified some issues, particularly around the management of dormant funds where effective monitoring is not currently in place and the previously agreed management action has not been implemented. It was noted that there has been a 72.7% increase in the level of dormant funds between July 2018 and March 2019.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | Up to date policy and procedures are in place for the appropriate management of the charitable funds | | | | ✓ |
| **2** | All charitable funds income received is appropriate and accounted for correctly (including gift aid) | | | ✓ | |
| **3** | All charitable funds expenditure is appropriate, authorised and within the terms of the relevant fund | | | | ✓ |
| **4** | Effective governance arrangements are in place for the charitable funds | | | | ✓ |
| **5** | Funds held in Trust are appropriately monitored, managed and invested | | ✓ | | |

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

### Design of Systems/Controls

The findings from the review have highlighted 1 issue that is classified as a weakness in the system control/design for Charitable Funds.

### Operation of System/Controls

The findings from the review have highlighted 2 issues that are classified as weaknesses in the operation of the designed system/control for Charitable Funds.

## 6. Summary of Audit Findings

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

### Objective 1: Up to date policy and procedures are in place for the appropriate management of the charitable funds

We identified the following areas of good practice:

- There is an updated core and non-core guidance on Charitable Funds expenditure which was submitted to the Trustee Board Committee in March 2019.
- There is also an up to date fund raising policy which was reviewed in September 2018.
- The Charitable Fund Financial Control Procedure (FCP) 2 have been updated and is accessible to relevant staff on Finance's shared drive.

There were no findings identified under this objective.

### Objective 2: All charitable funds income received is appropriate and accounted for correctly (including gift aid)

The following areas of good practice were noted:

- All 30 tested samples of the charitable fund income were traced to the bank.
- There are adequate systems in place to capture information that enables the reclamation of gift aid.
- Gift aid is championed by the fund raising department, wherever possible.
- A standard schedule is sent to HMRC on a timely basis for reclaiming gift aid.
- Gift aid monies were found to be reapportioned to the correct fund.

We identified the following finding in relation to this objective:

- Testing was undertaken on a sample of 30 receipts from various sources of the charitable fund income to ensure donation forms were completed, funds were banked, thank you letters were timely sent and gift aid forms were completed. Some exceptions were noted within the findings as detailed in appendix A.

**Objective 3: All charitable funds expenditure is appropriate, authorised and within the terms of the relevant fund**

The following area of good practice was noted:

- All expenditure items reviewed were appropriate to Fund purpose.

We identified the following finding in relation to this objective:

- Testing was undertaken on a sample of 30 expenditure items to establish if they were appropriate to the fund purpose, supported by required backing documents, adequate authorisation had been undertaken and transactions had been accurately entered into the Oracle system. Some exceptions were noted as detailed in appendix A below.

**Objective 3: Effective governance arrangements are in place for the charitable funds**

The following areas of good practice were noted:

- The Charitable Funds Committee is a sub-committee of the Board with an independent member as chair. Charitable funds are subject to regular monitoring and reporting to the Charitable Funds Committee.
- The meetings are held quarterly as per the agreed Terms of Reference.

There were no findings identified under this objective.

**Objective 5: Funds held in Trust are appropriately monitored, managed and invested.**

The following areas of good practice were noted:

- Cazenove Capital Management (CCM) provides details on the profit/loss of investments in a quarterly report and attends the Charitable Funds Committee meetings on a bi annual basis. This allows the representative to answer questions and give more detailed information about investment options/performance;

- The Health Board advises on their concerns on ensuring investments are in line and do not breach the ethical restrictions.

We identified two significant findings in relation to this objective:

- There has been an increase of 72.7% in the level of dormant funds between July 2018 and March 2019. There are currently no effective processes in place for monitoring and managing dormant funds. The previously agreed management action to improve the management of dormant funds has not been implemented.

## 7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

| Priority | H | M | L | Total |
|---|---|---|---|---|
| **Number of recommendations** | **1** | **1** | **1** | **3** |

| Finding: 1 - Dormant Fund Test Findings (Control Design) | Risk |
|---|---|
| The total amount of dormant charitable funds (funds that are not used for a period greater than one financial year) held by the UHB as at March 2019 (the latest available dormant fund analysis) was £1,065,811.69. The total amount of dormant charitable funds held by the UHB as at June 2018 was £616,999. This represents a 72.7% increase in dormant funds between July 2018 and March 2019.<br><br>Ten dormant fund accounts (under the administration of 7 fund holders) were selected for review and Clarification was requested as to:<br>• Why the funds are yet to be used.<br>• If there plans or any intention to use the fund<br>• Evidence to support spending plans/ intention to use the fund.<br><br>The results identified that:<br>• Six of the sampled fund holders responded however none of them could provide any evidence of clear expenditure annual plans.<br>• Two of the fund holders that responded were not sure of the current position of the funds. One of the fund holders stated that this was a fund held at an historical position, account was never actioned.<br>• One fund holder did not respond.<br><br>Following last year's audit, management agreed that regular review of dormant funds would be undertaken and fund holders would be contacted. However, there is still no system in place to show that Dormant Funds are reviewed to identify | Charitable funds income isn't maximised |

| | |
|---|---|
| reasons for dormancy and intentions/plans to use the funds in accordance with the funds stated purpose.<br><br>None of the 10 sampled Funds held evidence of formally documented expenditure plans that stated intended use, estimated costs and timescales for use.<br><br>In the selection of audit samples, funds with no movement for 1 year and prior year samples were not selected, however, it was noted that seven (totalling £238,739.97) of the eleven dormant funds that were sampled for last year's audit, still had no transactional movement in the last year. | |
| **Recommendation 1** | **Priority level** |
| Fund holders must be contacted and reminded that they should not allow funds to remain dormant and expenditure plans must be developed to ensure appropriate use of the funds. Where funds are not being utilised they should be reviewed and potentially re-allocated / transferred.<br><br>To ensure there is a robust and adequate control system in place, the FCP should include more information on the treatment of dormant funds such as the requirement for periodic reporting and update of dormant funds and periodic exercises where dormant funds are reviewed by Finance etc. | **High** |
| **Management Response** | **Responsible Officer/ Deadline** |
| This is a strategically important issue for the charity and a policy on the treatment of dormant funds will be specifically considered by the CFC/Trustee. This policy will consider these findings and recommendations. | Deputy Director of Finance<br><br>March 2020. |

| Finding 2: Charitable Fund Income Testing (Operating effectiveness) | Risk |
|---|---|
| As part of the audit, testing was undertaken on Charitable funds income to establish if donation forms were completed, funds were banked, thank you letters were timely sent and gift aid forms were completed where applicable.<br>A sample of 30 receipts was selected from the following sources:<br>• 9 Direct bank payments of which 3 were from the online fund raising platform;<br>• 16 Cash and cheque donations from Wards / Departments; and<br>• 5 legacy donations<br><br>The following issues were identified:<br>**Cash & Cheque donations:**<br>• 3/16 receipts were not supported by donation forms;<br>• 8/13 donation forms had no donor signature section within them. It is noted that these are the old style donation forms that are slowly being replaced as stocks are depleted;<br>• 1/5 with a donor signature section was not signed (4 were not applicable because they were not tax payers);<br>• 2/13 donor forms were not signed by the paying officer.<br>• 1/13 donations received was not timely paid to the Cashiers Office. 2/13 could not be determined if timely paid (date of submission to Cashier not stated). | Charitable funds income is not maximised.<br>Charitable funds income may be incorrectly recorded and or accounted for. |

| | |
|---|---|
| • 2/13 thank you letters could not be sent (blue forms were not received).<br>• 3/11 thank letters were not timely sent. They were sent between 13 & 52 days after receipt of the donation. The timing of 6/11 sampled could not be determined.<br>**Legacy Income:**<br>• 2/5 legacy income had thank you letters sent 40 and 50 days after receipt respectively. It is acknowledged that one of the letters was partly delayed due to waiting for information on the donor from solicitors. | |
| **Recommendation 2** | **Priority level** |
| Staff should be informed of the standardised documentation to be used for the completion of donations.<br>Management should inform relevant staff and ensure they are aware that:<br>• The donation form should be adequately completed.<br>• Donation form copies should also be timely forwarded to the key departments responsible for the processing of the donations.<br>• Thank you letters should also be timely dispatched to the donors. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| The Fundraising team will continue to engage with the Clinical Boards to ensure donation forms are completed correctly and submitted to the fundraising team within a timely manner. | Simone Joslyn<br>Head of Arts and Health Charity. March 2020. |

| Finding 3: Charitable Fund Expenditure Test (Operating effectiveness) | Risk |
|---|---|
| Testing was undertaken on a sample of 30 items of Charitable funds expenditure to establish if they:<br>• Were appropriate to the purpose of the fund.<br>• Had the required backing documents.<br>• Had been adequately authorised.<br>• Had been accurately entered into the Oracle system.<br>The results of the testing identified the following findings:<br>• Three items did not have the appropriate backing document to support the expenditure as follows:<br>o One item of expenditure was not supported by a Request for Payment from Charitable Fund form. It is acknowledged that an authorised Purchase Order was originally raised but was then cancelled to allow payment via BACS transfer. It is therefore evident that the expenditure was authorised but not on the correct form.<br>o One item lacked clarity between the backing documents and the details of the transaction as recorded on Oracle; and<br>o For one item the request for Payment from Charitable Fund form wasn't completed until a month after the expenditure was incurred.<br>• One item had the incorrect description recorded on Oracle. The supplier's name was used instead of the description as per the invoice. | Charitable funds expenditure may be inappropriate, excessive or may be incorrectly recorded |

| Recommendation 3 | Priority level |
|---|---|
| Management should remind key staff responsible for processing the Charitable fund expenditure to ensure that transactions have the required supporting documents and undergo the expected approval as stated within the Financial Control Procedure.<br><br>All transactions entered into Oracle should accurately match their supporting documents. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Staff will be reminded of the importance of ensuring that the correct supporting documentation exists at all times. | Alun Williams / November 2019 |

# 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.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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

# Cardiff and Vale University Health Board

# PCIC Clinical Board – Business Continuity Planning

# Final Internal Audit Report

# 2019/20

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



| | |
|---|---|
| **Review reference:** | C&V-1920-35 |
| **Report status:** | Final Internal Audit Report |
| **Fieldwork commencement:** | 6th September 2019 |
| **Fieldwork completion:** | 28th October 2019 |
| **Draft report issued:** | 31st October 2019 |
| **Management response received:** | 20th November 2019 |
| **Final report issued:** | 21st November 2019 |
| **Auditor/s:** | Olubanke Ajayi Olaoye, Senior Internal Auditor<br>Ian Virgill, Acting Head of Internal Audit |
| **Executive sign off:** | Lisa Dunsford, Director of Operations- PCIC Clinical Board |
| **Distribution:** | Chris Darling, Programme Manager- PCIC Clinical Board<br>Theresa Blackwell, PCIC Business Manager |
| **Committee:** | Audit Committee |

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

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

**Disclaimer notice - Please note:**

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

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

## 1. Introduction and Background

The review of the Business Continuity Planning arrangements within the Primary, Community & Intermediate Care (PCIC) Clinical Board has been completed in line with the Cardiff & Vale University Health Board 2019/20 Internal Audit Plan.

The relevant lead Director for the review is the Chief Operating Officer.

The UHB has a duty under the Civil Contingencies Act to ensure that they have effective business continuity plans in place. Business continuity is the strategic and tactical capability of Cardiff and Vale University Health Board to plan for and respond to incidents and business disruptions in order to continue business operations at an acceptable predefined level. Plans are typically designed to cope with incidents affecting all the organisation's business-critical processes and activities. Incidents can include for example: Loss of Power, water, IT systems, building fire or flooding.

The Health Board's Business Continuity Policy and supporting Business Continuity Planning Guidance states that Clinical Board leadership teams are accountable to the COO for ensuring implementation of the BC policy within their area of responsibility.

## 2. Scope and Objectives

The overall objective of the audit was to assess the adequacy of the systems and controls in place for Business Continuity Planning within the PCIC Clinical Board in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The purpose of this audit was to establish if the PCIC Clinical Board has appropriate processes in place to ensure Business continuity is appropriately managed and administered in accordance with Health Board policy and relevant legislation.

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

- The Clinical Board has robust processes in place for the development of Business Continuity plans in line with the Health Board's Business Continuity Policy;
- The Clinical Board has effectively identified and categorised it's specific services in relation to Business Continuity Management;
- Reliable and appropriate testing of disaster recovery processes is undertaken, specifically in relation to the regular testing of significant events;
- Training and awareness raising of staff on relevant business continuity procedures is undertaken; and

- Appropriate management structures & reporting systems are in place for dealing with business continuity incidents within the Clinical Board.

## 3. Associated Risks

The potential risks considered in the review were as follows:

- Non-compliance with legislation;
- Adequate service cannot be provided in the event of a significant event or in the face of adverse conditions; and
- PCIC is unable to resume service provision in a timely manner.

## OPINION AND KEY FINDINGS

## 4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Business Continuity Planning within the PCIC CB is **Reasonable Assurance.**

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

The current review has identified that there are generally good processes in place for the management of Business Continuity Planning within the PCIC Clinical Board.

There is overall Health Board Business Continuity Plan (BCP) guidance in place, the template from which has been adopted by the PCIC Business Units and Services Areas in the production of their individual BCPs. It was however observed that some Business Units / Service Areas that required a BCP did not currently have a fully complete and / or formally documented

one in place. It is noted that the PCIC Clinical Board has planned steps in place to ensure that all relevant service areas have a formally documented BCP.

In order to test for the robustness of BCPs, the following 4 Service Areas across 4 Business Units were reviewed:

- Urgent Primary Care Out of Office Hours (OOHs);
- Vale of Glamorgan Locality: Day time Services / Communication Hub; and
- North & West Locality: District Nursing:
  - District Nursing Night Visiting team; and
  - North Cardiff District Nursing team.

All areas sampled had a BCP and various processes were in place to ensure their robustness including:

- Consulting with stakeholders;
- Regular review and update of BCPs; and
- Having various groups in place through which information can be shared.

The review also noted that whilst there are effective Committees and Groups in place within the Clinical Board and its Business Units for managing and monitoring Business Continuity, the Terms of Reference (TOR) for a number of these were out of date.

## 5. Assurance Summary

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

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | The Clinical Board has robust processes in place for the development of Business continuity plans in line with the Health Board's Business Continuity Policy | | | ✓ | |
| **2** | The Clinical Board has effectively identified and categorised it's specific services in relation to Business Continuity Management | | | ✓ | |
| **3** | Reliable and appropriate testing of disaster recovery processes is undertaken, specifically in relation to the regular testing of significant events | | | | ✓ |
| **4** | Formal Training and Awareness of staff | | | ✓ | |
| **5** | Appropriateness of Management Structure & Reporting System | | | | ✓ |

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

### Design of Systems/Controls

The findings from the review have highlighted 1 issue that is classified as weaknesses in the system control/design for PCIC CB – Business Continuity Planning.

### Operation of System/Controls

The findings from the review have highlighted 3 issues that are classified as weaknesses in the operation of the designed system/control for PCIC CB – Business Continuity Planning.

## 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 Clinical Board has robust processes in place for the development of Business continuity plans in line with the Health Board's Business Continuity Policy**

The following areas of good practice were noted:

- The PCIC Clinical Board are aware of the Health Board's Business Continuity Planning Guidance; and
- There are a number of local procedures within PCIC and its Business Units / Service Areas which provide support in carrying out the respective BCPs; such as the PCIC major incident summary plan guide and action cards.

The following significant finding was noted under this objective:

- Some Business Units / Service Areas do not currently have a fully completed and / or formally documented BCP in place.

**Objective 2: The Clinical Board has effectively identified and categorised its specific services in relation to Business Continuity Management**

The following areas of good practice were noted:

- In instances where a business interruption takes place, relevant information is fed into the BCP to reflect changes;
- There is always a member of staff on call for every shift. 'On call' staff are aware of the existence of the BCPs and would have sufficient capacity to secure a site in a case of emergency; and
- Service areas which have an already developed BCP have all adopted the standardised Health Board BCP guidance template. Business impact assessment, risk reduction and continuity option has been included as a part of the BCP template completion requirement.
- For the 3 Business Units / Service Areas reviewed there are plans in place within their respective BCPs to ensure that services run smoothly in the case of an unexpected disruption.

- Names of relevant staff contacts responsible for key areas have been outlined within the individual services BCPs.
- The Emergency Preparedness, Resilience and Response (EPRR) team has a supporting role in the preparation and continuous update of the BCPs.

There were no significant findings noted under this objective.

**Objective 3: Reliable and appropriate testing of disaster recovery processes is undertaken, specifically in relation to the regular testing of significant events**

The following areas of good practice were noted:

- A Principle Challenge Desk Top Business Continuity exercise took place in October 2018. There are currently plans in place to carry out mini desktop exercises in the final quarter of this financial year.

  There are a number of examples of business continuity issues that have occurred within the areas identified within the audit where the Business unit teams have managed very effectively to ensure patient care and staff wellbeing is maintained. I.E – Power and IT failure in the OOH service, flooding of buildings in the Barry Communication Hub, Parkview Health Centre, requiring all services to be transferred and relocated within a very short time scales.

There were no significant findings noted under this objective.

**Objective 4: Training and awareness raising of staff on relevant business continuity procedures is undertaken.**

The following areas of good practice were noted:

- Business continuity training has been provided to GP practices.
- Bronze control training was undertaken for PCIC on-call staff which was run by the Director of Nursing and Project Manager of PCIC.

There were no significant findings noted under this objective.

**Objective 5: Appropriate management structures & reporting systems are in place for dealing with business continuity incidents within the Clinical Board.**

The following areas of good practice were noted:

- There are management structures in place for dealing with business continuity incidents within the Clinical Board. Some of these groups share

lessons learnt and periodic reporting is undertaken where expected. The following groups and committees exist:

- Clinical Board Group;
- PCIC Emergency Preparedness, Resilience and Response and Business Continuity Meeting; and
- PCIC's Quality & Safety Experience Committee.

- Each Business Unit has their Quality, Safety and Experience Committee meetings which feed into PCICs Quality, Safety and Experience Committee. This further feeds into the Health Board's Quality & Safety Committee; and
- For the 3 sample areas selected, there are efficient mediums through which issues and reports regarding BCPs can be reported and monitored.

The following significant finding was noted under this objective:

- On review of the management reporting structures at the Clinical Board Level and the 3 Business Units selected, it was noted that some of the groups and committees had their terms of reference out of date.

## 7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

| Finding 1 - PCICs Business Continuity Plan Document (Control design) | Risk |
|---|---|
| There is a PCIC major incident summary plan guide and various local guidance documents within the PCIC Clinical Board. There are escalation and action cards which can be used as a reference document where an unexpected situation arises. However, there is currently no overarching PCIC Business Continuity summary document in place.<br><br>As at the time of the audit fieldwork, 14/31 service areas had not provided the Clinical Board with a copy of a fully complete and formally documented BCP.<br><br>It was noted that there is a planned process in place to ensure relevant service areas have fully documented BCPs. A deadline has been given to all service areas to submit their BCPs by the end of December. However, there is a risk that services would not be adequately managed if an unexpected event occurs (within the period where the areas have no BCP) which might have an adverse effect and disrupt services. | Non-compliance with legislation |
| **Recommendation 1** | **Priority level** |
| Management should ensure that all Business Units and Service Areas which require a BCP produce a formally documented one as soon as possible. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| PCIC Clinical Board management are aware that all Business Units and Service Areas have been involved in the BCP process although not all have a written document completed and approved. Reviews are planned or have taken place | PCIC Business Manager / end December 2019 |

| | |
|---|---|
| with all Business Units and finalised documents are anticipated to be received by the Clinical Board in November and December 2019. One BCP (OOHs) will be submitted to PCIC QSE in November 2019 along with a briefing paper and process flowchart and the Director of Nursing will present the paper and flowchart. The other BCPs are anticipated to be submitted to PCIC QSE in January 2019 and will then enter an annual review process within their Business Units. | |

| **Finding 2 - Terms of Reference (TOR) (Operating effectiveness)** | **Risk** |
|---|---|
| The PCIC Clinical Board has a good governance and management structure and each Business Unit has a Quality, Safety and Experience Committee in place for dealing with BCP and related issues.<br><br>The Locality Quality, Safety and Experience Committees for the 3 Business Units reviewed had their TOR out of date at the following periods:<br>• Out of Hours Office (OOH) - March 2019;<br>• Vale of Glamorgan Locality: Day time Services/ communication hub - March 2019; and<br>• North & West Locality: District Nursing - May 2018.<br><br>The TOR for the PCIC Emergency Preparedness, Resilience and Response Business Continuity meeting are currently in draft.<br><br>Other groups and committees at the clinical board level also had their TORs out of date. These include:<br>• Clinical Board Group- due July 2019. | PCIC is unable to resume service provision in a timely manner |

| | |
|---|---|
| • Service Delivery Group- due January 2019. *No meeting has been held in the current year although as at the time of the audit fieldwork a meeting had been fixed for September. They are required to meet monthly.* | |
| **Recommendation 2** | **Priority level** |
| Management should ensure all terms of references are reviewed and updated as required. | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| PCIC Clinical Board Senior Management Team will ensure the terms of reference for any meetings they chair are reviewed and refreshed, and that future review dates are established.<br><br>The Business Units will be advised to review the terms of reference for their established meetings and ensure they are refreshed if needed.<br><br>This will also be added to the agenda for November 2019's PCIC Clinical Board Meeting, under a standing Governance update on Internal Audit. | Individual members of SMT / December 2019<br><br>Business Unit Leads / December 2019<br><br>PCIC Business Manager / November 2019 |

| Finding 3 – Awareness of a Business Continuity Plan (Operating effectiveness) | Risk |
|---|---|
| The Business Continuity Planning Guidance page 23 states:<br>*'(Insert Service Name) recognises that staff awareness of the BC Plan is essential to its success. In order to help to embed BCM, (Insert Service Name) will ensure that an ongoing programme of education and awareness is established to ensure that:*<br>• *Staff understand the risks, remain vigilant and know how to respond.*<br>• *Team members remain fully aware of their responsibilities and the actions expected from them. '*<br>Audit was informed that staff with key responsibilities as listed within the BCP are aware of what is expected and actions to take where disruption in services occurs.<br>Three Business Units (One with two additional Service Areas within the Business Unit) within the PCIC Clinical Board were reviewed to establish the level of awareness of business continuity. Two of the five Business Units and Service Areas only had a partial awareness of the BCP. These were the Vale of Glam: Daytime Services / Communication Hub and North & West Locality: North Cardiff DN Team. | Adequate service cannot be provided in the event of a significant event or in the face of adverse conditions |

| Recommendation 3 | Priority level |
|---|---|
| Management should ensure that all members of staff are made aware of the existence of a BCP, the risk associated with possible occurrences and how to respond in such an event. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Business Unit Leads will be asked to ensure that all Service Areas make all team members aware of the existence of a BCP, where the document is located, key risks for their Service Area, and their role in the use of the document. | Business Unit Leads / February 2020 |

| Finding 4- Clinical Board signoff of Business Continuity Plans (Operating effectiveness) | Risk |
|---|---|
| The Health Board's Business Continuity Planning Guidance Page 11 states that:<br>*'All local/operational BC plans will require approval and sign off by Clinical Boards who must retain an overarching view of all plans.'*<br>Audit was informed of plans to sign off BCPs by the end of the financial year. However, as at the time of the audit field work, none of the BCPs of the 3 Business Units (selected for review) had been signed off at the Clinical Board level. | Adequate service cannot be provided in the event of a significant event or in the face of adverse conditions |

| Recommendation 4 | Priority level |
|---|---|
| Management will ensure that all service areas which require a BCP have their plans signed off. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| One BCP (OOHs) will be submitted to PCIC QSE in November 2019 along with a briefing paper and process flowchart and the Director of Nursing will present the paper and flowchart. The other BCPs are anticipated to be submitted to PCIC QSE in January 2019 and will then enter an annual review process within their Business Units. The PCIC Business Manager maintains logs indicating the status of each BCP in the approval process and this will then form the basis of a tracker to ensure plans are reviewed on an annual basis within the Business Units. | PCIC Business Manager / January 2020 |

# Appendix B - Assurance opinion and action plan risk rating

## Audit Assurance Ratings

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

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

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

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

## Prioritisation of Recommendations

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

| Priority Level | Explanation | Management action |
|---|---|---|
| **High** | Poor key control design OR widespread non-compliance with key controls.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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

# Maelfa: Wellbeing Hub

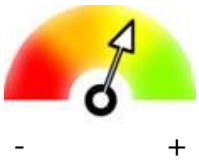
# Final Internal Audit Report 2019/20

## Cardiff & Vale University Health Board

## Private and Confidential

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

| Reasonable Assurance |
| --- |
|   |

**CONTENTS**



| | |
|---|---|
| **Review reference:** | SSU_CVU_1920_02 |
| **Report status:** | Final Report |
| **Fieldwork commencement:** | 8 July 2019 |
| **Fieldwork completion:** | 1 October 2019 |
| **Draft Report issued:** | 26 September 2019 |
| **Draft Report meeting** | 2 October 2019 |
| **Proposed Final Report issued** | 3 October 2019 |
| **Management response received** | 21 October 2019 |
| **Final report issued:** | 22 October 2019 |
| **Auditor/s:** | NWSSP: Audit & Assurance - Specialist Services Unit |
| **Executive sign off** | Abigail Harris, Executive Director of Planning |
| **Distribution** | Geoff Walsh, Director of Capital, Estates and Facilities<br>Jeremy Holifield, Head of Capital Planning<br>David Taylor, Capital Planning Manager |
| **Committee** | Audit Committee |

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

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

**Please note:**

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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

## 1. Introduction and Background

In December 2017, the Welsh Government outlined their plan to build 19 new integrated health and care centres across the country. The plan forms part of the Welsh Government's commitment to move care closer to home. The centres are intended to act as community hubs bringing together a range of public services on one site. The expectation is that all schemes should be delivered by 2021.

Included in the listing for the Primary & Community Care pipeline are three schemes for Cardiff & Vale University Health Board: of which the Wellbeing Hub at Maelfa is one.

The project will include the replacement of accommodation at Llanedeyrn Health Centre with modern and flexible primary care and community facilities to deliver Health & Wellbeing Services in conjunction with the Local Authority.

An Outline Business Case (OBC) for a capital investment of £12.75m has been submitted on 31st May 2019 to the Welsh Government to progress the project.

This will be the first audit of the project and will evaluate the processes and procedures that support its delivery.

## 2. Scope and Objectives

The review was undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of the University Health Board ('the UHB') for the management of capital projects, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

Accordingly, the focus of the audit was directed to the following areas:

- **Governance Arrangements –** assurance that adequate governance arrangements existed including management ownership, defined roles & responsibilities and clearly defined accountability & delegation arrangements.
- **Approvals –** assurance that appropriate internal / external approval mechanisms were applied as the project progressed through key junctures.
- **Business Case Development –** assessment of the adequacy of arrangements to develop the component elements of the five-stage business case including resource, structures, monitoring and reporting and ensure scrutiny comments were adequately addressed.

- **Contract Awards / Contract Documentation –** assurance that appropriate mechanisms had been applied at the appointment of contractors and design team members, ensuring compliance with local and national protocols. In addition, assurance that all contract documentation had been appropriately completed to the current stage of development.
- **Client Brief and Design Development** – assessment of the arrangements to define and sign-off the client brief and the engagement processes thereafter to develop the design.
- **Change Management** – assessment of the robustness of arrangements to manage the time, cost and quality implications arising from the implantation of client and design team changes.
- Identification of **any other issues** material to the successful achievement of the project's objectives.

## 3. Associated Risks

The potential risks considered at this audit included:

- Inadequate organisational and governance arrangements were in place;
- Roles and responsibilities had not been developed and assigned to appropriate individuals;
- Appropriate project management tools were not employed effectively at the programme;
- The project progressed at risk without appropriate approvals;
- The business case was not produced in a timely manner or was inadequate to define the case for change;
- The client brief was not adequately understood impacting outcomes and objectives; and
- Key objectives were at risk through the lack of management of changes.

# 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.

Noting the stage of the project, at the time of our review, general compliance was noted with the established control frameworks in each of the objective areas sampled.

However, certain enhancements have been recommended in respect of:

- Updating the Project Execution Plan, noting the UHB's movement to developing the Full Business Case;
- Attendance of nominated members at both Project Board and Project Team meetings;
- Update to the risk register for the financial risk of affordability against the benchmark base cost;
- Development of resource/ activity plans by work stream leads; and
- Contract documentation being appropriately addressed and executed.

The overall assurance determined is cognisant of these recommendations and the current stage of the project (i.e. awaiting approval of Outline Business Case).

Accordingly, against this context, the level of assurance has been assessed as **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 following table:

| Assurance Summary | |  |  |  |  |
|---|---|---|---|---|---|
| **1** | Governance arrangements | | | ✓ | |
| **2** | Approvals | | | | ✓ |
| **3** | Business Case Development | | | ✓ | |
| **4** | Contract Awards / Contract Documentation | | | ✓ | |
| **5** | Client Brief & Design Development | | | | ✓ |
| **6** | Change Management | | | | ✓ |

** 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 were classified as a weakness in the system control/design for managing the requirements of the Maelfa: Wellbeing Hub project.

### Operation of System/Controls

The findings from the review highlighted **four** issues that were classified as weaknesses in the operation of the designed system/control for managing the requirements of the Maelfa: Wellbeing Hub project.

## 6. Summary of Audit Findings

### Governance arrangements

**We sought assurance that appropriate governance arrangements were in place for the current project phase e.g. management ownership, defined roles & responsibilities and defined accountability & delegation arrangements.**

The project structure was formally developed and established both within the Project Execution Plan (PEP) and the Outline Business Case (OBC).

The Executive Director of Planning fulfilled the role of Project Owner. A review of meeting minutes confirmed the Project Owner discharged the expected governance requirements.

The Director of Capital, Estates & Facilities fulfilled the role of Project Director; and approved delegated authority for the day-to-day UHB responsibilities to the Head of Capital Planning. However, it was noted that the main point of contact for the project was the Capital Planning Manager. The PEP should be updated to reflect the current governance arrangements (**recommendation 1**).

No separate Project Board was established; rather project discussions were part of the SOFW: IOC Delivery Group (Shaping Our Future Wellbeing: In Our Community). Meetings were held on a quarterly basis, rather than on a bi-monthly basis, as detailed in the terms of reference; or the monthly basis as detailed in the PEP (**recommendation 1**).

Issues regarding attendance of nominated members were noted (**recommendation 2**). Whilst these members could be considered not to be key roles for the current stage of the project, the position should be reviewed as the project gains momentum.

A Project Team was established with appropriate terms of reference and monthly meetings being held. Similar issues regarding attendance of nominated project team members were also noted (**recommendation 2**).

However, taking into account the overall project governance arrangements in place, the level of assurance determined in this area as providing **reasonable assurance,** subject to the aforementioned.

## Approvals

**We sought assurance that appropriate internal / external approval mechanisms had been applied at the project progressed through key junctures.**

The UHB Board approved the OBC, prior to its submission to the Welsh Government on 30th May 2019. Scrutiny comments were received, addressed and returned by the UHB to the Welsh Government on 7th September 2019.

At the date of this audit, approval from the Welsh Government was awaited.

Outline planning permission was approved by Cardiff Council on 29th August 2019.

Acknowledging the current position in the approval process, the level of assurance determined in this area is **substantial.**

## Business Case Development

**We sought assurance of the adequacy of arrangements to develop the component elements of the five-stage business case including resource, structures,**

**monitoring and reporting; and ensured scrutiny comments were adequately addressed.**

The five-case business model had been followed in the development of the OBC.

Cost for the preferred option [new build facility] is £12.75m. Design development was predicated on a benchmark base cost determined and agreed with NWSSP: SES of £2,300 per sq. metre; with the OBC reporting at £2,392 per sq. metre for the project (less site-specific abnormal costs).).

To the point of this audit, work streams had not yet been formally established to support the Project Team. However, future work streams were defined. In the interim, there was evidence of appropriate consultation with stakeholders and clinicians to develop the project accordingly.

Moving forward, work stream leads should prepare resource/activity plans to target key outputs at key intervals to support the Project Board/ Team in the development of the FBC (**recommendation 3**).

Revenue implications of the project were reviewed at Project Team meetings, prior to submission of the OBC. Medium rated risks, and appropriate mitigating management actions, were added to the project risk register as a result of these discussions:

- Affordability of revenue funded services; and
- Potential increased revenue costs to the GP practice from relocating.

A **reasonable assurance** has been determined in relation to the processes in place to derive the Outline Business Case.

## Contract Awards / Contract Documentation

**We sought assurance that appropriate mechanisms had been applied at the appointment of contractors and design team members, ensuring compliance with local and national protocols. Further, we sought assurance that all contract documentation had been appropriately completed to the current stage of development.**

The procurement strategy was documented in the Outline Business Case and agreed for the Supply Chain Partner (SCP) and relevant external advisers.

The SCP and advisers were procured under the new Designed for Life: Building for Wales Framework (D4L: BfW). Contract documentation for the appointed advisers had been appropriately executed and prior to the commencement of any related project work.

However, a review of the contract held for the SCP noted that the main contract had not been signed by both parties, rather the parties had signed

Confirmation Notice 1 (**recommendation 4**). Despite this administrative oversight, all contract clauses had been adequately completed and it was confirmed that the SCP had undertaken no work prior to the signing of the contract.

We have therefore determined **reasonable assurance** in respect of contract awards to date, pending the full completion of the SCP contract.

## Client Brief and Design Development

**We sought assurance that processes were in place to define and sign-off the client brief; and that appropriate engagement processes were employed to develop the design.**

Full stakeholder involvement was evident in the development of the client brief and design:

- Engagement strategy – outlined the aims of the project and the events being held to ensure full participation from the users and those in the local community;
- Engagement paper – outlined the process of public engagement activity: including consultation with Communities First (which was still active at the time of the initial consultation) and the Third Sector (C3CS);and
- AEDET (Achieving Excellence Design Evaluation Toolkit) workshop – hosted by NWSSP: SES and sought input from team leaders and significant teams [who are to be involved in the wider project] into the design process.

The level of design completion at OBC submission was 1:100. At the date of the audit, work was commencing in relation to completion of the room data sheets.

The service model for the delivery of the change to clinical pathways had been considered as part of the design; with integration of third parties and the UHB to facilitate ease of access to the services and signposting where required.

It was noted, however, there would be no proposed change to the workforce model with clinics and community team bases to remain the same as the existing site but in a changed location.

A value engineering exercise was undertaken in March 2019 to review the design and identify further efficiencies to reach the cost plan as included in the OBC. The impact on cost of this exercise was a decrease of circa £45k.

In the context of the stage of the project at the point of our review, **substantial assurance** has been determined.

### Change Management

**We sought assurance that arrangements to manage the time, cost and quality implications arising from the implantation of client and design team changes were sufficiently robust.**

Appropriate change management processes had been applied and were cognisant of those processes followed for other UHB capital projects.

As reported in the Project Manager report, issued 6 August 2019, there had been 21 changes recorded with a total value of £300,723: of which £28,674 (two changes) were pending instruction.

A sample of 85% of the approved changes were selected for testing.

For each, the change management process had been adhered to and there was evidence of value for money being assessed before approval by the relevant officers. Approvals at Health Board level were within the appropriate delegated limits, noting that for one change [value: £200k], authorisation had also been sought from the Executive Director of Planning and the Chief Executive.

In the context of the stage of the project at the point of our review, **substantial assurance** has been determined.

## 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** | - | 1 | 3 | **4** |

| Finding: Project Execution Plan | Risk |
|---|---|
| Noting the time that has passed since the initial PEP was issued, amendments are required to reflect the correct governance framework as the UHB moves towards Full Business Case.<br>• delegated authority for day to day responsibilities – inclusion of the role of the Capital Planning Manager; and<br>• frequency of project board meetings – confirmation as to whether quarterly, bi-monthly or monthly. | Project management tools are not employed effectively at the programme |
| **Recommendation 1** | **Priority level** |
| The PEP should be updated accordingly and resonate with other supporting documentation (i.e. terms of reference) **(O)**. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Accepted. The PEP will be updated accordingly. | Director of Capital, Estates & Facilities<br>In line with the Full Business Case |

| Finding: Attendance at Project Board / Project Team meetings | Risk |
|---|---|
| A review of four of the Project Board (SOFW: IOC Delivery Group) meetings held [October 2018, December 2018, April 2019 and June 2019] noted regular non-attendance by the Corporate and Third Party nominated members of the Delivery Group [as per the terms of reference].<br><br>Seven Project Team meetings were reviewed [from February 2018 to date]. Whilst there was a pre-determined membership of the group [as per the terms of reference] a number of regular non-attendees were noted:<br><br>• two officers not attending for six of the meetings reviewed [N&W Locality Manager and Cardiff Council representation for Community Services]; and<br><br>• one officer not attending for five of the meetings reviewed [S&E Locality Manager].<br><br>It was noted that concerns regarding attendance at Project Team meetings were minuted in the February 2019 meeting; however, there were two further meetings before the aforementioned officers were minuted as being in attendance.<br><br>It is, however, acknowledged that given the stage of the project at which these meetings were held, the officers would not necessarily have held a key role in decision-making processes. | Inadequate organisational and governance arrangements are in place.<br><br>The project progresses at risk without appropriate approvals. |

| Recommendation 2 | Priority level |
|---|---|
| As the project gains momentum, Project Board and Project Team members should be reminded of the importance of attendance to ensure all discussions / decisions taken are suitably informed. | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Accepted. The terms of reference will be reviewed at the next meetings for the Project Board [SOFW:IOC Delivery Group and Project Team] with specific reference to the required nominated officers for each. | Director of Capital, Estates & Facilities<br>End November 2019 |

| Finding: Work streams | Risk |
|---|---|
| Best practice would observe work stream leads reporting and/or accounting to the Project Team/Board on the performance of the respective activities.<br><br>Work streams had not yet been formally established to support the Project Team. However, anticipated future work streams were defined.<br><br>In the interim, there was evidence of consultation with stakeholders and clinicians to develop the project accordingly. | Insufficient attention is maintained across all of the activities required to inform the Project Board/ Team. |
| **Recommendation 3** | **Priority level** |
| Work stream leads should produce resource/ activity plans for the attention of the Project Team/ Board **(O)** | **Low** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Accepted. At the last Project Team meeting [1 October 2019] the draft membership for each of the three work streams was reviewed. Further review of the roles and responsibilities for each will be undertaken. | Director of Capital, Estates & Facilities<br><br>End November 2019 |

| Finding: Contract Documentation | Risk |
|---|---|
| A review of the contract documentation for the SCP noted that the call off contract had not been signed by either party. However, both parties had signed the confirmation notice 1 [not applicable for the current stage of the project].<br><br>It was noted that the NHS common seal had already been attached to both the call off and confirmation notice sections of the contract documentation.<br><br>Whilst this error had been noted, it was confirmed that no work was undertaken by the SCP until the 'contract' documentation had been signed. | The project progresses at risk without appropriate approvals. |
| **Recommendation 4** | **Priority level** |
| Arrangements should be made to ensure the correct section of the contract is signed by both parties **(O)** | **Medium** |
| **Management Response** | **Responsible Officer/ Deadline** |
| Accepted. The contract was returned to the SCP at the end of September for signing and is currently with the Head Office for the second signatory. | Director of Capital, Estates & Facilities<br><br>End October 2019 |

## 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.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

## Cardiff and Vale University Health Board

# PCIC Clinical Board Continuing Healthcare : Adults Follow-Up

## Final Internal Audit Report

## 2019/20

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



| | |
|---|---|
| **Review reference:** | C&V-1920-07 |
| **Report status:** | Final Internal Audit Report |
| **Fieldwork commencement:** | 14th October 2019 |
| **Fieldwork completion:** | 15th November 2019 |
| **Draft report issued:** | 20th November 2019 |
| **Management response received:** | 21st November 2019 |
| **Final report issued:** | 21st November 2019 |
| **Auditor/s:** | Ian Virgill, Stuart Bodman |
| **Executive sign off:** | Steve Curry, Chief Operating Officer |
| **Distribution:** | Lisa Dunsford, PCIC Director of Operations<br>Kay Jeynes, PCIC Director of Nursing<br>Anna Mogie, Locality Lead Nurse<br>Helen Donovan, Locality Lead Nurse<br>Nicola Hughes, Locality Lead Nurse |
| **Committee:** | Audit Committee |

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

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

## 1. Introduction and Background

This follow-up review of Continuing Healthcare (CHC) within the Primary, Community and Intermediate Care (PCIC) Clinical Board was completed in line with the 2019/20 Internal Audit plan for Cardiff and Vale University Health Board.

The relevant lead Executive for the assignment is the Chief Operating Officer.

The original CHC Audit report was finalised in May 2017 and highlighted a total of eight issues, which resulted in an overall assurance rating of limited Assurance.

A first follow-up was then conducted in May 2018 which identified that although some progress had been made, five of the total eight management actions had not been fully implemented. The overall level of assurance therefore remained at Limited.

The findings from the original audit and first follow-up were reported within combined audit reports that covered both Adult and Children's CHC.

It has however now been agreed that as the processes relating to each type of CHC are separate, individual follow-ups would be undertaken for each area.

A separate follow-up report has therefore been produced in respect of Children's CHC within the Children & Women's Clinical Board.

## 2. Scope and Objectives

The objective of the original review was to assess the adequacy of arrangements for the management of CHC in order to provide assurance to the UHB Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the follow up review is to establish if the previously agreed management actions have been implemented, in order to ensure that there are appropriate systems and processes are in place for the assessment of CHC patients along with the commissioning and approval of placements and the on-going monitoring of these.

In following up the agreed actions the main areas that the review sought to provide assurance on were:

- There is a formally documented procedure in place for assessment, decision making and commissioning processes for CHC; and
- The quality of care provision is monitored.

## 3. Associated Risks

The potential risks considered in this review are as follows:

- Impact on the quality of patient care provision; and
- Financial loss due to inadequate management of CHC process/ performance management of providers.

## 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.

| | | |
|---|---|---|
| **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. |

It is evident that the Clinical Board has made progress towards implementing the outstanding agreed management actions from the original review. However, there is still one action that requires completion.

Work is ongoing between all parties to progress contractual arrangements between providers that will lead to a formalised Heads of Service Agreement (HoSA). All sampled CHC follow up annual reviews were undertaken in 2019 but there is an issue with PARIS management reports not fully capturing the assessments undertaken.

As detailed within section 5 below, the follow-up has concluded that one of the remaining outstanding management responses has been fully actioned and one has been partially actioned.

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with PCIC Clinical Board Continuing Healthcare: Adults Follow-Up has improved to **Reasonable Assurance**.

## 5. Summary of Audit Findings

Follow up work was undertaken to confirm the progress that the Health Board has made against the outstanding agreed management responses from the original audit, as detailed within Appendix A.

In summary, progress against the two outstanding agreed Adult CHC recommendations as stated in the previous follow up audit report that required implementation are as follows:

| Priority rating | No of management responses to be implemented | Fully actioned | Partially actioned | Not actioned |
|---|---|---|---|---|
| High | 2 | 1 | 1 | 0 |
| Medium | 0 | 0 | 0 | 0 |
| Low | 0 | 0 | 0 | 0 |
| **Total** | **2** | **1** | **1** | **0** |

In summary, the progress made against the two management responses that required implementation is as follows:

- Work is ongoing between all parties to progress contractual arrangements between providers that will lead to a formalised Heads of Service Agreement (HoSA) and it is acknowledged that process may take time to fully implement. (Partially Actioned)
- All patients sampled across the three Cardiff Localities (North & West, South & East and the Vale of Glamorgan) held a documented follow up annual review undertaken in 2019. (Fully Actioned)

| **Original Finding 2 – A timescale should be set to ensure the Head of Service Agreement (HoSA) is agreed promptly. (Operating effectiveness)** | **Risk** |
|---|---|
| The Head of Service Agreement is out of date and there is no timescale for its completion therefore there is no formal, in date framework contract in place for the provision of care. | Impact of placement delays on patient care. |
| **Original Recommendation** | **Priority level** |
| A timescale should be set to ensure the Head of Service Agreement is agreed promptly. | **High** |
| **Original Management Response** | **Responsible Officer/ Deadline** |
| The Director of Nursing has written to the leads for both local authorities to understand the timescales for the update of the Heads of Service Agreement, there has been no response. There is however a jointly commissioned working group, attended by the Health Board, which have been tasked with updating the agreement. This has a proposed finish date of April 2018, however, this date has not been formally communicated. | Director of Nursing |
| **Current Position** | |
| **Action Partially Complete**<br>Current documentary evidence was provided that shows that work is ongoing between all parties across the Local Authorities and the UHB to progress contractual arrangements between providers that will lead to formalised Heads of Service Agreement (HoSA). | |

| Updated Management Response | Updated Responsible Officer / Deadline |
|---|---|
| There has been significant progress with community stakeholders including Third sector providers, their legal representatives and Cardiff and Vale Local Authorities in developing an agreed contract process which will then lead to the updating of the Heads of service agreement. These discussions have been overseen by Regional Commissioning Board which has representatives from C&V UHB (PCIC and the Planning team) and both LA's. | Regional Commissioning Board April 2020 |

| Original Finding 3 - PCIC should ensure an annual review is carried out on existing CHC placements and evidence of this review should be maintained on the patients file. (Operating effectiveness) | Risk |
|---|---|
| Completion of annual reviews of Adult General and Learning Disability CHC clients is behind target. From testing completed, 12/22 files were missing annual reviews. Only 1 Children CHC file was missing an annual review. This is not mitigated by regular review of service providers as reliance is placed on the Care and Social Services Inspectorate reviews and these are not checked regularly unless informed by Local Authority that there is an issue.<br>Audit notes that for most of these there has been periodic contact with the clients. | Impact on the quality of patient care provision. |
| **Original Recommendation** | **Priority level** |
| PCIC should ensure an annual review is carried out on existing CHC placements as per the framework and evidence of this review should be maintained on the patients file. | **High** |

| | |
|---|---|
| | |
| **Original Management Response** | **Responsible Officer/ Deadline** |
| A schedule is in place to meet statutory requirements for review which is monitored at PCIC SDG (Performance monitoring meeting) also at Welsh government Complex Care board. There is recognition both locally and nationally that staffing establishments within the nurse assessor teams expected to undertake this work are limited and further put under pressure when safeguarding issues arise in Nursing homes which need immediate and often long term support. This risk is on the PCIC Risk register and additional resources have been highlighted for potential investment in the PCIC IMPT, the business case was not requested from the Executive team on this POD as a priority for funding. | Director of Nursing, PCIC |
| **Current Position** | |
| **<u>Action Complete</u>**<br>All 10 patients sampled from across the three Cardiff Localities (North & West, South & East and the Vale of Glamorgan) held a documented follow up annual review undertaken in 2019.<br>It is however noted that the testing identified that two Locality PARIS Reports (Vale and SE Cardiff) did not fully include confirmation of annual follow up assessments undertaken in 2019, although the PARIS entries themselves confirmed that they had been undertaken by Nurse Assessors. This issue has already been raised with management and is noted here for information only. | |

## Appendix B - Assurance opinion and action plan risk rating

### Audit Assurance Ratings

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

**Follow up -** All recommendations implemented and operating as expected.

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

**Follow up** - All high level recommendations implemented and progress on the medium and low level recommendations.

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

**Follow up -** No high level recommendations implemented but progress on a majority of the medium and low recommendations.

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

**Follow up -** No action taken to implement recommendations.

## Prioritisation of Recommendations

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

| Priority Level | Explanation | Management action |
|---|---|---|
| **High** | Poor key control design OR widespread non-compliance with key controls.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

## Cardiff and Vale University Health Board

# Children & Women's Clinical Board Continuing Healthcare: Children Follow-Up

## Final Internal Audit Report

## 2019/20

## NHS Wales Shared Services Partnership

## Audit and Assurance Services

**Contents** **Page**



**Review reference:** C&V-1920-07

**Report status:** Final Internal Audit Report
**Fieldwork commencement:** 14th October 2019
**Fieldwork completion:** 15th November 2019
**Draft report issued:** 21st November 2019
**Management response received:** 22nd November 2019
**Final report issued:** 25th November 2019

**Auditors:** Ian Virgill, Stuart Bodman

**Executive sign off:** Steve Curry, Chief Operating Officer

**Distribution:** Cath Heath, Children & Women, Director of Nursing
Paula Davies, Locality Lead Nurse

**Committee:** Audit Committee

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

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

**Disclaimer notice - Please note:**

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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

## 1. Introduction and Background

This follow-up review of Continuing Healthcare (CHC) within the Children & Women's Clinical Board was completed in line with the 2019/20 Internal Audit plan for Cardiff and Vale University Health Board.

The relevant lead Executive for the assignment is the Chief Operating Officer.

The original CHC Audit report was finalised in May 2017 and highlighted a total of eight issues, which resulted in an overall assurance rating of limited Assurance.

A first follow-up was then conducted in May 2018 which identified that although some progress had been made, five of the total eight management actions had not been fully implemented. The overall level of assurance therefore remained at Limited.

The findings from the original audit and first follow-up were reported within combined audit reports that covered both Adult and Children's CHC.

It has however now been agreed that as the processes relating to each type of CHC are separate, individual follow-ups would be undertaken for each area.

A separate follow-up report has therefore been produced in respect of Adult CHC within the PCIC Clinical Board.

## 2. Scope and Objectives

The objective of the original review was to assess the adequacy of arrangements for the management of CHC in order to provide assurance to the UHB Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the follow up review is to establish if the previously agreed management actions have been implemented, in order to ensure that there are appropriate systems and processes are in place for the assessment of CHC patients along with the commissioning and approval of placements and the on-going monitoring of these.

In following up the agreed actions the main areas that the review will seek to provide assurance on are:

- There is a formally documented procedure in place for assessment, decision making and commissioning processes for CHC;
- Contracts are in place for the provision of care;
- There are appropriate processes in place for contract management; and
- The quality of care provision is monitored.

## 3. Associated Risks

The potential risks considered in this review are as follows:

- Impact of placement delays on patient care;
- Impact on the quality of patient care provision; and
- Financial loss due to inadequate management of CHC process/ performance management of providers.

## 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.

| | | |
|---|---|---|
| **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. |

It is evident that the Clinical Board has made progress towards implementing the two outstanding agreed management actions from the original review.

Good practice is noted that a pilot Children's and Young People's Continuing Care Operational Policy has been agreed between Cardiff & Vale UHB, Cardiff Council and the Vale of Glamorgan Council.

KPIs in respect of Children's CHC have been fully introduced but are not currently subject to review and action by the Child Health Directorate.

As detailed within section 5 below, the follow-up has concluded that one of the outstanding management responses have been fully actioned and one has been partially actioned.

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Children & Women's Clinical Board Continuing Healthcare: Children Follow-Up has improved to **Reasonable Assurance**.

## 5. Summary of Audit Findings

Follow up work was undertaken to confirm the progress that the Health Board has made against the outstanding agreed management responses from the original audit, as detailed within Appendix A.

In summary, progress against the two agreed Children's CHC recommendations as stated in the previous follow up audit report that required implementation are as follows:

| Priority rating | No of management responses to be implemented | Fully actioned | Partially actioned | Not actioned | Not Applicable |
|---|---|---|---|---|---|
| High | 0 | 0 | 0 | 0 | 0 |
| Medium | 2 | 1 | 1 | 0 | 0 |
| Low | 0 | 0 | 0 | 0 | 0 |
| **Total** | **2** | **1** | **1** | **0** | **0** |

In summary, the progress made against the two outstanding management responses that required implementation is as follows:

- SLAs have been introduced in respect of CHC placement providers, and whilst CHC KPIs have been introduced these are not subject to review and action within the Child Health Directorate. (Partially Actioned)
- A Joint Working Agreement between Cardiff & Vale UHB, Cardiff Council and the Vale of Glamorgan Council that includes a Children's and Young People's Continuing Care Operational Policy has been developed in 2019. (Fully Actioned)

| **Original Finding 4 – The Directorate has commissioned an external expert to lead on the development of an integrated joint protocol which will be agreed between the Directorate and both Local Authorities. (Operating effectiveness)** | **Risk** |
|---|---|
| There is no National Framework in place for Children and Young Peoples CHC and there is no local policy or procedure in place to adopt the Welsh Government guidance. | Impact of placement delays on patient care. |
| **Original Recommendation** | **Priority level** |
| The Children CHC team should develop a local procedure that sets out how they adopt the Welsh Government guidance. | **Medium** |
| **Original Management Response** | **Responsible Officer/ Deadline** |
| The Community Child Health Directorate will develop a local Operational Policy based on WG CC Guidance for Children. The policy will include:<br>• The CVUHB Appeals Process as WG Children's Guidance is not specific; and<br>• Recommendation of key performance indicators for children's CHC. | Paula Davies, Lead Nurse, CCH<br>October 2017 |
| **Current Position** | |
| **<u>Action Complete</u>**<br>A Joint Working Agreement between Cardiff & Vale UHB, Cardiff Council and the Vale of Glamorgan Council that includes a Children's and Young People's Continuing Care Operational Policy has been developed in 2019. | |

| Original Finding 5 - Absence of CHC Placement SLAs and monitoring via CHC KPIs (Control Design) | Risk |
|---|---|
| Performance KPIs for adult general focus on number of clients and costs, there are no KPIs that cover aspects such as timing delays and quality of patient care.<br>Children residential placements are jointly commissioned with the LA, contracts are commissioned and held by LA and are not specific to health. Therefore there are no service user agreements that are specific to commissioning health aspects. Due to this there are no KPIs for monitoring within Children CHC, internally performance and timescales are monitored but they are not always compliant due to resourcing. | The quality of care provision is monitored and periodic reports on CHC and the associated costs are produced and submitted to appropriate groups for review and action. |
| **Original Recommendation** | **Priority level** |
| Individual Service User Agreements should be produced to cover health aspects of child residential placements and KPIs developed/expanded to monitor performance internally. | **Medium** |
| **Original Management Response** | **Responsible Officer/ Deadline** |
| The Community Child Health Directorate will agree a process for KPI's to be measured and reported on in line with other Directorate Performance Management. | Paula Davies, Lead Nurse, CCH<br>October 2017 |

| Current Position |
| --- |
| **Action Partly Completed**<br>Testing identified that where appropriate, SLAs are in place between the Health Board and Continuing Care placement providers.<br><br>Continuing Care KPIs have been developed and introduced within the Community Child Health Directorate during 2018/19 and these are also in place through to October 2019.<br><br>However, there is no evidence that Continuing Care KPIs have been presented to the Directorate Performance Management meetings or any other Directorate group between April 2018 and October 2019 or to peers in neighbouring Health Boards. |

| Updated Management Response | Updated Responsible Officer / Deadline |
| --- | --- |
| KPI's have been collated and discussed in local team meetings, however, they have not been regularly reported into Directorate Performance meetings. When they have there are no minutes available to provide evidence of this. Going forward they will be reported into Directorate Quality, Safety and Patient Experience and a standing agenda item at the monthly meetings. This has already commenced and they were reported into November's meeting. Regular audits will be commenced to verify data reporting sources as accurate. An admin post has recently been recruited to for the disability futures programme and will support this audit and data collection.<br><br>There are some KPI's which stand out as they have consistently low scores, this is largely due to capacity of the Continuing Care team to complete the assessment | Paula Davies, Lead Directorate Nurse<br><br>June 2020 |

| | |
|---|---|
| processes in line with WG timescales. This will improve with the recruitment of a designated nurse assessor post which will be advertised soon. The draft revised WG Guidance for Children's Continuing Care has also lengthened these timescales as a result of consultation across Wales.<br><br>The directorate does not currently have access to a commissioning manager. A joint commissioning post has been agreed and is due to be advertised. This post is supported by the Disability Futures Programme and will provide development of joint commissioning and contracting arrangements, contract monitoring across our jointly funded health and social care packages. This commissioning manager will support the reporting of KPI's across Health Boards and Local Authorities as appropriate.<br><br>The Directorate will commence a pilot of a newly formed Regional Multi-Agency Children's Continuing Care Panel in January 2020 in line with the new Joint Operational Protocol. There will be representation form the UHB, Cardiff and Vale LA on this Panel. | Paula Davies, Lead Directorate Nurse<br><br>December 2020 |

## Appendix B - Assurance opinion and action plan risk rating

### Audit Assurance Ratings

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

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

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

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

### Prioritisation of Recommendations

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

| Priority Level | Explanation | Management action |
|---|---|---|
| **High** | Poor key control design OR widespread non-compliance with key controls.<br>PLUS<br>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.<br>PLUS<br>Some risk to achievement of a system objective. | Within One Month* |
| **Low** | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>These are generally issues of good practice for management consideration. | Within Three Months* |

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