Public Audit Committee

Tue 07 September 2021, 09:00 - 12:30

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Agenda

1. Welcome and Introductions

John Union

2. Apologies for Absence

John Union

3. Declarations of Interest

John Union

4. Minutes of the Committee meeting held on 6th July 2021

John Union

4 - Draft Unconfirmed Audit Committee Public Minutes 06.07.2021 - V2.NF.pdf (10 pages)

5. Action log following meeting held on 6th July 2021

John Union

5 - Public Action Log following 06-07-2021 - V1.pdf (2 pages)

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

John Union

7. Items for Review and Assurance

7.1. Internal Audit Progress and Tracking Reports

Ian Virgill

7.1 - A&A Progress Report cover September 21.pdf (2 pages)
7.1.1 - A&A Progress Report September 21.pdf (14 pages)

7.2. Job Planning Update

Stuart Walker

7.2 - Job Planning Update.pdf (2 pages)

7.2.1 - Appendix 1&2 Audit & Assurance Committee Meeting 07-09-2021.pdf (2 pages)

7.3. Audit Wales Update

Wales Audit

7.3 C&VUHB AC Update (September 2021).pdf (10 pages)

7.4. Audit of Accounts Addendum Report

Wales Audit

7.4 - Audit of Accounts Addendum.pdf (12 pages)

7.5. Review of WHSSC Governance Arrangements

Nicola Foreman

7.5 - Review of WHSSC Governance Arrangements.pdf (13 pages)

7.6. Review the System Of Assurance Strategy

Nicola Foreman

7.6 - Assurance Strategy.pdf (2 pages)
7.6.1 - Assurance Strategy 21-24 - Appendix 1.pdf (19 pages)
7.6.2 - Assurance Map C&V UHB - Appendix 2.pdf (1 pages)

8. Items for Approval / Ratification

8.1. Declarations of Interest and Gifts and Hospitality Tracking Report

Nicola Foreman

8.1 - Declarations of Interest and Gifts and Hospitality Tracking Report_Aug 21.pdf (4 pages)

8.2. Regulatory Compliance Tracking Report

Nicola Foreman

8.2 - Regulatory Compliance Covering Report.pdf (5 pages)
8.2.1 - Regulatory Heat Map.pdf (3 pages)

8.3. Internal Audit Tracking Report

Nicola Foreman

8.3 - Internal Audit Tracker Covering Report September 2021.pdf (3 pages)
8.3.1 - Internal Audit Tracker Sept 2021.pdf (11 pages)
8.3.2 - Internal Audit Summary Tables - Appendix 1 September 2021.pdf (2 pages)

8.4. Audit Wales Tracking Report

Nicola Foreman

8.4 - External Audit Recommendation Tracking report covering report - September 2021.pdf (2 pages)
8.4.1 - WAO Sept 2021.pdf (3 pages)
8.4.2 - External Audit Summary Table - Appendix 1 (Sept 2021).pdf (1 pages)

9. Items for Information and Noting

9.1. Internal Audit reports for information:

Ian Virgill

1. Legislative, Regulatory, & Alerts Compliance
2. Healthy Eating Standards - Hospital, Restaurant, & Retail Outlets
3. Cancellation of Outpatient Clinics Follow-up (Mental Health Clinical Board)
4. Ultrasound Governance (Clinical Diagnostics and Therapeutics Clinical Board)

9.1.1 - Legislative, Regulatory & Alerts Compliance.pdf (18 pages)
9.1.2 - Healthy Eating Standards - Hospital.pdf (12 pages)
9.1.3 - Cancellation of Outpatient Clinics Follow Up (MHCB).pdf (17 pages)
9.1.4 - Ultrasound Governance (CD&T CB).pdf (16 pages)

10. Review and Final Closure

10.1. Items to be deferred to Board / Committee

John Union

10.2. To note the date, time and venue of the next Committee meeting: Tuesday 9th November 2021 at 9.00am

Unconfirmed Minutes of the Public Audit and Assurance Committee
Held on Tuesday 6th June 2021 9:00am – 12:30pm
Via MS Teams

Chair		
John Union	JU	Independent Member – Finance
Present:		
Ceri Phillips	CP	Vice Chair
Mike Jones	MJ	Independent Member – Trade Union
David Edwards	DE	Independent Member – ICT
In Attendance:		
Anthony Veale	AV	Audit Wales
Catherine Phillips	CP	Executive Director of Finance
Darren Griffiths	DG	Audit Wales Manager
Ian Virgil	IV	Head of Internal Audit
Mark Jones	MJ	Audit Wales Financial Manager
Nicola Foreman	NF	Director of Corporate Governance
Nigel Price	NP	Local Counter Fraud Specialist
Rachel Gidman	RG	Executive Director of People and Culture
Wendy Wright	WW	Deputy Head of Internal Audit
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		

Minute Ref	Agenda Item	Action
AAC 21/07/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the Public Audit & Assurance Committee meeting	
AAC 21/07/002	**Apologies for Absence** No Apologies were provided.	
AAC 21/07/003	**Declarations of Interest** There were no declarations of interest	
AAC 21/07/004	**Minutes of the Committee meeting held on 13th May & 10th June 2021** The minutes of the meetings held on 13th May and 10th June 2021 were received. **The Committee resolved that:** a) The minutes of the meetings held on 13th May and 10th June 2021 be approved as a true and accurate record of the meeting.	
AAC	**Action log following meeting held on 13th May 2021**	

21/07/005	The action log was received and the CC advised the Committee that all of the actions were in hand, had been completed, were on the agenda for the meeting or had been scheduled for a future meeting **The Committee resolved that:** a) The action log from 13th May 2021 was received and noted by the Committee	
AAC 21/07/006	**Any other urgent business: To agree any additional items of urgent business that may need to be considered during the meeting** No urgent business was discussed.	
AAC 21/07/007	**Internal Audit Progress and Tracking Reports** The Head of Internal Audit (HIA) provided the Committee with a brief update against the Audit plan for 2021/22 that was agreed in April 2021. There were no final reports from the 2021/22 plan to be shared however, 7 reports from the 2020/21 plan, which were not finalised in time for the Committee Meeting in May 2021, were shared. The HIA confirmed that the outcomes from the completed reports were included in the annual opinion for 2020/21 The Deputy Head of Internal Audit (DHIA) highlighted that the planning environment for 2021/22 had been challenging and she thanked the Management teams for offering their time to help complete the review. She confirmed that reasonable assurance with a range of medium and low priority recommendations was given for the review into the Engagement Around Service Planning. The DHIA commented on the Data Quality Performance Report and advised that the audit was undertaken during a period when resources and processes were undergoing significant change. She highlighted the report provided reasonable assurance with a range of medium and low priority recommendations with a focus on policy and procedures. She added that there some enhancements of governance arrangements were required specifically concerning the operational cancer group and she highlighted the importance of strengthening the validation of data. The Children's & Women's Clinical Board - Rostering in Community Children's Nursing report was discussed. The DHIA confirmed that the Audit was requested by the Clinical Board with an appetite to improve their efficiency and effectiveness. Reasonable assurance was provided with a range of medium and low priority recommendations. The HIA commented on the Staff Recruitment Board which received a reasonable assurance rating. The audit had focused on the processes in place for nurse recruitment which were very robust and had good controls in place. He informed the committee that his team had also planned to look at the controls in place for temporary recruitment but due to timing and the focus on mass vaccination at the time they were not able to complete the testing as planned.	

	The HIA highlighted the Report into the Wellbeing hub at Maelfa which was a capital project where some issues were raised around completion of contract documentation and the timeliness of payments of the schemes. He advised that the report issued a reasonable assurance rating and he provided the Committee with assurance that some robust actions were agreed to address the areas of concern. The HIA confirmed that his team had made progress with five audits from the current year's plan and they were also in the early stages for planning for another two. The HIA highlighted the following changes to the Audit Plan for 2021/22: - ALNET Act – Initially planned for 2021/22 but following further discussions with the Executive Director of Therapies and Health Science it was agreed to defer this to the 2022/23 plan - Consultant Job Planning Follow Up – At the time of producing the 2021/22 plan the follow up of the consultants job planning audit had not completed. As the report issued a reasonable level of assurance a further update would not be required. **The Committee resolved that:** a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports was considered. b) The proposed amendments to the Internal Audit Plan for 2021/22 were approved.	
AAC 21/07/008	**Audit Wales Update** Darren Griffiths, Audit Wales (DG-AW) highlighted 2 matters: The Phase two structured assessment work would be undertaken in two stages. He advised that phase one had been completed and phase two would focus on the Health Boards corporate governance, financial management arrangements and how the arrangements had changed since the previous assessment. Phase two would also look at how learning from the pandemic was shaping future arrangements for ensuring good governance. The field work was currently under way with the aim to report findings in September 2021. DG-AW highlighted the follow up of radiology services audit which would focus on progress made to date against implementing the recommendations of the 2016 review and that this field work was underway. **The Committee resolved that:** a) The Committee noted the Audit Wales update.	**AWAW**

AAC 21/07/009	**Structured Assessment 2021 (Phase One) – Operational Planning Arrangements** DG-AW highlighted how Internal Audit focused on the 2021/22 planning arrangements and described how the work Audit Wales were undertaking focussed on Q3 & Q4 planning arrangements. He advised that the report was positive and found that the health boards planning arrangements were robust and effective but there was still a need to strengthen the health boards overall arrangements for monitoring and reporting on operational delivery, particularly to the Strategy & Delivery (S&D) Committee and to the Board. No recommendations were made but they would be incorporated into the phase 2 work and the assessment of whether there has been any improvement in reporting progress to the S&D Committee and Board as part of the 2021/22 plan. The CC queried a reference in the report to the fact that there would be no monitoring or reporting of the Health Boards overall performance and delivery from Q3 and Q4 from the previous year and whether this was incorporated into the current year's planning process. DG-AW responded that Audit Wales specifically looked into the 2021/22 plan but had seen from preliminary phase 2 assessments that there had been improvements to how the plan had been prepared for the 2021/22 and he noted the adoption of the plan of the page which provided a clear and succinct summary of the key milestones and targets that the health board was working towards The UHB Vice Chair highlighted that the report confirmed that the Health Board were developing the process for enhancing its monitoring and reporting arrangements and he queried whether Audit Wales concerns would be alleviated if those plans were implemented. DG-AW responded that it would cover their concerns but caveated this by confirming that they would need to see evidence of the arrangements operating effectively which is why they did not put forward any recommendations. He also acknowledged that Audit Wales could see that the Health Board was on a journey of improvement in terms of enhancing monitoring arrangements. He stated that they were willing to give more time for the arrangements to bed in and be implemented before providing any recommendations. The Director of Corporate Governance (DCG) highlighted that at the last board meeting they had brought a first draft of the integrated Board report and was presented in the private session as more work was required but it would run in parallel with the reports that were already presented in public. She added that the reporting in regards to the S&D committee that they are currently reporting the flash reports that come to the Management Executive meetings were now going into the S&D committee so by the time the phase 2 work begins there will be evidence of work being progressed. The HIA commented that as part of their plan for the year they would also be looking at the delivery of the 2021/22 plan which would provide further assurance of those processes.	

	The Committee resolved that: a) The Audit Wales update was noted.	
AAC 21/07/010	**Rollout of the COVID-19 vaccination programme in Wales** The DG-AW advised that the report was the outcome of a facts based review and did not provide any judgements as is usually the case with national reports. The report highlighted that the programme was delivered at significant pace with the milestones in the Welsh Government (WG) vaccination strategy providing a strong impetus to drive the programme. He highlighted that vaccine uptake was high with lower uptake in some ethnic groups and within the more deprived communities. He commented that some vaccination sites had been more effective than others and that some sites may become unavailable as they return to normal use. He added retaining workforce reliability would be vital especially to support the autumn booster programme, if introduced, and he added that there were many positive learning examples of how the programme was rolled out. He suggested that the NHS and WG should look to apply that learning to wider immunisation strategies and the delivery of other programmes across the NHS. **The Committee resolved that:** a) The Committee noted the Audit Wales update	
AAC 21/07/011	**Procuring and Supplying PPE for the COVID-19 Pandemic** The DG-AW confirmed that the report specifically focussed on the national efforts to supply the Health and Social Care sectors in Wales. He added that a review of the arrangements for local procurement for PPE or the logistical arrangements in place to locally distribute PPE directly to frontline staff were not reviewed. The report found that NWSSP overcame some of the early challenges to provide the level PPE required without having to run stock at a national level. The review did find, through staff surveys undertaken by the BMA and RCN in Wales that some staff had reported experiencing some shortages in PPE and others had suggested that they felt they should have received a higher level of PPE than required by guidance. The DG-AW highlighted that whilst good arrangements were put in place by most governments and NWSSP to procure PPE, some contract award notices were not published in all cases within 30 days. 8 recommendations were made to address weaknesses and areas for improvements. The Executive Director of Finance (EDF) commented that it was reassuring to see the Health Board measured against standard benchmarks in an emergency situation. She queried how much consideration was given to the fact that they were operating in an emergency situation and therefore may not have been able to do everything that they would normally do in a non-emergency environment.	

	The DG-AW responded that the report recognised the extraordinary circumstances and the way in which the NHS had been operating. He highlighted that there was an issue with the stockpile in place as they had prepared for an influenza pandemic not coronavirus. In terms of preparation there was significant work to be done to procure appropriate PPE to meet the demands of the pandemic. He stated that the investigation demonstrated that the system, as a whole, was very effective at working at pace and transforming at pace to meet challenges. He added going forward there would be a need to ensure minimum standards were being adhered to. **The Committee resolved that:** a) The Committee noted the Audit Wales update	
AAC 21/07/012	**Welsh Health Specialised Services Committee (WHSSC) Governance Arrangements** The DG-AW confirmed that the review found that the governance arrangements, management operations, and planning arrangements had improved since previous reviews in 2015 but the impact of the pandemic meant that WHSSC would still require a clear strategy to recover services. He highlighted that Audit Wales had made a number of recommendations to WHSSC and the Welsh Government. The management responses would be presented to the Audit Committee separately as they were not available for the meeting. DG-AW added that no specific recommendations were made for individual Health boards but he drew attention to the fact that the committee may want to reflect on findings in relation to the flows of assurance between the joint committee and individual boards. **The Committee resolved that:** a) The Committee noted the Audit Wales update	
AAC 21/07/013	**Declarations of Interest and Gifts and Hospitality Tracking Report** The DCG reminded the Committee that her team request and update Declarations of Interest on an annual basis. At the May committee meeting it was confirmed that a significant amount of work had been undertaken over the previous 12 months to increase the number of declarations made. The DCG confirmed that the report set out the current position and highlighted that the number of declarations would increase as the year progressed as the process for recording entries re-started each year. She informed the Committee that her team maintained a record of previous declarations that can be referred to and that they also work closely with the counter fraud team to monitor declarations of interest. The DCG highlighted that the Health Board was looking to work with Betsi Cadwaladr to make the system more automated and that an update would be shared at the next committee meeting.	

	The Committee resolved to: a) Note the ongoing work being undertaken within Standards of Behaviour b) Note the update in relation to the Declarations of Interest, Gifts, Hospitality & Sponsorship Register	
AAC 21/07/014	**Regulatory Compliance Tracking Report** The DCG highlighted that there was an ongoing audit in this area and that whilst the system had been in place for two years her team were looking to improve the systems in place to provide greater assurance to the Committee. The DCG highlighted that two entries had been added to the tracker since it was last presented, one in relation to the British Standards institute and another in relation to a food hygiene inspection. She also highlighted inspections that were due to take place between the date of the committee and September 2021. The DCG advised that most regulatory inspections had not taken place routinely due to Covid but that inspection visits were beginning to increase. **The Committee resolved to:** a) Note the inspections which had taken place since the last meeting of the Audit Committee in April 2021 and their respective outcomes. b) Note the continuing development of the Legislative and Regulatory Compliance Tracker.	
AAC 21/07/015	**Internal Audit Tracking Report** The DCG informed the committee that she and her team had been tracking audit recommendations for the previous 3 years as agreed with Internal Audit so that the Committee did not lose sight of recommendations. 126 recommendations were recorded which was an increase of 20 since last reported. The DCG advised that the increase was due to the end of year internal audits that were pushed through at the end of the previous financial year. The DCG highlighted that of the 126 recommendations: - 60 were recorded as complete - 33 were recorded as partially complete - 33 had no reported action taken since the previous committee meeting. The DCG informed the committee that Internal Audit undertake an assurance check on completed actions to provide the Committee with further assurance that recommendations are actually completed and that this work was undertaken in advance of each Audit committee meeting. **The Committee resolved to:** a) Note tracking report in place for tracking audit recommendations made by Internal Audit.	

	b) Note that progress would be seen over coming months in the number of recommendations which are completed/closed.	
AAC 21/07/016	**Audit Wales Tracking Report** The DCG highlighted that there were some ITC recommendations that came to the committee in May 2021 that were not included in the current tracker which would be added and tracked in the usual way in advance of the next committee meeting. The DCG highlighted that of the 21 recommendations: - 7 were recorded as complete - 12 were recorded as partially complete - 2 had no reported action taken since the previous committee meeting. **The Committee resolved to:** a) Note progress which had been made in relation to the completion of Audit Wales recommendations. b) Note the continuing development of the Audit Wales Recommendation Tracker.	
AAC 21/07/017	**Risk Management Strategy & Action Plan** The DCG highlighted that within the Health Board's standing orders there was a requirement for the Board to sign off its Risk Management Board Assurance Framework arrangements on an annual basis. In addition to that an internal audit had been undertaken which prompted recommendations that had been incorporated into the revised strategy and procedure. She informed the Committee that the Strategy, Procedure and Action Plan had been presented to the Management Executive and that Board Members had also participate in risk appetite sessions. The DCG reminded the Committee that the development of the strategy was an ongoing piece of work with a need to continually remind and train people of developments and up to date processes. She informed the Committee that a member of her team who meets with clinical boards and corporate directorates to provided training on risk management processes, systems and scoring to gain some consistency. She added that the plan on a page provided the committee with a clear direction of travel and expected outputs by the end of the year. **The Committee resolved to:** a) Approve updated Risk Management and Board Assurance Framework Strategy and Risk Management Procedure b) Note the Action Plan for the implementation of the revised Strategy and Procedure Khan Raj 08/31/2021 16:26:13	
AAC 21/07/018	**Self-assessment of effectiveness**	

	The DCG reminded the Committee that the results had come to the Committee previously with the Board and individual Committee results. She advised that on this occasion only the Audit committee self-assessment responses were shared. A total of 6 responses were received and she added that a commitment had been made to increase the response rates to the surveys. Four actions from the survey would be taken forward and the DCG confirmed that an action plan had been developed to monitor progress against these. **The Committee resolved to:** a) Note the results of the Committee's self-assessment Effectiveness Review for 2020-21. b) Approve the action plan at Appendix 1.	
AAC 21/07/019	**Outstanding Audit Recommendations Update:** **I. 2018/19** **II. 2019/20** The DCG shared an update on progress made against outstanding aged recommendations from the internal audit tracker. For 2018/19 entries the DCG highlighted the following: • 9 of the 12 entries were complete • Of the 3 outstanding recommendations one related to the Terms of Reference for the Strategic Commissioning meeting and it was proposed that the entry be closed as complete given work undertaken in the area. The additional 2 recommendations related to the Legislative/Regulatory Compliance tracker and Health & Safety and Fire Safety. The DCG advised that a further an internal audit had been commissioned on the Health Board's regulatory tracker and that an independent review had been undertaken on the Health Board's Health & Safety team. These two recommendations were also recommended for closure. For 2018/19 entries the DCG highlighted the following_There were 33 entries left on the tracker • 8 recommendations were complete • 25 recommendations remained incomplete – the DCG highlighted the detail in the report and asked that the recommendations contained therein be approved. The DCG confirmed that assuming the proposals were agreed the Internal Audit Tracker would carry forward 18 recommendations for the year 2019/20 into September's Committee meeting with the intention that further progress would be made against those entries prior to that meeting. The HIA queried one action that was being proposed to remove (AUDIT CUHB 19/20 – 23 - Freedom of Information). He highlighted that the plan detailed training was to be delivered on this for the financial year but queried whether it should remain on the tracker until the training had been delivered.	

	The DCG confirmed that it would remain on the tracker until a time and date had been confirmed for the delivery of this but she was confident that this could be confirmed before the next Audit committee meeting. **The Committee resolved to:** a) Note the Outstanding Audit Recommendations Update – 2018/19 and 2019/20 b) Approve the proposals for the future recording and removal of historic recommendations Health Board's Internal Audit Tracker.	
AAC 21/07/020	**Internal Audit reports for information**: The Following Internal Audit Reports were shared for noting and information: 1. Annual Planning Process 21/22 Report 2. Engagement Around Service Planning Report 3. Data Quality Performance Reporting (Single Cancer Pathway) Report 4. Infrastructure / Network Management Report 5. C&W CB – Rostering in Community Children's Nursing Report 6. Staff Recruitment Report 7. Wellbeing Hub at Maelfa Report **The Committee resolved to:** a) Note the Internal Audit reports.	
AAC 21/07/021	**NHS Counter Fraud Services in Wales - Q4 Report** The EDF shared the report for information and noting. She proposed that if any future reports received by herself, the DCG or Executive Director of People and Culture that may be of interest be circulated and noted at the upcoming committee meetings. **The Committee resolved to:** **a)** Note NHS Counter Fraud Services in Wales - Q4 Report	
AAC 21/07/022	**Items to be deferred to Board / Committee** No Items were noted.	
AAC 21/07/023	**To note the date, time and venue of the next Committee meeting:** Tuesday 7th September 2021 at 9.00am	

Public Action Log
Following Audit & Assurance Committee Meeting
6th July 2021
(For the Meeting 7th September 2021)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
Actions in Progress					
AAC 20/11/023	Job Planning Update	To provide a further update in 6 months' time.	Stuart Walker	07.09.21	Update to be brought to the meeting on 7 September 2021. Agenda Item 7.2
AAC 21/04/007	Internal Audit Progress and Tracking Reports	The Director of Corporate Governance (DCG) asked the HIA if the Mental Health aspects had been identified elsewhere, and the HIA responded that it was not in the plan currently, however discussions would be held with the END and the DCG to incorporate it into the plan for next year.	Ian Virgil	07.09.21	Update to be brought to the meeting on 7 September 2021.
AAC 21/04/012	Review the system of assurance	DCG would work with the Management Executives (ME) to develop an assurance strategy	Nicola Foreman	07/09/2021	Update to be brought to the meeting on 7 September 2021. Agenda Item 7.6
AAC 21/06/006	Audit Wales ISA 260 Report	Following audit certification by the Auditor General Audit Wales will issue a separate report setting recommendations and management's responses.	Audit Wales	TBC	Report will be considered at a future meeting of the Audit and Assurance Committee
AAC 21/07/008	Audit Wales Update	The field work is currently under way for the Phase two structured assessment work and they are aiming to report their findings for September	Audit Wales	09/11/2021	Update to be brought to the meeting on 9 November 2021.
Actions referred to Board / Committees					

Report Title:	**Internal Audit Progress Report**								
Meeting:	Audit & Assurance Committee						**Meeting Date:**	07/09/21	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**	**X**	**For Information**		
Lead Executive:	Director of Governance								
Report Author (Title):	Head of Internal Audit								

Background and current situation:

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

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

The 2021/22 plan was formally approved by the Audit Committee at its April 21 meeting.

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

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

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

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

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

The report also includes details of a small number of proposed adjustments to the content of the plan and changes to the planned timings for delivery of audits.

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

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

Recommendation:

The Audit & Assurance Committee is asked to:

- **Consider** the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports.
- **Approve** the proposed amendments to the Internal Audit Plan for 2021/22.

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

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

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

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee September 2021

NWSSP Audit and Assurance Services

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Contents

1. Introduction

This progress report provides the Audit & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2021/22 Internal Audit plan.

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.

The plan for 2021/22 was agreed by the Audit & Assurance Committee in April 2021 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

The assignments noted in the table below are those which had been planned to be reported to the September Audit Committee but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
Surgery CB – Theatres Utilisation	Work in Progress		Delays in obtaining access to patient records required to complete testing.

3. Outcomes from Completed Audit Reviews

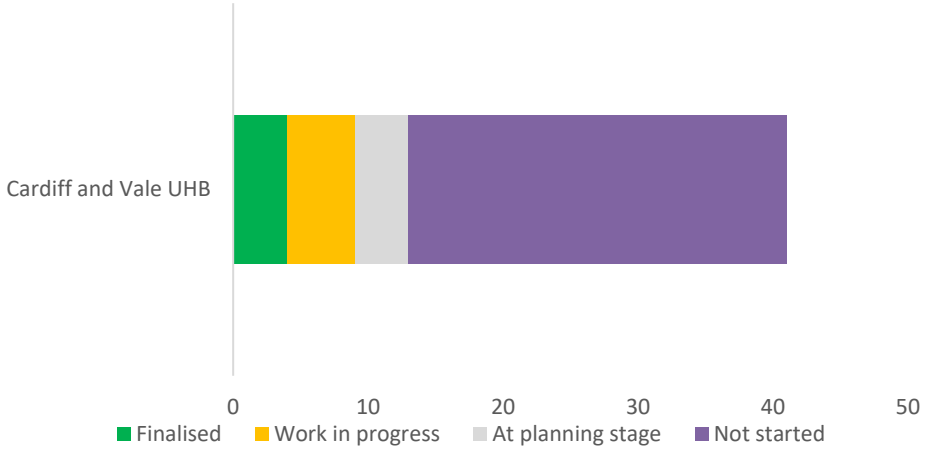
Four assignments have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

The Executive Summaries from the finalised assignments are reported in Section five. The full reports are included separately within the Audit Committee agenda for information.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Regulatory, Legislative & Alerts Compliance	Reasonable	
Healthy Eating Standards - Hospital Restaurant & Retail Outlets		
Mental Health CB – Cancellation of Outpatient Clinics Follow-up		
CD&T CB - Ultrasound Governance	Limited	

4. Delivery of the 2021/22 Internal Audit Plan

There are a total of 41 reviews included within the 2021/22 Internal Audit Plan, and overall progress is summarised below.



From the illustration above it can be seen that four audits have been finalised since the Committee met last.

In addition, there are five further audits that are currently work in progress with a further four at the planning stage.

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.

Appendix B highlights the times for responding to Internal Audit reports.

Appendix C shows the current level of performance against the Audit & Assurance Key Performance Indicators.

5. Proposed Changes to the 2021/22 Plan

The following audit has been proposed for deferral from the 21/22 plan:

- **Quality & Safety Governance**

  The Director of Nursing has requested that this audit be deferred to the 22/23 plan. QS&E Governance arrangements are currently being reviewed by Audit Wales and a new Framework is also being introduced within the Health Board.

Adjustments have been proposed to the planned timing for the following audit:

- **Health & Safety**

  The Chief Executive has requested that this audit be moved from Q2 to Q4. An external review of Health & Safety has recently been undertaken and our internal audit will therefore focus on providing assurance around progress made against the resultant action plan.

The proposed changes detailed above have been reflected within the table at Appendix A, subject to approval by the Committee.

6. Final Report Summaries

6.1 Legislative, Regulatory & Alerts Compliance

Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to Legislative, Regulatory and Alerts compliance, to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

Overview

Our overall assurance rating reflects the need to make enhancements to both the design and operation of the control environment, to provide greater assurance to the Health Board.

We acknowledge that resource pressures coupled with the impact of COVID-19 has limited the extent to which some areas have been able to progress. Our recommendations support the Health Board's recovery journey.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance **Low to moderate impact** on residual risk exposure until resolved	 2019/20

Assurance summary

Assurance objectives		Assurance
1	The robustness of the 'Legislative and Regulatory Tracker'	Reasonable
2	The management of regulatory alerts, safety notices and other communications.	Reasonable

Matters Arising		Control Design or Operation	Recommendation Priority
1	Design of the Legislative and Regulatory Tracker	Design	Medium
2	Operating effectiveness of the Legislative and Regulatory Tracker	Operation	Medium
3	Assurance Report - Legislative and Regulatory Tracker	Operation	Low
4	Tracking and monitoring Welsh Health Circulars	Design	Medium
5	Assurance Reporting of Welsh Health Circulars	Design	Medium
6	Assurance Process for Patient Safety Alerts	Operation	Medium
7	Assurance Reporting for Patient Safety Alerts	Operation	Low
8	Safety Notices and Important Documents Management Policy & Procedure	Operation	Low

6.2 Healthy Eating Standards - Hospital Restaurant & Retail Outlets

Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the University Health Board (UHB) in relation to the Healthy Eating Standards for Restaurant and Retail Outlets, in order to provide assurance to the UHB's Audit Committee that risks material to the achievement of the systems objectives were managed appropriately.

Overview

We identified no significant issues for reporting in our review.

Matters arising identify minor weaknesses in system design, or are of an advisory nature, which if taken forward would assist in raising the profile and position of the Standards.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary

	Assurance objectives	Assurance
1	The Standards are clearly documented	Substantial
2	Governance arrangements provide effective oversight of the Standards	Reasonable
3	The audit outputs of the HB's Public Health Team are effectively reported and acted upon	Reasonable

Matters Arising

		Control Design or Operation	Recommendation Priority
1	Design and standing of the Healthy Eating Standards	Design	Low
2	Lack of clarity of governance arrangements	Design	Medium
3	Refinement of Audit Process and Associated Outputs	Operation	Medium

6.3 Mental Health CB – Cancellation of Outpatient Clinics Follow-up

Rating	Indicator	Definition
Reasonable Assurance		All high level recommendations implemented and progress on the medium and low level recommendations.

Significant work has been undertaken towards implementing the recommendations in the original audit report, which is demonstrated by a move in assurance rating from Limited to Reasonable. The rationale for holding reasonable assurance is largely drawn from our ability to verify the design of controls, but the implementation of the controls requires a further period to become embedded. Our follow up recommendations raised in this review support an upward trajectory of enhanced assurance.

A detailed written procedure has been developed which includes a comprehensive proforma form to be used and covers all the issues identified as requiring attention. This should aid implementation of an improved and consistent approach to outpatient clinic cancellations going forward. Looking ahead, it is inevitable that further work and time will be required to fully embed the procedure, whilst being tried and tested by the Clinical Board.

A monthly cancellation report has been developed which has been automatically run and issued from April 2021. The report shows the total number of cancellations and rebooked appointments in the month, analysed by clinic, reason and subsequent outcome, which is supported by detailed information for each clinician and each patient affected. We acknowledge the report is in its infancy and whilst it begins to tell a story which is clinically useful, when we reviewed the reports, we highlighted issues which require addressing to support the further development of the report.

Progress against the original recommendations to be implemented is as follows:

Priority rating	Number of responses to be implemented	Fully actioned	Partially actioned	Not actioned
High	2	2	0	0
Medium	3	1	2	0
Total	**5**	**3**	**2**	**0**

Follow Up Recommendations raised through this review:

Priority rating	Follow up recommendations
High	0
Medium	3
Low	1
Total	**4**

6.4 Ultrasound Governance (CD&T Clinical Board)

Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to ultrasound 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.

Overview

This report provides limited assurance for Ultrasound Governance arrangements, which stems from issues relating to the design and implementation of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2).

Governance arrangements were found to be lacking and require review to effectively direct and oversee the implementation of the requirements prescribed by the revised policy and procedure.

Two high priority recommendations are proposed, which fall under the scope of objectives one and two.

Report Classification

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	-

Assurance summary

	Assurance objectives	Assurance
1	Design and implementation of ultrasound governance arrangements	Limited
2	Roles and responsibilities	Limited
3	Servicing, maintenance, repair and quality assurance	Substantial
4	Procurement of diagnostic and therapeutic ultrasound equipment	Substantial
5	Ultrasound training	Reasonable

Matters Arising

		Control Design or Operation	Recommendation Priority
1	Lack of communication of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2)	Operation	High
2	Absence of Clinical Board assurance to the Executive Director of Therapies and Health Science	Operation	Medium
3	Design and feedback of the Medical Ultrasound Risk Management Procedure	Design	Medium
4	Ultrasound governance arrangements require review	Operation	High
5	Roles and responsibilities outlined by procedure require formalisation	Operation	Medium

ASSIGNMENT STATUS SCHEDULE

Planned output.	No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current progress	Assurance Rating	Planned Audit Committee
Legislative, Regulatory & Alerts Compliance	06	Corporate Governance	Q1		Final Report Issued August 21	Reasonable	Sept
Healthy Eating Standards - Hospital Restaurant & Retail Outlets	11	Public Health	Q1		Final Report issued August 21	Reasonable	Sept
CD&T CB – Ultrasound Governance	27	COO	Q1		Final Report issued August 21	Limited	Sept
Mental Health CB – Cancellation of Outpatient Clinics Follow-up	29	COO	Q2		Final Report issued August 21	Reasonable	Sept
Surgery CB – Theatres Utilisation	25	COO	Q1		Work in progress		Nov
Five Steps to Safer Surgery Checklist	16	Medical	~~Q1~~	Q2	Work in progress		Nov
Retention of Staff	09	Workforce	Q2		Planning		Nov
Clinical Audit	15	Medical	Q2		Work in progress		Nov
IT Service Management (ITIL)	19	Digital & Health Intelligence	Q2		Work in progress		Nov
Medicine CB – QS&E Governance Framework	23	COO	Q2		Planning		Nov
Medical Equipment and Devices	35	Therapies & Health Sciences	Q2		Planning		Nov
Capital Scheme - Genomics	*SSU*	*Strategic Planning*	*Q2*		*Work in progress*		*Nov*
Management of staff Sickness Absence	07	Workforce	Q2		Planning		Feb
IM&T Control & Risk Assessment	02	Digital & Health Intelligence	Q3				Feb

Planned output.	No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current progress	Assurance Rating	Planned Audit Committee
UHB Core Financial Systems	03	Finance	Q3				Feb
Claims Reimbursement	04	Nursing	Q3				Feb
Whistle Blowing Policy	05	Corporate Governance	~~Q2~~	Q3			Feb
Compliance with Welsh Language Act	08	Workforce & OD	Q3				Feb
Nurse Bank	13	Nursing	Q3				Feb
Medical & Dental Staff Bank	14	Medical	Q3				Feb
Chemocare IT System	21	Digital & Health Intelligence	Q3				Feb
Security of Network and Information Systems (NIS) Directive Implementation	22	Digital & Health Intelligence	Q3				April
Specialist Services CB	26	COO	Q3				Feb
Financial Plan / Reporting	33	Finance	Q3				April
Post Contract Audit of DHH Costs	34	Finance	~~Q1~~	Q3			Feb
Delivery of 21/22 Annual Plan	37	Strategic Planning	Q3				April
Estates Assurance – Waste Management	*SSU*	*Finance*	*Q3*				*Feb*
Estates Assurance - Decarbonisation	*SSU*	*Finance*	*Q3*				*April*
Risk Management	01	Corporate Governance	Q4				April
Vaccination Programme (Flu / Covid)	10	Public Health	Q4				April
Health & Safety	18	CEO	~~Q2~~	Q4			April

Planned output.	No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current progress	Assurance Rating	Planned Audit Committee
IT Strategy	20	Digital & Health Intelligence	Q4				April
Mental Health CB	28	COO	Q4				April
Children & Women CB	30	COO	Q4				April
PCIC CB - GP Access	24	COO	~~Q2~~	Q4			April
Recovery of Non-COVID services / Delivery of Planned Care	31	COO	Q3/4				May
Performance Reporting	32	COO	Q3/4				May
Shaping Future Wellbeing in the Community Scheme	*SSU*	*Strategic Planning*	*Q4*				*May*
Capital Systems Management	*SSU*	*Strategic Planning*	*Q4*				*May*
Major Capital Scheme – UHW II	*SSU*	*Strategic Planning*	*Q1-4*		*On-going observer role, proactive input, and overview of the progression through the period.*		*n/a*
Development of Integrated Audit Plans	*SSU*	*Strategic Planning*	*Q1-4*		*Plans will be developed for inclusion within the respective business case submissions for relevant major projects/ programmes.*		*n/a*
Reviews Deferred / Removed from the plan							
ALNET Act	36		Q2		Director of Therapies and Health Sciences requested Deferral to 22/23 plan as work currently on-going to embed processes within the Health Board. Agreed by June AC.		
Consultant Job Planning Follow-up	17	Medical	Q4		Removed as assurance level increased to Reasonable after		

Planned output.	No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current progress	Assurance Rating	Planned Audit Committee
					20/21 follow-up – Agreed by June AC		
Clinical Board's QS&E Governance	12	Nursing	~~Q2~~	Q4	Director of Nursing requested deferral to 22/23 plan. QS&E Governance arrangement currently being reviewed by Audit Wales and a new Framework is also being introduced. – To be agreed by September AC.		

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Legislative, Regulatory & Alerts Compliance	Reasonable	Final	20/08/21	14/09/21	25/08/21	25/08/21	G
Healthy Eating Standards - Hospital Restaurant & Retail Outlets	Reasonable	Final	22/07/21	12/08/21	12/08/21	13/08/21	G
CD&T CB – Ultrasound Governance	Limited	Final	27/07/21	12/08/21	24/08/21	25/08/21	R
Mental Health CB – Cancellation of Outpatient Clinics Follow-up	Reasonable	Final	04/08/21	26/08/21	13/08/21	16/08/21	G

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2021/22	G	April 2021	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 2021/22	A	80% 4 from 5	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 4 from 4	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	75% 3 from 4	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 4 from 4	80%	v>20%	10%<v< 20%	v<10%

Report Title:	**Job Planning Update**	**Agenda Item no.**	**7.2**
Meeting:	**AUDIT AND ASSURANCE COMMITTEE**	**Meeting Date:**	**07/09/21**
Status:	**For Discussion**	**For Assurance** x	**For Approval** **For Information**
Lead Executive:	**Executive Medical Director**		
Report Author (Title):	**M&D e-Systems Advisor**		

Background and current situation:

This is the second update following the original Audit report produced in May 2018 where 6 issues were identified and resulted in 'Limited Assurance'.

An initial Audit follow-up report in January 2020 identified that not all issues had been fully addressed but it was accepted that a clear action plan was in place and a further report was planned for January 2021.

Since that time the new Allocate electronic job planning system, included in the plan, has been successfully imbedded into the Health Board and good progress has been made. Excellent engagement has been seen, despite progress being hampered by Covid.
In addition to this and in line with the procedure, the new job planning cycle will mean that all Consultants and SAS Grades will have a job plan that runs from April to March each year. At present we have requested that the current or most recent job plans are entered on to the job planning system with a view to move to the new cycle from April 2022.

In the most recent and final Audit report, completed in January 2021, testing had concluded that the agreed management actions had now been fully implemented, or were in the process of being implemented, for the last four outstanding recommendations originally raised. This progress has resulted in a final assessment of 'Reasonable Assurance'.

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

- Allocate eJob Planning software in place – Live as of 30th November 2020
- Consultant Job Planning Procedure published and SAS Procedure ready
- Job Planning Lead appointed
- Medical & Dental e-Systems Advisor in post
- Dedicated Web Pages created, resources developed
- Drop in sessions for Management Teams and Clinicians well attended
- Support offered to Clinical Boards and Management Teams
- Reporting features communicated to Boards via OPG and well received
- Increased progress with good quality Job Plans entered on the system
- Visibility, equity and consistency of plans entered within departments
- Compliance increased from 17% in 2018 to 35% (as at 13th August 2021)
- Target of >85% by April 22

Please see Appendix 1 & 2 (attached) for an overview of progress to date and level of improvement in the quality of data held and available to Clinical Boards and the Organisation as a whole.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):
The Job Planning system is helping to ensure that job planning is undertaken in a fair, reasonable and transparent way and is aligned with prudent health care and the strategic objectives of the organisation. This project seeks to ensure consistency in job planning across the organisation, and is also delivered in a way ensuring an engaged and valued workforce.

Recommendation:

Approve and **continue to support** the use of e-Job Planning to further increase information available to the Health Board in order to improve capacity and demand planning and aid the Covid recovery process.

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

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

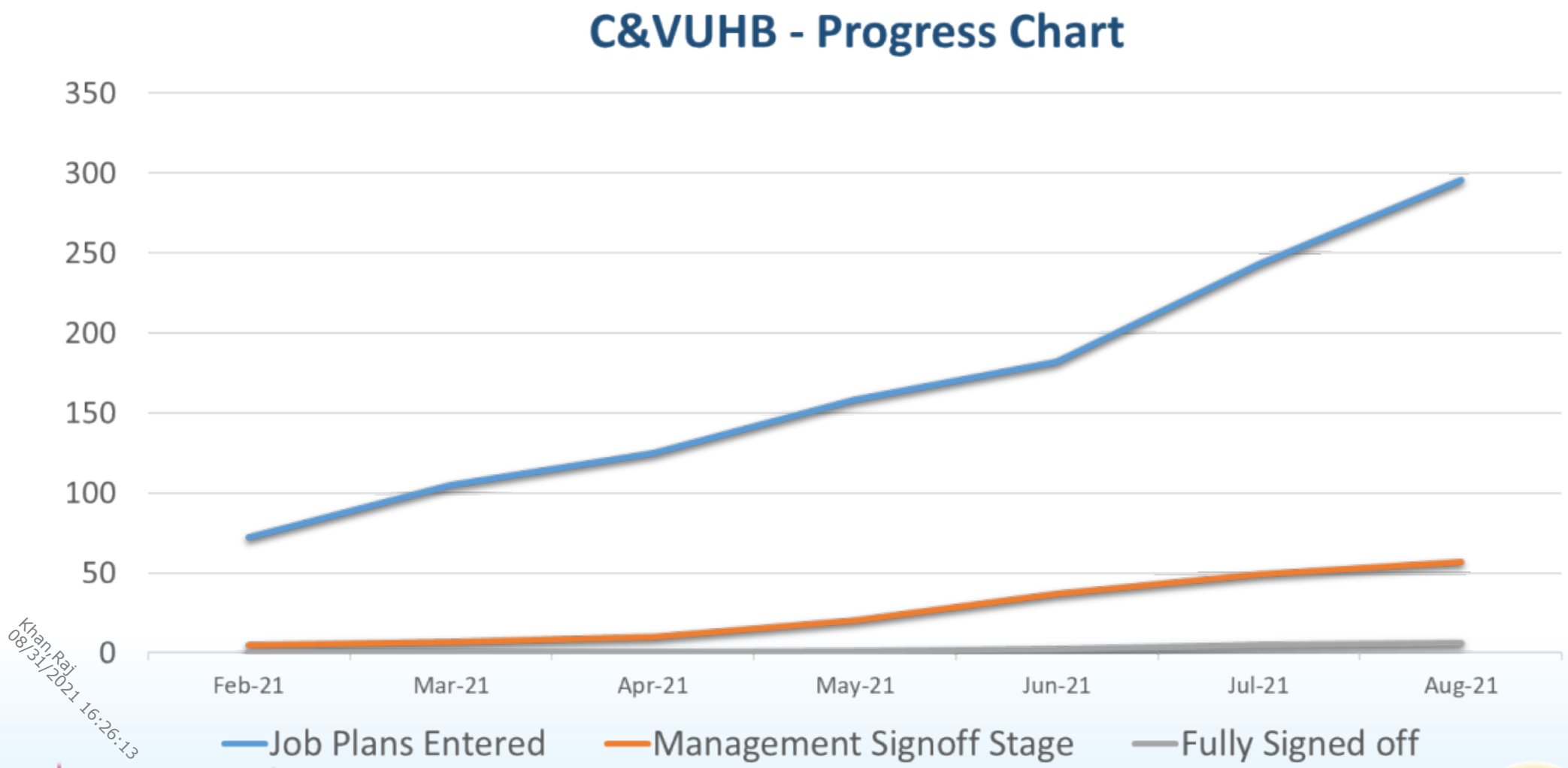
Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention		Long term	√	Integration		Collaboration	√	Involvement	

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

Appendix 1 – Current progress C&VUHB (10-08-2021)

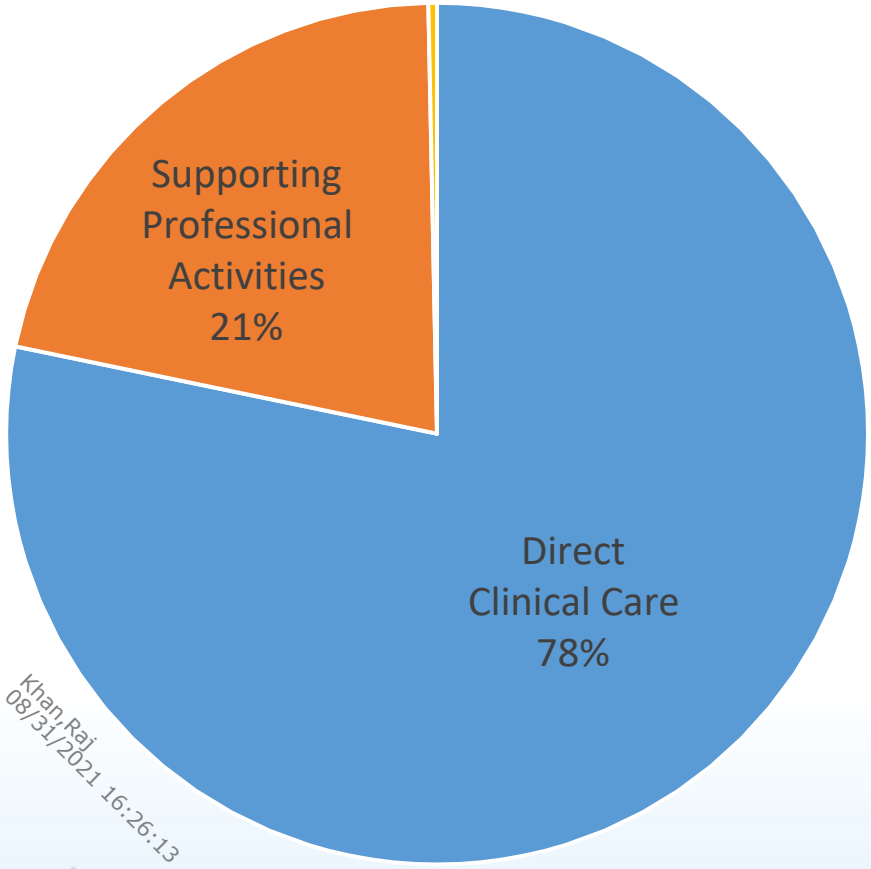
Total job plans in the UHB - 885



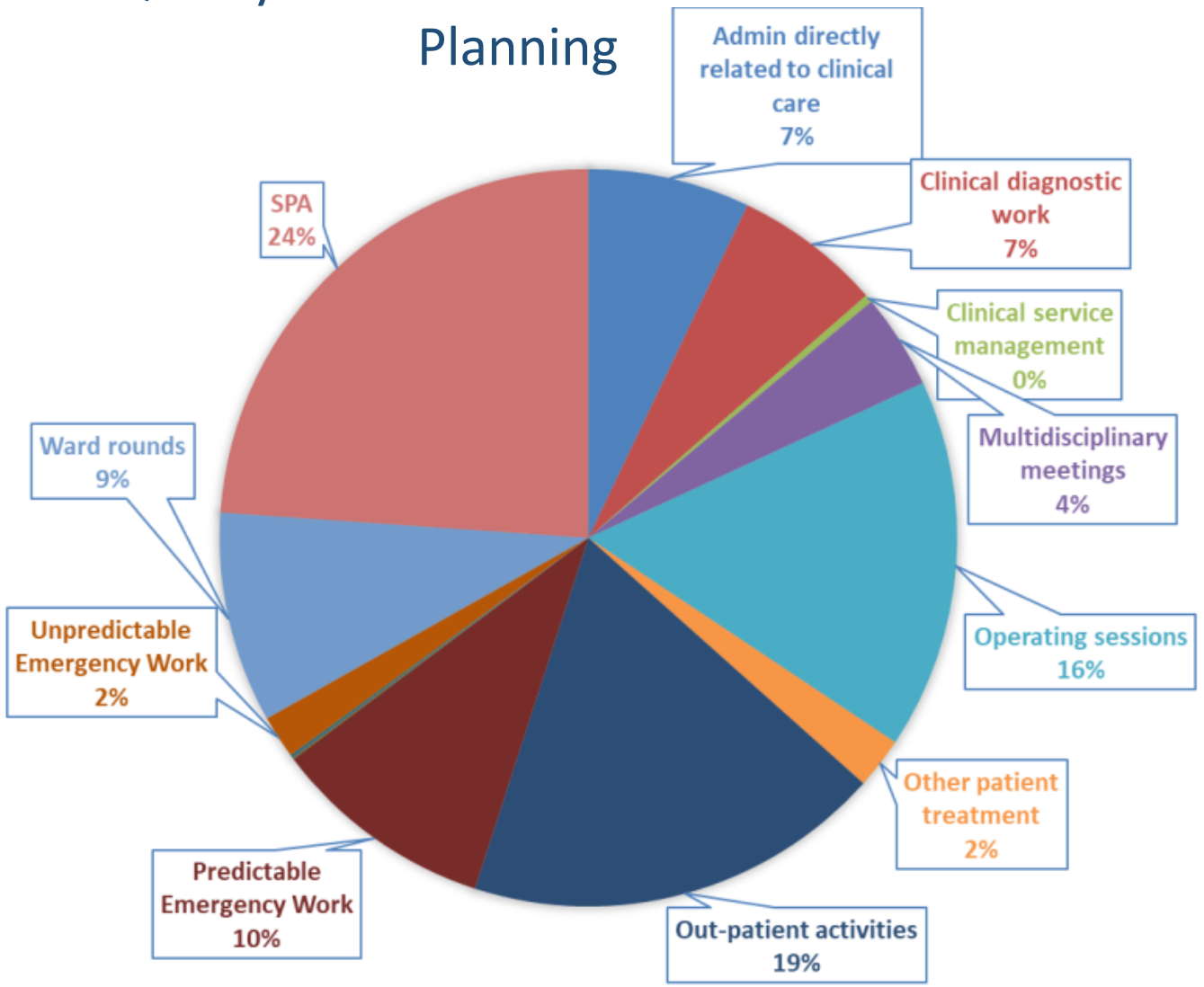
Khan Raj
08/31/2021 16:26:13

Appendix 2 – Overall data for C&VUHB

Quality of data available from ESR previously



Quality of data available with E-Job Planning



Archwilio Cymru
Audit Wales

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

Date issued: August 2021

Document reference: 2457A2021-22

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

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

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

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Contents

Audit Committee Update

About this document

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

Financial audit update

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

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2020-21 Performance Report, Accountability Report, and Financial Statements	The Audit and Risk Committee is due to consider our Audit of Accounts Addendum Report on 7 September 2021.
Audit of the 2020-21 Charitable Funds' Financial Statements	We are due to present our 2021 Audit Plan to trustee members on 23 September 2021.

Performance audit update

3 We have not completed any performance audit work since the Committee last met in July 2021. **Exhibits 2 and 3** set out the performance audit work included in our current and previous Audit Plans that is currently underway and planned work not yet started or revised.

Exhibit 2 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Structured Assessment 2020 - Supplementary Outputs Executive Leads – Director of Corporate Governance and Executive Director of People & Culture	To support our annual structured assessment work, we are undertaking further work to pull together two all-Wales outputs. The first output was published in January and focussed on how NHS bodies have governed differently during the COVID-19 crisis. The second output will focus on arrangements to support staff well-being during the pandemic and will be published in September / October.	Current status: All-Wales output on staff well-being being drafted Planned date for consideration: November 2021*
Orthopaedic Services – Follow-up Executive Lead – Chief Operating Officer	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges. Our findings will be summarised into a single national report with supplementary outputs setting out the local position for each health board.	Current status: Report being drafted Planned date for consideration: November 2021*
Quality Governance	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and	Current status: Report being drafted

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Executive Leads – Executive Nurse Director and Executive Medical Director	processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured assessment work across Wales which has pointed to various challenges with quality governance arrangements.	Planned date for consideration: November 2021*
Structured Assessment 2021 Executive Lead – Director of Corporate Governance	Our annual structured assessment is one of the main ways in which the AGW discharges his statutory requirement to examine the arrangements NHS bodies have in place to secure efficiency, effectiveness, and economy in the use of their resources. Our work in 2021 will be undertaken in two phases, as follows: • Phase 1 will examine the operational planning arrangements of each NHS body. • Phase 2 will look at the governance and financial management arrangements of each NHS body.	Current status: Phase 1 – completed; Phase 2 – Fieldwork underway Planned date for consideration of Phase 2 report: November 2021*
Follow-up of radiology services Executive Lead – Chief Operating Officer	In 2016, we undertook a review of radiology services. The work examined the actions the health board was taking to address the growing demand for radiology services, and the extent to which those actions were providing sustainable and cost-effective	Current status: Fieldwork underway Planned date for consideration: November 2021*

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
	solutions to the various challenges that existed at the time. We made a number of recommendations to the health board. This work will follow-up progress against these recommendations.	

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

Exhibit 3 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Review of Unscheduled Care Executive Lead – Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	Current status: Data analysis currently being completed with a national commentary due for publication in the Autumn. Date for consideration to be confirmed
Local Work 2021	The precise focus of this work is still to be determined.	Date for consideration to be confirmed

Good Practice events and products

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

5 In response to the COVID-19 pandemic, we have established a **COVID-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to prompt some thinking and support the exchange of practice. As part of the project, we held a COVID-19 Learning Week in March 2021. The material from the COVID-19 Learning Week is available here.

6 We have not held any good practice events or published any good practice products since the Committee last met in July 2021. Details of future events are available on the GPX website.

NHS-related national studies and related products

7 We have not published any NHS-related or relevant national studies since the Committee last met in July 2021.

8 However, the Committee may wish to note our Annual Report and Accounts 2021-22 published in June 2021. The report provides a summary of the changes made to the original work programme set out in our Annual Plan 2020-21 in response to the COVID-19 pandemic. It also contains our financial and accountability statements for the past year. A selection of case studies is included within this report to give more of an insight into some of the projects that we've been involved with and the impact that work has made.

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

Archwilio Cymru
Audit Wales

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

Audit year: 2020-21

Date issued: August 2021

Document reference: 2549A2021-22

This document has been prepared 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.

Contents

Audit of accounts report addendum

Introduction

1 This report is an addendum to our Audit of Accounts Report that we presented to you on 10 June 2021. It sets out the recommendations arising from our audit of the 2020-21 accounts, and also provides an update on the progress you have made against our previous years' recommendations.

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

Recommendations from this year's audit

3 In our Audit of Accounts Report we noted that we would present a separate report with details of the recommendations arising from our financial audit work. **Exhibits 1 to 6** set out six audit findings and recommendations, together with the management responses to each of them.

Exhibit 1

Matter arising 1 - related party declarations were not distributed to associate members	
Findings	We found that the Health Board had not distributed related party declaration-returns to its four associate members. At our request, the required declarations were issued to the members in May and were duly returned. One of the associate members declared that they are the Director of Social Services for the Vale of Glamorgan Council (VOGC). This declaration led to additional disclosures in the financial statements of the Health Board's material 2020-21 transactions and balances with VoGC.
Recommendation	The Health Board should issue its annual related party declarations to associate members.
Accepted in full by management	Accepted
Management response	Agree this should of happened as part of end of year arrangements and Associate Board Members should

Matter arising 1 - related party declarations were not distributed to associate members	
	have been included as has happened with previous years.
Implementation date	May 2022.

Exhibit 2

Matter arising 2 –Windows 7 and Windows Server 2008 operating systems are unsupported	
Findings	We found that the Health Board uses a number of unsupported operating systems within its IT infrastructure. We have previously recommended that the Health Board replaces its Windows Server 2003 and Windows XP devices, but it has not done so. We established that as at the end of May 2021, the Health Board still operated seven Windows Server 2003 machines; and 22 Windows XP devices. This year, we found that the Health Board also uses Windows 7 desktop devices (approximately 9,000) and WS2008 servers (approximately 168) both of which have been unsupported since January 2021. These devices and servers are therefore vulnerable, which could be exploited by malicious individuals/entities.
Recommendation	The Health Board should replace its unsupported servers and devices. Where replacement is not currently feasible, the Health Board should ensure that robust mitigating arrangements are in place. Looking forward, the Health Board needs to be proactive, with better planning for its timely replacement of unsupported IT operating systems and devices.
Accepted in full by management	Yes.

Matter arising 2 –Windows 7 and Windows Server 2008 operating systems are unsupported	
Management response	There are ongoing programmes in place to replace or upgrade all affected devices.
Implementation date	Windows 7 replacement - February 2022 Servers – March 2023

Exhibit 3

Matter arising 3 –the IT Disaster Recovery plan is potentially outdated	
Findings	We found that the Health Board has not reviewed its IT data recovery (DR) by the due date. The Health Board has committed to reviewing it annually. We found that, instead, the Health Board has tested some of the operational-level restores, which has included the testing of parts of the DR plan.
Recommendation	The Health Board should test its DR plan to gain assurance that IT systems can be restored if needed. The Health Board should review the DR plan regularly, and in doing so ensure that changes to the infrastructure and network are fully considered. Once updated and finalised, the Health Board should tested the revised DR plan to ensure that it works as intended.
Accepted in full by management	Yes.
Management response	The IT DR Plan is being reviewed and updated as part of a programme to refresh IT Security documentation.
Implementation date	Completion - February 2022.

Exhibit 4

Matter arising 4 – the IT change control policy and procedures are draft	
Findings	The Health Board's IT Change Control Policy, and the underlying procedural documents, set out how it manages, approves, and authorises changes to the IT infrastructure and network. However, the Health Board's IT change-control procedure is a draft document.
Recommendation	The Health Board should update its IT change control policy and procedure.
Accepted in full by management	Yes.
Management response	The change control policy is being updated and will be implemented as part of the new Ivanti helpdesk implementation project which includes change control functionality.
Implementation date	Completion - February 2022.

Exhibit 5

Matter arising 5 – the IT1 & 2 data centre is inadequate	
Findings	The Health Board's IT1 and 2 data centre rooms are the secondary data centres, which are located some 200 yards, from the main data centres. In 2020, the rooms had been damage by water from a blocked toilet, causing access to be temporarily restricted. We established that the Health Board has identified a number of issues with the IT and environmental controls in these rooms and that they need an upgrade.
Recommendation	The Health Board should evaluate and consider upgrading its IT1 and IT2 data centre controls, or,

Matter arising 5 – the IT1 & 2 data centre is inadequate	
	decommissioning and replacing them with a better, fit for purpose, data centre.
Accepted in full by management	Yes.
Management response	Future reliance on these rooms is being reviewed and potential part decommissioning will be considered.
Implementation date	November 2022.

Exhibit 6

Matter arising 6 – Secure storage of backup tapes required	
Findings	We established that the Health Board's data backup tapes are regularly moved from the UHW data centres to Woodland House, where the backup tapes are stored in a secure and locked room near the IT department offices. However, we established that they are not stored in a fireproof and waterproof container(s). It is good practice for backup tapes to be located and stored in a fireproof and waterproof container(s).
Recommendation	The Health Board should strengthen the storage of its back up tapes.
Accepted in full by management	Yes.
Management response	Data back-up tapes are stored offsite. The sheer volume makes storage in fireproof safe impossible. In addition, all latest backups of data is backed up to disc offsite in rooms with fire suppression.

Matter arising 6 – Secure storage of backup tapes required	
Implementation date	Complete - All latest backups of data is backed up to disc offsite in rooms with fire suppression.

Recommendations from last year's audit

4 **Exhibit 7 sets out last year's** recommendations along with our comments on the progress officers have made implementing them.

Exhibit 7: progress against previous years' recommendations

Audit Year	Recommendation	Progress
2019-20	**Some of the accounting processes and records need to be simplified, with far less use of manual adjustments to financial ledger outputs** The Health Board should re-evaluate why so many manual adjustments are currently necessary and, in doing so, liaise with us and consider engaging with a health board that has the same finance system and avoids a similar level of manual intervention.	The Health Board made limited changes for 2020-21 and we understand that it is committed introduce changes for 2021-22. We will liaise regularly with senior finance officers on the changes being considered. Our 2022 Audit Plan will provide an update.
2019-20	**The quality of some of the Health Board's underlying working papers requires further improvement** The Health Board should review and simplify its supporting records for certain areas of its annual financial statements, including the inappropriate use of manual data entry (rather than formulas) within spreadsheets. To aid the review the Health Board should liaise with us to understand how some of the documentation affects our audit.	The Health Board made limited changes for 2020-21 and we understand that it is committed introduce changes for 2021-22. We will liaise regularly with senior finance officers on the changes being considered. Our 2022 Audit Plan will provide an update.

2019-20	**Related party declarations need to be signed and submitted after the end of each financial year.** The Health Board should update its annual related-party declaration so that it specifies that the independent member/senior officer must consider the whole financial year and therefore sign and submit it after 31 March, or on departure if that is relevant.	Last year the Health Board agreed to revert to requesting returns after each 31 March year end (for the financial year just passed). The Health Board adopted a two phases approach where, for 2020-21, it issued related party declarations in January and February 20201 and then requested updated copies in April 2021. All updated declarations were received apart from one senior officer. The senior officer did provide an updated declarations once reminded as part of our audit process.

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

Report Title:	**Audit Wales Review of WHSSC Governance Arrangements**	**Agenda Item no.**	**7.5**
Meeting:	**Audit and Assurance Committee**	**Meeting Date:**	**07/09/21**
Status:	**For Discussion**	**For Assurance**	**For Approval**	**For Information X**
Lead Executive:	**Nicola Foreman (Director of Corporate Governance)**		
Report Author (Title):	**Marcia Donovan (Head of Corporate Governance)**		

Background and current situation:

By way of background, in 2015 the Good Governance Institute and Healthcare Inspectorate Wales each undertook reviews of WHSSC's governance arrangements. These reviews highlighted several areas of concern including, amongst others, concerns regarding decision making and conflicts of interest, a need to strengthen its clinical governance arrangement, improve clinical engagement and strengthen its approach to monitoring service quality.

Following on from those reviews, Audit Wales undertook a further review of WHSSC's governance arrangements, with such review being undertaken during 2020 and (due to COVID) completed in 2021.

Audit Wales issued their findings in a report dated May 2021 and entitled "Welsh Health Specialised Services Committee Governance Arrangements". Whilst the said report acknowledged that some aspects of WHSSC's governance arrangements had improved following the 2015 reviews, there were still some areas of concern. These concerns are set out in the Audit Wales report as a number of recommendations, of which four are for WHSSC to consider and address, and three are for the Welsh Government to consider and/or address. A copy of this report was presented to the Audit and Assurance Committee ("Audit Committee") at the Audit Committee's meeting held on 6 July 2021.

Audit Wales has informed the Welsh Health Boards' Board Secretaries of (i) WHSSC's proposed management responses and (ii) Welsh Government's management responses to their respective recommendations set out in the report. A copy of WHSSC's proposed management responses are set out in Appendix 1 to this report and a copy of the Welsh Government's responses are set out in Appendix 2.

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

The purpose of this report is to ensure that the Audit Committee has sight of the management responses to the recommendations made by Audit Wales and to assist the Audit Committee with monitoring the progress being made by both WHSSC and the Welsh Government to meet the said recommendations. It is anticipated that any such progress will be tracked via the WHSSC's

usual governance arrangements, including via the WHSSC's regular reporting mechanism to the individual Health Boards via its Joint Committee status.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.): None

Recommendation:

The Committee is requested to:
NOTE (i) the proposed management responses of WHSSC and (ii) the management responses of the Welsh Government, in response to Audit Wales' 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		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	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		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Equality and Health Impact Assessment Completed:	Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

APPENDICES

Appendix 1 – Response to the Recommendations from the Audit Wales Report Welsh Health Specialised Services Committee Governance Arrangements

Appendix 2 – Letter from Welsh Government to Audit Wales – Welsh Government's Management Response

Appendix 1

Response to the Recommendations from the Audit Wales Report Welsh Health Specialised Services Committee Governance Arrangements

In May 2021, Audit Wales published the "Welsh Health Specialised Services Committee Governance Arrangements"[1] which found that the governance, management and planning arrangements at WHSSC have improved, however the impact of COVID-19 will require a clear strategy to recover key services and that the Welsh Government's long-term model for health and social care 'A Healthier Wales', and the references made to WHSSC should be re-visited.

Audit Wales made a number of recommendations for both WHSSC and Welsh Government and the management response to the WHSSC recommendations are outlined below:

Recommendation	Response/ Action	By when	By whom
Quality governance and management			
R1 Increase the focus on quality at the Joint Committee. This should ensure effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients.	We accept the recommendation and intend to take the following actions. We will include in our routine reports to Joint Committee (JC) on quality, performance and finance a section highlighting key areas of concern to promote effective focus and discussion. We will develop a revised suite of routine reports for JC that will include elements of the activity reporting, that we introduced during the pandemic, and will take into account the quality and outcome reporting that is currently being developed by Welsh Government (WG).	Sept 2021 Mar 2022	WHSSC Executive leads WHSSC Executive leads

[1] Welsh Health Specialised Services Committee Governance Arrangements (audit.wales)

Recommendation	Response/ Action	By when	By whom
	We will encourage members of the JC to engage in consideration and discussion of key areas of concern that are highlighted. We will include routinely at JC an invitation for an oral report to be delivered by, or on behalf of, the Chair of the WHSSC Quality & Patient Safety Committee (Q&PSC) based on the written report from the Chair of Q&PSC.	Sept 2021 Sept 2021	Chair of WHSSC Chair of WHSSC
Programme Management			
R2 Implement clear programme management arrangements for the introduction of new commissioned services. This should include clear and explicit milestones which are set from concept through to completion (i.e. early in the development through to post implementation benefits analysis). Progress reporting against those milestones should then form part of reporting into the Joint Committee.	We accept the recommendation and intend to take the following actions. **a) Building Programme Management competency/capacity** A number of new staff have recently joined WHSSC in senior positions in the planning team who bring with them strong programme and project management skills. There are 'lunch and learn' sessions planned to share this approach, and the use of common templates is embedding, it is anticipated that this approach will grow programme management competency and capacity within the organisation. The approach is already starting to embed in the way the planning team operates, with programme management approaches already	To commence Sept 2021	WHSSC Director of Planning

Recommendation	Response/ Action	By when	By whom
	applied to the two strategic pieces committed to through the 2021 ICP (namely paediatrics and mental health) and to the management of the CIAG prioritisation process. Common templates apply to highlight and exception reporting, risk logs and timelines/milestones. **b) Programme management on WHSSC commissioned services.** Programme arrangements have previously been used for strategic service reviews and the development of the PET (positron Emission Therapy) business case. We will further develop this approach as outlined above, i.e. through a common approach to programme management across the organisation and to and the use of common templates. These will become the basis of reporting through programme structures and as necessary to joint committee. **c) HB Commissioned Services** – when services are not the sole responsibility of WHSSC, and where the senior responsible officer is outside of WHSSC, we will contribute to the programme arrangements, offering clarity about the role of WHSSC and		

Recommendation	Response/ Action	By when	By whom
	the scope of the responsibilities it has within the programme. We will seek to deliver against any key milestones set, and report progress, risk and exception accordingly.		
Recovery Planning			
R3 In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on: a. the backlog of waits for specialised services, how these will be managed whilst reducing patient harm. b. potential impact and cost of managing hidden demand. That being patients that did not present to primary or secondary care during the pandemic, with conditions potentially worsening. c. the financial consequences of services that were commissioned and under-delivered as a result of COVID-19, including the under-delivery of services commissioned from England. This should be used to inform contract negotiation.	We accept the recommendation and recognise the post COVID-19 recovery challenges. We intend to take the following actions. **a) Managing backlog of waits whilst reducing harm** i. Introduction of real-time monitoring and reporting of waiting times to Management Group and Joint Committee ii. Review of recovery plans with Welsh provider Health Boards, iii. Regular Reset and Recovery meetings with services to monitor performance against plans. Significant variance from plans will be managed through the WHSSC escalation process Iv. Introduction of the WHSSC Commissioner Assurance Framework (CAF), v. Workshop with Joint Committee members on how to deliver 'equity' in specialised services. Report shared with HBs and WG.	 Sep 2021 Jul 2021 From Apr 2021 In place In place Completed May 2021	WHSSC Executive leads WHSSC Executive leads

Recommendation	Response/ Action	By when	By whom
	b) Potential impact and cost of managing hidden demand.		
	i. Introduction of demand monitoring compared to historical levels for high volume specialties, findings to be reported to the WG Planned Care Board and HBs to inform non-WHSSC commissioned pathway development.	In Place	WHSSC Executive leads
	ii. Appointment of an Associate Medical Director for Public Health to work with Health Board Directors of Public Health to assess impact.	Q3/Q4 2021/22	
	c)Financial consequences of services that were commissioned and under-delivered as a result of COVID-19	In Place	
	i. This information is already captured through our contract monitoring process and compared against the national block contract framework implemented to maintain income stability through COVID-19. This will inform future planned baselines and contract negotiation, where the negotiation is within our control. WHSSC is working with contracted providers across Wales and England to establish their specialised recovery trajectories		

Recommendation	Response/ Action	By when	By whom
	and where appropriate will secure recovery funding from WG to direct to providers for recovery performance if above established contracted baseline levels. **d) Reporting Analysis** We will review and analyse the business intelligence gathered from the actions outlined in points a,b and c above and use the real-time and historical data to inform our decision making on managing existing, and developing new specialised commissioned services. We will report our analysis and outcomes to the Joint Committee, Welsh Government and the Management Group as appropriate.	Sept 2021	
Specialised Services Strategy			
R4 The current specialised services strategy was approved in 2012. WHSSC should develop and approve a new strategy during 2021. This should: a. embrace new therapeutic and technological innovations, drive value, consider best practice commissioning models in place elsewhere, and drive a short, medium, and long-term approach for post pandemic recovery. b. be informed by a review of the extent of the wider services already commissioned by WHSSC, by	We accept the recommendation and work had begun on developing a new Commissioning strategy, however the COVID-19 pandemic delayed progress. To move forward the new specialised services strategy will be informed by the WG policy for reset and recovery. We intend to take the following actions. **a. Embrace New Innovations** i. We will continue to utilise our well-established horizon scanning	Q4 2021/22 In place Jul 2021	WHSSC Managing Director

Recommendation	Response/ Action	By when	By whom
developing a value-based service assessment to better inform commissioning intent and options for driving value and where necessary decommissioning. The review should assess services: • which do not demonstrate clinical efficacy or patient outcome (stop); • which should no longer be considered specialised and therefore could transfer to become core services of health boards (transfer); • where alternative interventions provide better outcome for the investment (change); • currently commissioned, which should continue (continue).	process to identify new therapeutic and technological innovations, drive value and benchmark services against other commissioning models to support , short, medium, and long-term approach for post pandemic recovery ii. We will continue to develop our relationship with NICE, AWMSG and HTW in relation to the evaluation of new drugs and interventions, iii. We will engage with developments for digital and Artificial Intelligence (AI), iv. We will continue our regular dialogue and knowledge sharing with the four nations' specialised services commissioners, v. We will continue to build upon our existing relationships with the Royal Colleges, vi. We will continue to develop our work on value-based commissioning, vii. We will develop a communication and engagement plan to support and inform the strategy. viii. As previously agreed with Joint Committee a stakeholder engagement exercise will be undertaken to gain insight on long term ambitions and to inform how	Q3 2021/22 In place Dec 2021 Dec 2021	

Recommendation	Response/ Action	By when	By whom
	we shape and design our services for the future. This will inform the Specialised Services Strategy and the supporting the 3 year integrated commissioning plan.		
	b. Approach to Review of Services will be considered in strategy engagement		
	i. The draft strategy will consider our approach to the review of the existing portfolio of commissioned services and undertake a value based services assessment to assess if existing services are still categorised as specialised,	Sept 2021	
	ii. We will continue to undertake our annual prioritisation panel with HB's to assess new specialised services that could be commissioned,		
	iii. We will continue to undertake a process of continuous horizon scanning to identify potential new and emerging services and drugs, and to focus on existing and new hyper-specialised services,		
	iv. WHSSC will investigate opportunities for strengthening its information function through internal re-organisation and investment. This will include the development of an outcome		

Recommendation	Response/ Action	By when	By whom
	manager post to support both the WHSSC strategic approach to outcome measurement as well as a feasibility analysis of currently available tools. We will pursue our planned investment to utilise the SAIL database with a view to assessing the population impact of services in a number of pilot areas. As previously agreed with the Joint Committee a stakeholder engagement exercise will be undertaken to gain insight from our stakeholders on long term ambitions and to inform how we shape and design our services for the future. This will inform transferring commissioned services into and out of the WHSSC portfolio to meet stakeholder and patient demand.		

Appendix 2 – Letter from Welsh Government to Audit Wales – Welsh Government's Management Response

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Mr Adrian Crompton
Auditor General for Wales
Audit Wales Head Office
24 Cathedral Road
Cardiff
CF11 9LG

c/o Dave.Thomas@audit.wales

2 June 2021

Dear Adrian

Welsh Health Specialised Services Committee (WHSSC) Governance Arrangements: Report of the Auditor General for Wales, May 2021

Thank you for the above Audit Wales report, published on 12 May.

I welcome your conclusion that governance arrangements and decision making at WHSSC have improved since previous reviews. The WHSSC team has worked hard to make these changes and I will expect them to make further progress by addressing your recommendations in relation to an increased focus on quality, programme management, COVID-19 recovery and the specialised services strategy. My officials will be following up on these areas at their regular meetings with WHSSC.

In terms of your recommendations to the Welsh Government, I set out my initial response below, although these may well be subject to any views from the new Minister in light of her priorities.

Recommendation 5: Independent Member recruitment – accepted and action in train

I am aware there have been challenges in securing nominations from health boards to undertake the independent member role at WHSSC. My officials have been looking at options in relation to recruitment, remuneration and retention of independent members and I am currently considering their advice before the matter is raised with the Minister. There are a number of options, some of which could be achieved relatively simply and others which would require changes to the legislation. I will write to you again when we have a clear way forward.

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Recommendation 6: Sub-regional and regional programme management (linked to recommendation 2 directed to WHSSC) – accepted

As you have highlighted, whilst some key service areas like major trauma have been developed successfully and with good collaboration across organisations, the timelines around such changes have been slow and often hampered by a lack of clarity on who is driving the process. I agree with your view that end-to-end programme management of such schemes, which are not within the sole remit of WHSSC, should be strengthened. The National Clinical Framework which we published on 22 March, sets out a vision for a health system that is co-ordinated centrally and delivered locally or through regional collaborations. Implementation will be taken forward through NHS planning and quality improvement approaches and our accountability arrangements with NHS bodies.

Recommendation 7: Future governance and accountability arrangements for specialised services – accepted in principle

A Healthier Wales committed to reviewing the WHSSC arrangements alongside other hosted national and specialised functions, in the context of the development of the NHS Executive function. The position of WHSSC within this landscape needs to be carefully considered. On the one hand, there are strengths in the current system whereby health boards, through the joint committee, retain overall responsibility for the commissioning of specialised services. This requires collaboration and mature discussion from both the commissioner and provider standpoint. However, I recognise the inherent risk of conflict of interest in this arrangement and note the reference made in your report to the Good Governance Institute's report of 2015 which suggested a more national model may be appropriate.

In my letter to health boards of 14 August 2019, I indicated that, as recommended by the Parliamentary Review, the governance and hosting arrangements for the existing Joint Committees would be streamlined and standardised. I also said that it was intended the NHS Executive would be become a member of the Joint Committees' Boards in order to ensure there is a stronger national focus to decision making. However, the thinking at the time was that the joint committee functions would not be subsumed into the NHS Executive function. We will continue to look at this as the NHS Executive function develops further and I will update you should there be any change to the direction of travel I indicated in 2019.

Yours sincerely

Dr Andrew Goodall CBE

cc: Chair of the Senedd Public Accounts Committee.

Report Title:	**Assurance Strategy 2021-24**								**Agenda Item no.**	**7.6**	
Meeting:	**Audit and Assurance Committee**								**Meeting Date:**	**07/09/21**	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**				
Lead Executive:	**Director of Corporate Governance**										
Report Author (Title):	**Director of Corporate Governance**										

Background and current situation:

At the April 21 Meeting of the Audit and Assurance Committee approval was given to develop an Assurance Strategy for the implementation of a Framework of Assurance.

The paper in April described that the organisation had a number of tools which provided assurance but no overarching strategy which pulled those tools together to give an overall view on assurance.

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

The attached Assurance Strategy, Appendix 1, has been developed to aid the Board in identifying overall assurance but also identifying areas of weakness and duplication.

Attached at Appendix 2 is an example of how an Assurance Map could be developed to provide an overall view of assurance for the Board. It will also indicate where there is duplication and maybe where those resources could be better targeted elsewhere.

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

Implementing the Assurance Strategy will improve the overall governance of the organisation and the assurance provided to the Board by identifying gaps or limited assurance. This in turn will enable better targeting of resources in order to obtain assurance where required.

Recommendation:

The Audit and Assurance Committee are requested to **recommend approval** of the Assurance Strategy to the Board.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		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	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

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

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

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Cardiff and Vale University Health Board Assurance Strategy					
Document Reference No:	C&V UHB TBC	**Version No:**	1	**Previous C&V UHB Ref No:**	N/A
Document Type:	Corporate Strategy			Non-Clinical	
Issue Date:	Xxxx 2021				
Implementation Date:	Xxxx 2021				
Review Date:	Xxxx 2022 (1 year post issue date).				
Documents to be read alongside this policy:	• Standing Orders • Scheme of Reservation and Delegation • Standing Financial Instructions • UHB 024 - Risk Management Procedure • UHB 435 - SOP Managing Concerns • UHB 043 – Raising Concerns (Whistleblowing Policy) • UHB470 – Risk Management and Board Assurance Framework Strategy				
Executive Summary:	This strategy sets out the UHB's approach to the Assurance Strategy. For more information on the Assurance Strategy please contact the Director of Corporate Governance: Nicola.Foreman@Wales.nhs.uk				

Disclaimer

The latest version of this document is located on the UHB's intranet. Please check the review date and if there are any doubts contact the author.

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Author/Reviewer:	Director of Corporate Governance
Document Owner:	Director of Corporate Governance
Accountable Executive:	Director of Corporate Governance
Consultation method/time period:	
Consultees:	
Approved by:	
Date approved:	
Scope:	UHB Wide

Engagement has taken place with:

Name	Title	Date Consulted

Version Control Table

Version	Issue Date	Summary of Amendment
1	25.11.2021	New Strategy to be approved by the Board in

		November 2021

Important Note:
The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as 'uncontrolled' and, as such, may not necessarily contain the latest updates and amendments.

Contents

Introduction

1. Assurance is term that is often used although not always fully defined. Within the NHS it has become an ever increasingly important concept. The introduction over a decade ago of the requirement for the Chief Executive, on behalf of the Board, to write and publish an Annual Governance Statement, made sure public sector organisations were able to demonstrate that they are properly informed about the totality of their risks. Put simply they needed to have confidence in their governance framework.

2. Over a number of years organisational failures, within both the public and private sector have been attributed to poor governance or failings in risk management. The response to this has been heightened control in these areas via legislation and publications of governance codes. Yet the failures continue to happen and therefore concentration has shifted to assurance and how Boards of Directors know what is being undertaken in their name.

3. The Health Board understands the challenges that large and complex organisations face when developing robust governance, risk management and assurance systems that are both proportionate and fit for purpose.

Aim

4. The aim of this strategy is to ensure that there is a common understanding throughout the Health Board of what is meant by assurance and its importance in a well- functioning organisation.

5. Assurance is underpinned by a number of elements: a robust governance framework with clearly defined and understood strategic objectives, a developed maturity in relation to risk management and effective internal controls. Assurance is about getting the right balance of strategy, risk and control. It is acknowledged that it is never possible to provide complete and absolute assurance and as such the concept of reasonable assurance is adopted.

Our Assurance Vision

6. Our vision is to ensure an assurance system exists that adds value to the Health Board by eliminating duplication of effort and resources, reducing the burden of bureaucracy and providing a central point of expertise in relation to governance, risk management and assurance.

7. We aspire to provide guidance on how to assess the value of assurance more widely across the Health Board. The promotion of a better understanding of assurance should lead to improved knowledge of the systems and processes in place. This should in turn lead to an improvement in the assurance tools used in the Health Board and the ability the Health Board has to address identified gaps.

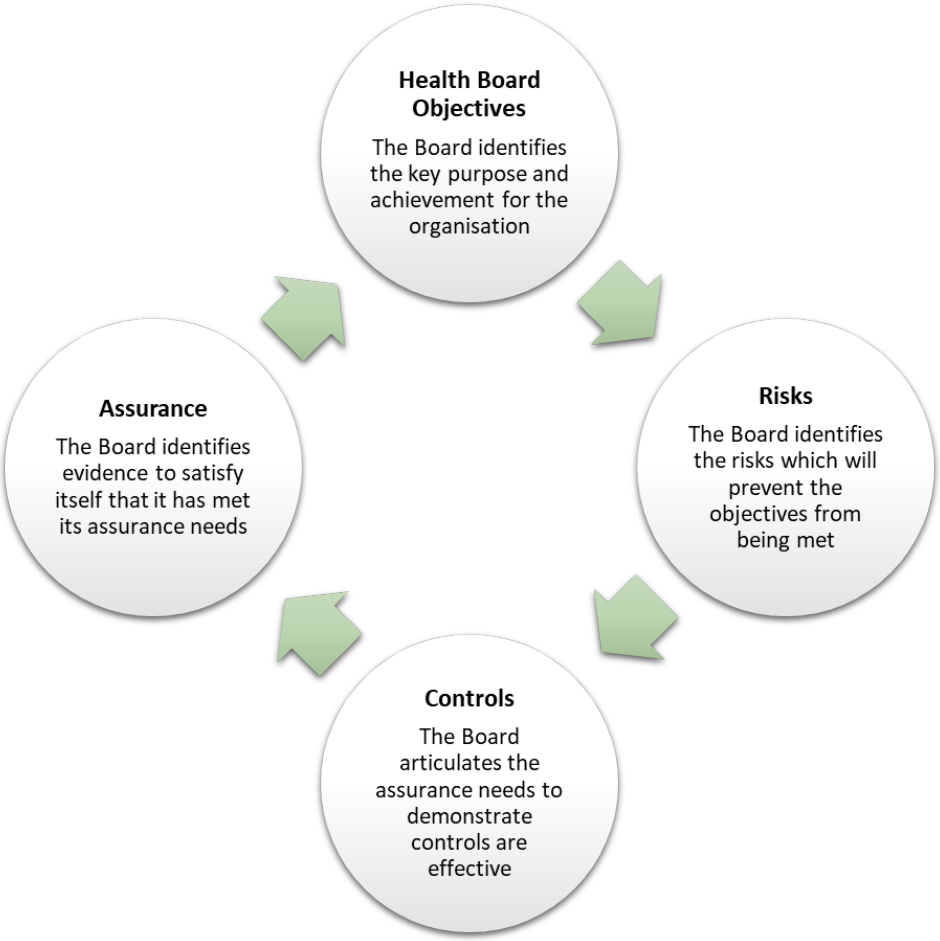
The Assurance System

8. The assurance system will enable the Board and senior management to review the corporate governance, risk management and internal control framework and address any weaknesses identified.

9. It is the policy of the Health Board to ensure that there is a robust methodology for enabling evidence based assurance to be provided to the Health Board on the key risks and the key controls within the organisation as well as stakeholders as required and at the appropriate levels.

10. The methodology is based on the principles of assurance in relation to risk management as defined by the HM Treasury Orange Book, Management of Risk – Principles and Concepts. These principles, which have been expanded to cover all areas of governance, and the method of application within Cardiff and Vale University Health Board, can be found at Appendix 1.

11. The following diagram summarises a model of assurance within the NHS, considered applicable for the Health Board



Benefits of an Assurance System

12. An assurance system achieves a number of benefits:

- Provides confidence in the operational working of the Health Board.
- Maximises the use of resources available in terms of audit planning, avoiding duplication of effort.
- Ensures assurances are appropriately gathered, reported and that the governance structure is working as intended
- Identifies any potential gaps in assurances relating to key risks and key controls, and that these are understood and accepted or addressed as necessary
- Supports the preparation of the Annual Governance Statement within the Annual Report and regular assurance reports to the Audit and Assurance Committee.

Implementation of the Assurance Strategy

13. The implementation of this strategy will be achieved through clear leadership, effective delivery and defined roles and responsibilities. Roles and responsibilities in relation to assurance within the Health Board can be found in Appendix 3. This document applies to all areas of activity within the Health Board. All employees of the Health Board, including individuals employed by a third party, by external contractors, as voluntary workers, as students, as locums or as agency staff are required to comply with any requirements in relation to assurance noted within this Strategy.

14. The Director of Corporate Governance acts as a champion for this area, providing support across the Health Board.

15. All members of the Health Board will be involved in the evaluation of assurance, except where delegated to Committees of the Board.

16. The Health Board will ensure that the appropriate infrastructure in terms of Committee and individual responsibilities is in place to facilitate the embedding of the Assurance Strategy. The Corporate Governance Directorate will deliver education and training across the organisation on an on-going basis, ensuring that guidance follows best practice.

Types, Sources and Levels of Assurance

17. There are three types of assurance that can be sought: verbal, written and empirical. All can be of use depending on the circumstances. Each will be valued differently depending on other factors. There are many sources of assurance, examples of which can be found in Appendix 2.

18. The Health Board has defined the overarching Lines of Defence (levels of assurance) within its Risk Management and Board Assurance Framework Strategy as noted below:

Level 1 – Operational (Management)
Level 2 – Oversight functions (Board or Committees)
Level 3 – Independent (Audits / Reviews / Inspections etc.)

19. Supplementary assurance processes developed within the Health Board will have their levels of assurance cross matched using the overarching levels set out above.

20. Management has the primary responsibility for providing assurance on the adequacy of risk management and internal control, which is often subject to challenge from the oversight functions for example the Audit and Assurance Committee. It is however essential that there are robust frameworks in place to support the managerial assertions about the adequacy and effectiveness of internal control.

21. Independent assurance is used to confirm management assertions and is often seen as of highest value. This is however dependent on many other factors as noted below.

Assurance Values

22. Regardless of the type, source and level of assurance there are a number of issues that impact on its value, all of which need to be considered:

Age – the time elapsed since assurance was obtained, this may erode the value of assurance.

Durability – whether it endures as a permanent assurance on an historical matter e.g. Auditors Report on Financial Statements, or loses relevance over passage of time e.g. clinical audit.

Relevance – the degree to which assurances aligns to specific area or objective over which it is required.

Reliability – trustworthiness of the source of assurance.

Independence – the degree of separation between the function over which assurance is sought and the provider of assurance.

23. The value of assurances used for the Board will be assessed by the Corporate governance Directorate.

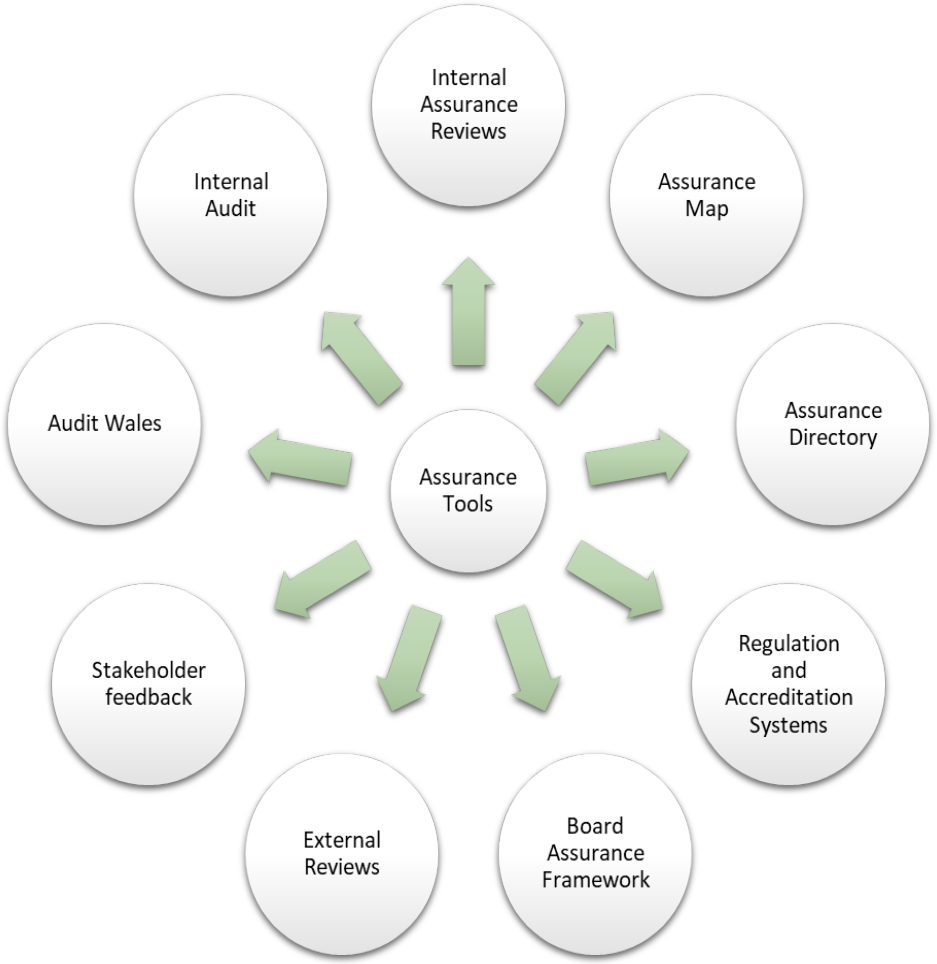
Assurance Reporting / Use of the Assurance Information

24. The various mechanisms and tools described in the strategy will enable the assurance process and the assurance information that is produced as a result to be assessed in terms of value and enable any gaps in assurance identified to be reported, at an appropriate level, and addressed, where considered necessary.

Assurance Tools

25. A number of mechanisms, known as Assurance Tools, will be used as part of the methodology for providing evidence based assurance.

26. There are various assurance tools which feed into the overall system of assurance. Through the mapping of sources of assurance, issues can be identified relating to gaps in control or gaps in assurance, and duplication of effort. Where the need for additional control measures or assurances are recognised, these will be reported through an appropriate mechanism, e.g. addition to risk register, performance reporting, or the Board Assurance Framework.



Assurance Directory

27. An Assurance Directory is a central register of assurances, detailing the types and value of assurance. This will maintained by the Corporate Governance Directorate. The

information held within the Directory is used to create a map of assurances.

Assurance Map

28. An Assurance Map is created in order to obtain clarification in relation to assurance currently provided. There is more than one purpose for such a map and this will depend on who wants the map and why. One map should not be everything to everyone and therefore a number of different maps at various levels can be produced. Assurance Maps can be used at different levels and for different reasons as determined by need. The starting point can also vary depending on purpose.

29. Gaps, including where assurance has been provided but is deemed to be insufficient and duplications of assurance can be identified and addressed thereby consolidating assurance and reducing the amount of irrelevant information provided. Assurance maps will be created and maintained by the Corporate Governance Directorate.

Internal Assurance Reviews

30. Internal assurance reviews may be undertaken in any area of the Health Board and are one of the ways the Health Board assures itself that relevant standards, regulation and other requirements including best practice are being met. Whenever internal assurance reviews are undertaken, terms of reference are prepared and agreed by all parties. The Corporate Governance Directorate provides support for such reviews. E.g. Health and Safety Review.

Internal Regulation and Accreditation Systems

31. Internal regulation and accreditation systems ensure that suitable evidence exists to support adherence with regulation and accreditation standards. The Risk and Regulation Team track Legislative, Regulatory and Alerts compliance which is then reported to the Audit and Assurance Committee.

Board Assurance Framework

32. The Board Assurance Framework, an NHS requirement, sets out the strategic objectives, identifies risks in relation to each strategic objective and the controls to mitigate these risks. The details of the assurances on the effectiveness of these controls are also included. As such gaps in controls and assurances can be identified and acted upon. This forms an integral part of the risk management reporting system. This document is then used as a tool for further discussion in relation to the levels of assurance received and required at Board and Board Committee level as set out in the Risk Management and Board Assurance Framework Strategy. The Board Assurance Framework also provides the starting point for the Health Board to record the risks in relation to the strategic objectives that then link and are cross referenced to the Corporate Risk Register.

Internal Audit

33. Internal Audit is an independent objective function which can help the Health Board accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, internal control, and governance processes. The scope of reviews are agreed in advance with relevant Executive Directors and Management Executive, and the annual Internal Audit plan agreed by the Audit and Assurance Committee. Contingency days may be built into the Internal Audit plan to allow for any issues identified where review or further assurance may be required.

Clinical Audit

34. Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery and improve the overall quality of services.

Audit Wales

35. The Auditor General is the statutory external auditor of most of the Welsh public sector. This means that he audits the accounts of county and county borough councils, police, fire and rescue authorities, national parks and community councils, as well as the Welsh Government, its sponsored and related public bodies, the Senedd Commission and National Health Service bodies.

    The Auditor General's role includes examining how public bodies manage and spend public money, including how they achieve value in the delivery of public services. The Auditor General publishes reports on that work, some of which are considered by the Welsh Parliament's Public Accounts Committee

Stakeholder Feedback

36. Valuable assurance is provided to the organisation through feedback from stakeholders, including patients, visitors, our staff, and partner organisations. The views of our patients are captured through various including patient safety visits. Additionally, internal feedback processes provide additional sources of assurance, including:
    - Surveys carried out with patients and staff
    - Reactive risk processes, such as complaints, claims, inquests or incidents
    - Monitoring and compliance information received from other organisations such as the Community Health Council (CHC) an Independent watchdog and Healthcare Inspectorate Wales (HIW) an independent inspectorate and regulatory of healthcare in Wales.

External Reviews

37. The Corporate Governance Directorate administer the coordination and evaluation of recommendations arising from external agency visits, inspections and accreditations and the process for disseminating and performance managing the implementation of actions arising from the recommendations and providing assurance against them.

Training

38. There is no mandatory training associated with this policy. Ad hoc training sessions based on an individual's training needs will be defined within their annual appraisal or job plan.

Monitoring Compliance

39. Compliance with the document will be monitored in line with the key principles and applications as set out in Appendix 1 as summarised below.

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring (job title)	Frequency of monitoring	Group or Committee that will review the findings and
System of internal control/effectiveness of assurance strategy	Internal audit of Board Assurance Framework	Head of Risk and Regulation	Annual	Audit Committee

Review

40. This policy will be reviewed in 3 years, unless best practice dictates the need for an earlier review.

References

41. The Assurance Strategy forms a key component of the wider Health Board governance framework and links closely to the Risk Management and Board Assurance Strategy.

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- The International Standards Organisation (2018). ISO 31000:2018 Risk Management-Guidelines. Available at: https://www.iso.org/standard/65694.html
- Welsh NHS Confederation (2009). The Pocket Guide to Governance in NHS Wales. Available at: http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Confed%20-%20Governance%20Pocket%20Book%20FINAL%5B1%5D.pdf

42. Equality Impact Assessment

C&V UHB aims to design and implement services and policies that are fair and equitable. As part of its development, this Strategy and its impact on staff, patients and the public have been reviewed in line with the Cardiff and Vale's Equality Impact Assessment. The purpose of the assessment is to improve service delivery by minimising and if possible removing any disproportionate adverse impact on employees, patients and the public on the grounds of race, socially excluded groups, gender, disability, age, sexual orientation or religion/belief.

The equality impact assessment has been completed and has identified impact or potential impact as "no impact".

Appendix 1: Assurance Principles and Application

Assurance Principle	Application within the Health Board
1. Planning to gain assurance Overall assurance will only be gained if there is a strategy for obtaining it. The Assurance Strategy should be approved by the Board and the Audit and Assurance Committee. Supporting processes for obtaining assurance should be embedded into existing processes.	An Assurance Strategy, which reflects the assurance system in operation within the Health Board and therefore the supporting processes, has been approved at Board Level after consultation with the Audit Committee. The Assurance Strategy has been prepared to align with the other key strategies such as the Risk Management and Board Assurance Framework Strategy.
2. Making explicit the scope of the assurance boundaries To form an overall opinion the scope of the processes need to include the whole of the organisation's governance, risk and performance management lifecycle. Whilst this does not reflect the need to review every risk and internal control it should cover: Assurance on the Risk Management Strategies and how these work in practice (the extent to which line managers review the risks and controls within their responsibility and maintain dynamic risk and performance management arrangements) Assurance on management of risks and controls themselves. Assurance on the adequacy of the assurance processes.	The Corporate Governance Directorate will be responsible for ensuring that there is adequate assurance on the risk management system and the risks / controls themselves. The overall Assurance and Risk Management system is subject to Annual Audit.
3. Evidence The evidence supporting assurance should be sufficient in scope and weight to support the conclusion and be: - Relevant - Reliable - Understandable - Free from material misstatement - Neutral / free from bias - Such that another person would reasonably come to the same conclusion All evidence does not carry the same weight and should be weighted in accordance to independence and relevance. Evidence may be flawed in terms of both quality and quantity, leading to limitations in the assurance that can be provided.	The Corporate Governance Directorate will define 'what good evidence looks like', ensuring that the details within this principle are adhered to.

Appendix 1: Assurance Principles and Application

(continued)

Assurance Principle	Application within the Health Board
4. Evaluation The objective is to evaluate the adequacy of: - the governance and risk policies and strategies to achieve their objectives; - the risk management processes designed to constrain residual risk to the risk appetite; - Identify limitations in the evidence provided or in the depth or scope of the reviews undertaken - Identify gaps in control and / or over control and provide the opportunity for continuous improvement - Support the preparation of the Annual Governance Statement as part of the Annual Report.	The independent review of all key areas will be co-ordinated by the Corporate Governance Directorate. The Audit and Assurance Committee will approve the internal and external audit plans. Gaps and duplications in assurance will be identified by the development of an assurance map, the responsibility for which falls within the remit of the Corporate Governance Directorate. A directory of sources of external assurances will be maintained. This will populate, in part, the assurance directory, which will also contain internal sources of assurance. Central reviews of evidence held will be undertaken by the Corporate Governance Directorate. Training and guidance will be provided across the Health Board to enable Clinical Boards and Corporate Directorates to be the first line of evidence assessment.
5. Reviewing and Reporting Assurances are reported from many different sources within an organisation and therefore the Assurance Strategy needs to define stages where assurances will be evaluated and opinions reported through the various layers of management to the Health Board. Assurance opinions need to be reported clearly and worded so as to clearly communicate the scope and criteria used in arriving at those conclusions.	The Assurance Strategy makes it clear that assurances for the Health Board will be assessed in terms of value by the Corporate Governance Directorate. Training and education will be undertaken across the Health Board in relation to reporting of assurances.

Source: *The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004)*

Appendix 2: Sources of Assurance (examples only)

Source	Assurance Scope	Assurance Process	Type	Level
Audit Wales	Financial accounts and	Financial audit and review reports	Written	3 - Independent Assurance
Internal Audit	All areas related to corporate governance, risk management and internal control. Will be limited by number of days in audit plan and expertise of staff	Head of Internal Audit Opinion and individual review reports. Scope of reviews agreed in advance with relevant Executive Directors. Internal Audit Plan agreed with Audit and Assurance Committee	Written	3 - Independent Assurance
Clinical Audit	Area under review, defined by the Clinical Audit Plan	Report to Quality, Safety and Effectiveness Committee with oversight through Audit and Assurance Committee	Written	1 - Operational Assurance / 3 - Independent Assurance
Audit Committee	All areas related to corporate governance, risk management and internal control, as determined by Terms of Reference	Report to Health Board annually through Annual Report to the Board and update to Health Board via issue of minutes after each meeting and Chairs report to the Board	Written and Verbal	2 - Oversight function
Management Executive	All areas related to corporate governance, risk management and internal control	Report relevant areas to Health Board	Written or Verbal	1 - Operational Assurance
Other Accreditation Systems	Restricted to area of accreditation	Report to relevant Committee and regulatory compliance tracked through Audit and Assurance Committee	Written	3 - Independent Assurance
Integrated Performance report	Specific to identified targets, internal and external, for finance, performance, quality and workforce	Reports to relevant Committees of the Board culminating in integrated report to Board	Written	1 – Operational Assurance 2 – Oversight function

Walkabouts	Specific to area of visit	Reports to Patient Safety and Experience Team	Empirical	1 - Operational Assurance
Information Governance Toolkit	Specific to area of responsibility	Reports to Management Executive and, DHI Committee etc.	Written	1 - Operational Assurance, 2 – Oversight function
Patient Feedback	Specific where internally driven	Reports Quality, Safety and Experience Committee	Written	3 - Independent Assurance

Appendix 3: Responsibilities

The **Chief Executive Officer** has overall responsibility for the system of internal control within the Health Board and for preparing an Annual Governance Statement within the Annual Report.

The **Director of Corporate Governance** has delegated authority for the assurance system that underpins the Annual Governance Statement.

The **Head of Risk and Regulation** is accountable to the Director of Corporate Governance for the overall delivery of the Health Board's Assurance strategy and the Risk Management and Board Assurance Framework Strategy and is responsible for overseeing the systems for assuring compliance with regulatory standards.

The **Head of Corporate Governance** is accountable to the Director of Corporate Governance for the overall performance of corporate governance functions including the system of internal control.

The **Corporate Governance Directorate** is responsible for the:

- maintenance of key assurance tools
- education and training programme in relation to assurance processes, accreditation, assessment and supporting evidence
- assessment of assurance and evidence in relation to compliance with regulations
- provision of consultancy and advice in relation to assurance, accreditation, assessment and supporting good evidence processes.

All Executive Directors are responsible for the related management assurances in relation to those strategic objectives delegated to them by the Chief Executive.

All Clinical Board Directors are responsible for the management of risks and internal controls and assurance within their Clinical Boards

All Managers are responsible for the management of risks and internal controls within their area.

All members of staff are responsible for adhering to internal controls in the undertaking of their work.

The Health Board is responsible for clarifying expectations around the scope and depth of Board assurance requirements.

The **Audit and Assurance Committee** supports the Board by critically reviewing the governance, risk and assurance processes on which the Board places reliance. At the corporate level these include systems of internal control, including the risk management system and the Board Assurance Framework.

Appendix 4: Glossary and definitions of terms used

The terms in use in this document are defined as follows:

Assurance – 'confidence based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved' (*Building the Assurance Framework: A Practical Guide for NHS Boards (2003), Department of Health)*

Reassurance – the process of telling others that risks are controlled without providing reliable evidence in support of this assertion

Risk – the uncertainty of outcome, whether positive opportunity or negative threat, of actions and events

Risk Management – the system for identifying, assessing and responding to risks

Corporate Governance – the 'system by which organisations are directed and controlled in order to achieve their objectives and meet the necessary standards of accountability and probity' (*Department of Health)*. Governance refers to many areas including clinical, information, human resources; all of which fall under the remit of the phrase 'corporate governance' in relation to this document

Internal Control – a method of restraint or check used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation; the result of robust planning and good direction by management

Key Risk / Key Control – risk to the achievement of a strategic objective / control to mitigate key risks

Evidence – information that allows a conclusion to be reached

Sufficient – in relation to the definition of assurance given above sufficient is defined as whatever is adequate to provide the level of confidence required for the Health Board

Reasonable – based on sound judgement

Empirical based on observation or experience

Accreditation – to be awarded official recognition

Assessment – a review of evidence in order to form an opinion; this can be undertaken either internally in the form of a self-assessment or by a third party

Compliance – to act in accordance with requirements

Stewardship – entrusted with the responsibility for and on-going management of a particular area

Stakeholders – person or persons with an interest in the Health Board

Management assertions – a statement made, whether verbal or written

Appendix 5: Using Assurance Sources in Practice

Assurance maps can be created in a variety of different ways, depending on the required purpose. Maps may be used to show:

- Sources of assurance for a given area, topic or target
- Sources of assurance on identified risks e.g. against specific targets or across different areas of business
- Sources of assurance on the effectiveness of control measures
- How the assurances are reported and at what level of the organisation
- Areas where further assurance may be required, or areas of duplication

The examples below demonstrate different functions of an assurance map, and how these can be used by different audiences.

Example 1: Identified Sources of Assurance for a Integrated Performance Report target e.g. RTT waiting time over 36 weeks

Source	Assurance Scope	Assurance Process	Type	Level
Integrated Performance report	Specific monitoring of performance against the target and assessment of data quality	Reports to Strategy and Delivery Committee and The Health Board	Written	1 – Operational Assurance
Audit Wales	Review of data quality for all NHS Delivery Framework targets	Data quality audit and review reports. Scope of review agreed nationally.	Written	3 - Independent Assurance
Internal Audit	Testing of process for recording clock stops and breaches along the pathway by random sample basis. Scope of reviews agreed in advance with relevant directors.	Report to Audit Committee	Written	3 - Independent Assurance
Adult Inpatient Survey	Sample interview survey conducted on a quarterly basis.	Report to Quality, Safety and Experience Committee and Health Board	Written	3 - Independent Assurance
Clinical Audit	Review of adherence to admission criteria in theatres. Scope agreed as part of local clinical audit plan	Report to Quality Safety and Experience Committee	Written	1 - Operational Assurance / Independent Assurance

Example 2: Identified Sources of Assurance for Information Governance

Source	Assurance Scope	Assurance Process	Type	Level
Integrated Performance report	Specific monitoring of performance against the target and assessment of data quality	Reports to Digital Health Intelligence Committee and Health Board	Written	1 – Operational Assurance
External Audit	Review of data quality for all NHS Delivery Framework targets	Data quality audit and review reports. Scope of review agreed nationally.	Written	3 - Independent Assurance
Internal Audit	Independent review of Information Governance as required bythe Information Commissioner. Scope of reviews agreed in advance with relevant directors. Internal Audit Plan agreed with Audit and Assurance Committee	Report to Audit Committee	Written	3 - Independent Assurance
Clinical Audit	Review of adherence to Health Records Policy Scope agreed as part of local clinical audit plan	Report to Quality, Safety and Effectiveness Committee.	Written	1 - Operational Assurance / Independent Assurance

ASSURANCE MAPPING 2021/22 (DRAFT EXAMPLE)

				Line of Defence	Date of Assurance	Line of Defence	Date of Assurance	Line of Defence	Date of Assurance		Overall Level of Assurance
	Areas of responsibility			Level 1 (Management)		Level 2 (Board or Committee)		Level 3 (External)			
Corporate Directorate / Clinical Board											
Strategic Planning											
Capital and Estates											
Quality and Safety											
Worforce and OD											
Corporate Governance	Risk Management			Risk registers for Corporate Directorates and Clinical Boards		Corporate Risk Register Reported to the Board and excerpts to Committees of the Board	Jul-21	Internal Audit of Risk Management - reasonable assurance	May-21		
	Regulatory Compliance					Regulatory Tracker Reported to Audit Committee	Jul-21	Internal Audit on Regulatory Compliance - reasonable assurance	Jun-19		
	Policy and Procedures Management			Policy on policies in place	Jul-21			Internal Audit on Regulatory Compliance - reasonable assurance	Jun-19		
	Board and Committee Administration					Committee effectivenss reviews		Structured assessment			
	Standing Orders & Sceheme of Delegation					Annual Update to Board	May-21				
	Board Assurance Framework					BAF reported to Board and individual risks on BAF to Committees	Jul-21	Internal Audit of Risk Management	May-21		
Digital Health Intelligence											
Public Health											
Finance											
Tranformation											
Communications											
Medicine											
Surgery											
C,D&T											
Children and Womens											
Specialist Services											
PCIC	General Medical Services										
	General Dental Services										
	Community Pharmacy Servicse										
	Optometry Services										
	North West Clusters										
	South East Cardiff Clusters										
	Vale Clusters										
Mental Health											

Report Title:	**Declarations of Interest, Gifts, Hospitality & Sponsorship**								
Meeting:	**Audit & Assurance Committee**					**Meeting Date:**	**07/09/21**		
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		**X**
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Risk and Regulation Officer**								

Background and current situation:

As previously agreed by the Audit & Assurance Committee an update on Declarations of Interest, Gifts, Hospitality and Sponsorship ('declarations') will be provided to each Audit Committee for information. This report provides an up to date report and assessment for the first quarter of Financial Year 2021/22.

The focus for Standards of Behaviour monitoring throughout this period has remained 'decision makers' i.e. employees at Band 8A or higher.

Standards of Behaviour messages have been shared monthly via Global Emails, reinforced by notifications on CEO connects in September, October and December 2020. Since January 2021 ESR has contained a news 'banner' detailing the Standards of Behavior messages and the ability to submit declarations on ESR. Additionally, Band 8A and above receive a monthly targeted email reminder, generated via ESR, identifying the requirement for declarations.

Throughout this Financial Year employees have been provided with the ability to submit their declarations on ESR or in a soft copy via a group mailbox monitored by the Risk and Regulation Team.

As previously reported The Risk and Regulation team have worked with colleagues from Betsi Cadwaladr University Health Board to put in place Declarations of Interest software. However, despite the team's best efforts these discussions show little likelihood of resulting in a satisfactory process and this option is now discounted.

Instead it is now intended to better utilise ESR for the submission, and monitoring of declarations. From the experience of this system over the last six months it is considered that ESR can meet the aim of a modernised and user-friendly process that will ultimately result in a more comprehensive register of interests.

To enable better use of ESR for this purpose, and to improve employee understanding and compliance, the Risk and Regulation Team will complete the following priority actions within this financial year:

- Revise the Standards of Behaviour Procedure to clarify that declarations need to be made within the financial rather than the calendar year.
- Provide guidance within the Standards of Behaviour Procedure to employees and line managers on how to use ESR for the recording of declarations.

- Work with Workforce Information Team to refine the process for notifying employees that their declarations are outstanding.
- Maintain the overall Standards of Behaviour communication plan identified above.
- Utilise ESR to obtain a snap-shot analysis of declarations made by employees below band 8A.

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

ESR lists 1568 employees at band 8A or higher.

The Standards of Behaviour policy requires 'decision making' employees to provide a declaration annually. Analysis of the current register illustrates that 1124 of the target cohort have made a declaration in the period Sep 20 – Sep 21 and this is a compliance of 72% with our Standards of Behaviour policy.

Alongside this ongoing compliance the Risk and Regulation team have received an additional 80 declarations during this financial year; 75 have been recorded and 5 require follow up action.

Analysis of these DoI shows:

- 15 declarations related to secondary employment.
- 10 declarations related to gifts/hospitality or sponsorship.
- 8 declarations related to loyalty conflicts.
- 2 declarations related to indirect conflicts i.e. spouse/relative etc.
- 40 nil declarations.

Based on the RAG rating below, one recorded declaration (loyalty conflict) is graded as medium risk but with clear evidence of line manager awareness; the remaining declarations are graded as acceptable and low risk.

Level of Conflict Key:

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

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

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

Further assurance should be taken from the Corporate Governance Team's ongoing work with the Health Board's Countefraud Department for the investigation of specific cases and also

following recent developments that will allow Declarations to be lodged and recorded through soon to be acquired specialist software which will allow a more efficient and all encompassing approach to be taken to the recording of declarations.

Recommendation:

The Audit & Assurance Committee is asked to:

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

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

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

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

Report Title:	**Legislative and Regulatory Tracker Report**								
Meeting:	**Audit and Assurance Committee**						**Meeting Date:**	**07/09/21**	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

An internal audit was undertaken in relation to Legislative, Regulatory and Alerts Compliance during July and August 2021. The outcome of that audit, which is shared with the committee at this meeting provided a 'reasonable' assurance rating with 8 recommendations in total, 3 of which specifically related to the Legislative and Regulatory Tracker.

These recommendations were all accepted by the Director of Corporate Governance. Two of the ratings were classed as medium priority and one was rated as a low priority.

Good progress was made on the development of the Legislative and Regulatory Tracker during the audit and further work has been undertaken since the report was agreed internally. This progress can be seen the attached report and in the summary of action taken detailed below. There is still some minor additional work to be undertaken to ensure that the recommendations contained in the internal audit report are fully met. This action will be undertaken prior to November's Audit and Assurance Committee Meeting to ensure that the tracker continues to be fit for purpose in providing assurance.

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

Working alongside Internal Audit, the Risk and Regulation Team have improved the content and style of the Regulatory Tracker so that additional assurance can be provided to the Committee.

The below recommendations were made by internal audit. The action taken by the Risk and Regulation Team is also set out in relation to the recommendations made.

Recommendation 1:
The design of the Legislative and Regulatory Tracker should be reviewed through the lens of an assurance tool, to provide greater clarity to the Audit Committee.

- 'Initial Inspection Date' and 'Date for implementation of Recommendations' columns have been added. These columns, and the data contained within them will enable the Committee to have a greater understanding of the progress made against recommendations with reference to the passing of time. These columns will also be used to populate the 'RAG rating' column for consistency in approach.

Historically the 'RAG rating' column has been populated with reference to subjective considerations of recommendation owners. The 'RAG rating' column will now be populated on the basis of time until, or time since the date for implementation of recommendations. All complete entries will be RAG rated green. Prior to completion of a recommendation the following RAG rating system will apply:

Green – Over 1 month until due date for implementation of recommendation
Amber – Due date for implementation of recommendation within 1 month; and
Red – Due date for implementation of recommendation met or exceeded.

- *Assurance Committee* – The Assurance Committee will continue to be populated with the detail of the Committee to which compliance with recommendations will be reported to. Additional detail will be sought so that relevant sub – groups and committees are also listed.

  The main improvement in this area will be found in the management comments section where a note will be shared to confirm when the recommendations or inspections were last reported to the relevant assurance Committee, if at all. Confirmation of this has not been received from all recommendation owners at the time of writing but updates have been confirmed for the following Regulators:

  - Cardiff and Vale of Glamorgan Food Hygiene Ratings
  - Fire and Rescue Services
  - Health Inspectorate Wales; and
  - The Information Commissioners Office.

  An improved position will be shared at November's committee meeting.

- *The format of the Tracker does not capture the focus or titles of regulatory reports, e.g., within the Information Commissioner's Office section there is no reference to data protection or cyber security elements of the 2020 report.*

  This detail will continue to be populated and improved as entries are added and further detail is provided. By way of an example the Committee is referred to the detail contained within the Information Commissioners Office section of the tracker.

  The Committee should also be aware that there are a number of Regulator headings within the tracker that have no entries recorded against them. At the time of reporting the Risk and Regulation team are unaware of any active recommendations for these regulators, the headings have however intentionally been retained within the tracker for reference purposes.

Recommendation 2:
The Legislative and Regulatory Tracker should be reviewed, to ensure consistency in approach arising from regulatory inspections, to offer comparable assurance to the Audit Committee.

The priority to be attached to each recommendation detailed within the tracker will continue to be scrutinised at assurance Committees. Recommendation owners will also be provided with an

Inspection Summary Sheet prior to each Audit and Assurance Committee meeting to populate and share key issues with the Risk and Regulation Team so that assurance can be provided to the Committee that appropriate ongoing monitoring of recommendations is taking place, including the identification of high level recommendations and any concerns.

At previous meetings entries for the Information Commissioners Office (ICO) inspection were reported in more detail than other regulators. At July's Audit and Assurance Committee meeting the detail of 14 recommendations for a single inspection were included within the tracker, whereas similarly large inspections for Pharmacy only included 1 entry.

Moving forward the ICO inspection will be recorded as one entry within the tracker with the detail of each recommendation continuing to be reported to the Digital Health and Intelligence Committee and the Risk and Regulation Team for oversight. The Audit and Assurance Committee will be provided with a summary of progress since the last Committee meeting and confirmation that the inspection has, or has not, been reviewed or considered by the relevant Assurance Committee or Group. The same approach will be adopted for all such entries moving forward.

Whilst these changes have been made work still needs to be undertaken to populate the new columns added and to integrate the changes made so that recommendation leads provide updates in an appropriate format and Risk and Regulation Team can then translate that feedback into a digestible format to provide to the Audit and Assurance Committee that recommendations are being progressed.

Recommendation 3
Consideration should be given to the ask of the Audit Committee based upon the information they are presented within the Legislative and Regulatory Tracker and whether they are able to fulfil their responsibilities.

The changes made to the content of the attached tracker and this report should now satisfy the Committee that this recommendation is being met.

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

The improvements made to the tracker and the ongoing review of progress against regulatory body inspections and recommendations should reduce the risk that key regulatory requirements are missed.

The procedure for tracking such progress will also enable the Audit and Assurance Committee to have oversight of Health Board's compliance with regulatory requirements so that appropriate action can be taken to address emerging trends.

The Regulatory Bodies which inspect Cardiff and Vale UHB are listed within the tracker and include the bodies detailed at Appendix 1.

Recommendation:

For Members of the Audit Committee to:

(a) Approve the approach taken by the Risk and Regulation Team to the tracking and reporting of compliance with regulatory inspections and recommendations.
(b) Approve the assurance provided by the Regulatory Tracker and the confirmation of progress made against recommendations.
(c) To note the continuing development of the Legislative and Regulatory Compliance Tracker.

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

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

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

Appendix 1 – Regulatory Bodies

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

Clinical Board	Directorate	Regulatory body/inspector	Service area	Initial - Inspection Date:	Title of Inspection/Regulation/Standards	Lead Executive	Assurance Committee or Group	Accountable individual	Next Inspection Date	Recommendation Narrative / Inspection outcome	Date for Implementation of recommendations:	Management Response / Update	RAG Rating	Please Confirm if completed (c), partially completed (pc), no action taken (na)
ALL WALES QUALITY ASSURANCE PHARMACY														
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy SMPU	TBC	Quality Assurance of Aseptic Preparation Services	Execdutive Medical Director	QSE Committee/ Management of medicines group	Darrel Baker	TBC	166 actions 16 overdue actions remain	15/07/2021	Pharmacy Quality System recovery action plan developed and under weekly review by the Clinical Board. 5 oldest incidents, non-conformances and change controls now closed.		**PC**
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy UHL	TBC	Quality Assurance of Aseptic Preparation Services	Execdutive Medical Director	QSE Committee/ Management of medicines group	Darrel Baker	TBC	91 actions 4 overdue actions remain	15/07/2021	4 overdue actions remain. Work remains ongoing within the clinical board to ensure that these are closed as soon as possible.		**PC**
BRITISH STANDARDS INSTITUTE														
CD&T	MPCE	BSI	Clinical Engineering, CEDAR	TBC	ISO9001:2015	Executive Director of Therapies and Health Science	QSE Committee	Edward Chapman/Kathy Ikin/Rhys Morris	TBC	C2 Non-conformities 1. No clear professional leadership in place 2. lack of space to operate efficiently and safely.	01/06/2020	Directorate Management Team have resolved all outstanding issues.		**C**
CARDIFF AND VALE OF GLAMORGAN FOOD HYGIENE RATINGS														
Capital, Estates & Facilities	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Aroma Plaza Coffee Outlet, UHL	Various	REGULATION (EC) NO 852/2004; FOOD HYGIENE (WALES) REGULATIONS 2006; GENERAL FOOD REGULATIONS 2004 & REGULATION (EC) NO. 178/2002; FOOD HYGIENE RATING (WALES) ACT 2013	Executive Director of Strategic Planning	Health and Safety	Simon Williams	Unannounced	Between 17th March 20201 and 7th July 2021 5 inspections were undertaken at: Central Food Processing Unit (UHW) - Rating 3	TBC	An update was shared at the July Health and Safety Committee Meeting. Should any further inspections take place they will be reported at the October 2021 Health and Safety Committee meeting.		**C**
COMMUNITY HEALTH COUNCIL														
Estates	Facilities	Community Health Council	CRI Car Park	N/A	Community Health Council Inspection	Executive Director of Strategic Planning	Capital Management Group/Strategy and Delivery Committee	Director of Capital Estates and Facilities	Unnanounced	6 recommendations	31/12/2021	An action plan has been agreed with the CHC for implementation of all recommendations by December 2021		**PC**
Estates	Facilities	Community Health Council	Disabled Car Park	N/A	Community Health Council Inspection	Executive Director of Strategic Planning	Capital Management Group/Strategy and Delivery Committee	Director of Capital Estates and Facilities	Unnanounced	10 recommendations	N/A	**The Director of Capital Estates and facilities has confirmed that all recommendations are complete.**		**C**
FIRE AND RESCUE SERVICES														
Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Lansdowne Ward, St David's Hospital	TBC	Regluatory Reform (Fire Safety) Order 2005	Executive Director of Strategic Planning	Health and Safety	Head of Health and Safety	Not Required	Failed to comply with requirements of safety order. Schedule of works required included: 1 x management 1 x estates	N/A	Completed - Inspection found non-compliance but insufficient for enforcement notice. Inspector may return to check works have been completed.		**C**
Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Sam Davies Ward, Barry Hospital	TBC	Regluatory Reform (Fire Safety) Order 2005	Executive Director of Strategic Planning	Health and Safety	Head of Health and Safety	Not Required	Failed to comply with requirements of safety order. Schedule of works required included: 2 x estates	N/A	Completed - Inspection found non-compliance but insufficient for enforcement notice. Inspector may return to check works have been completed.		**C**
Medicine	Capital and Asset Management	Fire and Rescue Services	Ward A6	TBC	Regluatory Reform (Fire Safety) Order 2005	Executive Director of People and Culture	Health and Safety	Head of Health and Safety	Not Required	Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises. Aritcle 17: Maintenance - Fire resisting doors are not adequately maintained	N/A	Completed - Inspection found non-compliance but insufficient for enforcement notice. Inspector may return to check works have been completed.		**C**
Specialist Services	Capital and Asset Management	Fire and Rescue Services	Rookwood Hospital, Artificial Limb Centre	TBC	Regluatory Reform (Fire Safety) Order 2005	Executive Director of People and Culture	Health and Safety	**Head of Health and Safety**	Not Required	Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.	N/A	Completed - Inspection found non-compliance but insufficient for enforcement notice. Inspector may return to check works have been completed.		**C**
Mental Health	Capital and Asset Management	Fire and Rescue Services	Vale Mental Health Services, Barry Hospital	TBC	Regluatory Reform (Fire Safety) Order 2005	Executive Director of People and Culture	Health and Safety	**Head of Health and Safety**	Not Required	Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.	N/A	Completed - Inspection found non-compliance but insufficient for enforcement notice. Inspector may return to check works have been completed.		**C**
Mental Health	Capital and Asset Management	Fire and Rescue Services	Hafan Y Coed UHL	20/07/2021	Regluatory Reform (Fire Safety) Order 2005	Executive Director of People and Culture	Health and Safety	**Head of Health and Safety**	10/12/2021	Duty of Works: EN01 - (EN3/21) Article 8 - Duty to take general fire precaution's is not being complied with EN3/21 Schedule states: "During the inspection carried out on 14th April 2021 there was evidence of illicit smoking found throughout the premises. These matters have previously been raised by this Authority and also within previous FRA's carried out by the UHB fire safety advisor. This is unacceptable. The UBN's smoking policy should be appropriately managed to ensure that smoking and ignition sources are controlled and monitored to reduce the potential for accidental and deliberate fire setting."	19/05/2021	An acknowledgement reciept was dated 28/04/2021 signed by the executive assisstant to the CEO. Robust control measures have been agreed and implemented between the Director of CEF and senior premises managers. This has been communicated to the enforcing authority. A further inspection was carried out on 20th May by the enforcing authority and due to a number of non compliances found at that time an EN 03 was served i.e. ' Enforcement Notice not complied with'. This matter is now in the hands of the Fire Authority's Compliance team for deliberation.		**PC**

Mental Health	Capital and Asset Management	Fire and Rescue Services	Hafan Y Coed UHL	20/07/2021	Regluatory Reform (Fire Safety) Order 2005	Executive Director of People and Culture	Health and Safety	**Head of Health and Safety**	Not required	Duty of Works: 1. Article 8 Duty to take general fire precautions. 1.1 Fire and smoke resisting doors were being held in the open position with wedges. 1.1.1 Wedges, hooks and any other devices in use at the present time as a means of holding the self-closing fire and smoke resisting doors in the open position shall be removed to ensure that the doors are effectively self-closing. 2. Article 14 Emergency routes and exits. 2.1 Emergency exit doors between the enclosed secured compound areas cannot be easily and immediately opened in an emergency. 2.1.1 It is noted that due to the type of occupancy it is essential for security reasons to keep some escape doors secured, however when requested, a member of staff was unable to open the door between the secured compounds. In the event of an emergency this would prevent or delay ongoing escape into the adjoining area. A means of control should be provided such that these doors can be opened by staff, on confirmation of the fire signal, when it becomes necessary to evacuate to an adjoining secure assembly point. 3. Article 17 Maintenance. 3.1 The fire alarm system is inadequately maintained. 3.1.1 At the time of the inspection it was noted the Fire Alarm Panel illustrated a number of system faults. To ensure the continuing good operation of the fire alarm system, routine	20/07/2021	An acknowledgement reciept was dated 28/04/2021 signed by the executive assisstant to the CEO. Robust control measures have been agreed and implemented between the Director of CEF and senior premises managers. This has been communicated to the enforcing authority. A further inspection will take place on or after 20th July 2021.		**C**
HEALTH EDUCATION AND IMPROVEMENT WALES														
HEALTH INSPECTORATE WALES														
Children & Women	Maternity	HIW	Maternity Services	TBC	HIW	Executive Nurse Director	QSE Committee	Head of Midwifery	**TBC**	HIW are undertaking a national review of maternity services across Wales (Phase 2). **Letter recevied 13/1/21 from HIW Phase 2 on hold.**	Details of community maternity sites sent to HIW 17.07.20 and self assessement sent 24.07.20.	On hold. An update on all HIW inspections are shared at each Quality, Safety and Experience Committee. Updates were last shared at the June QSE Committee - Further updates will be shared in September.		**N/A**
Mental health	Community Mental health	HIW	Cardiff North West Gabalfa Clinic CMHT	TBC	HIW	Executive Nurse Director	QSE Committee	Director of Nursing, Mental Health	**TBC**	Pre inspection information to be submitted by March 9th. 29.01.20 HIW informed of two liaison members of staff to work with HIW team. **Inspection was cancelled due to Covid 19.**	**N/A**	Gabalafa clinic. Not on current planned inspections programme. Can be removed.		**C**
CD&T	Radiology, Medical Physics and Clinical Engineering	HIW	Diagnostic Radiology	TBC	Ionising Radiation (Medical Exposure) Regulation 2017 -IR(ME)R	Executive Director of Therapies and Health Science	QSE Committee	Andrew Gordon/Kathy Ikin	17-18th August 2021	Notification of inspection received IM(ME)R Inspection. Contact details provided to HIW 15.05.21	N/A	An update on all HIW inspections are shared at each Quality, Safety and Experience Committee. Any further updates on this inspections will be shared in September.		**N/A**
Mental Health	Community Mental health	HIW	Community Mental Health	TBC	HIW	Executive Nurse Director	QSE Committee	Director of Nursing for Mental health Services	**TBC**	National Review of Mental Health Crisis prevetnion in the Community List of contacts sent 5th May 2021. Aiming for interviews July 2021	**N/A**	Any further updates on this inspections will be shared at September's QSE meeting.		**NA**
PCIC	GP Practice	HIW (GP Announced visit)	Waterfront Medical Centre	TBC	HIW	Executive Nurse Director	QSE Committee	Director of Nursing, PCIC	TBC	Cancelled no further date received	N/A	Awaiting update from HIW. Any further updates on this inspections will be shared at September's QSE meeting.		**NA**
Medicine	EU/WAST	HIW	EU/WAST	TBC	HIW	Executive Nurse Director	QSE Committee	Director of Nursing Medicine	TBC	Themaitc revew.The focus of the review is to consider the impact of ambulance waits outside Emergency Departments (ED) on patient safety, privacy, dignity and their overall experience	N/A	Any further updates on this inspections will be shared at September's QSE meeting.		**N/A**
HEALTH AND SAFETY EXECUTIVE														
HUMAN TISSUE AUTHORITY														
CD&T	Haematology	HTA	South Wales BMT Programme	TBC	Human Tissue Act	Executive Director of Therapies and Health Science	QSE Committee	Xiujie Zhao	expected Jan/Feb 23	No Major deficiencies, minor actions to complete.	N/A	WBS Audit January - no major deficiencies, some minor actions to complete. HTA confirmed that after a risk-based assessment that the service was low risk for non-compliance and that inspection was not necessary on this cycle.		**C**
CD&T	Haematology	HTA	Stem Cell processing Unit (HTA)	TBC	Human Tissue Act	Executive Director of Therapies and Health Science	QSE Committee	Alun Roderick/Sarah Phillips	expected Jan/Feb 23	No Major deficiencies, minor actions to complete.	N/A	WBS Audit January - no major deficiencies, some minor actions to complete. HTA confirmed that after a risk-based assessment that the service was low risk for non-compliance and that inspection was not necessary on this cycle.		**C**
INFORMATION COMMISSIONERS OFFICE														
Digital Health Intelligence	IM&T and Information Governance	ICO	Digital Health	13/03/2020	ICO Data Protection Audit	Director of Digital Health	Digital and Health Intelligence Committee	James Webb	25/10/2021	25 recommendations were made in relation to Governance and Acocuntability. 1 of these recommendations required urgent action, 14 were rated high, 7 medium and 3 low. 20 recommendations were made in relation to Cyber Security. 1 of these recommendations required urgent action, 9 were rated high, 9 medium and 1 low. An overall assurance rating of reasonable was achieved in both areas.	25/10/2021	At July's committee meeting a total of 14 recommendations remained outstanding. 1 of these actions had completed, 9 were partially completed and 4 had no action taken since July's committee meeting. The ICO will inspect in October 2021 to review progress. 13 recommendations therefore remain live. Updates continue to be shared and scrutinised at the Health Board's Digital Health and Intelligence Committee. An update was last shared in June 2021 and the next update will be shared in October 2021.		**PC**
JOINT EDUCATION ACCREDIATION COMMITTEE														

Specialist Services	Haematology	JACIE	South Wales BMT Programme	TBC	6th edition of JACIE standards	Executive Medical Director	QSE Committee	Keith Wilson	01/02/2023	Minor deficiencies noted	01/10/2019	Programme received formal re-accredition notice - There are ongoing discussions with the executive board regarding a new facility for BMT/Haematology as the service will not achieve re-accredition post the next inspection cycle.		**PC**
MEDICAL GENETICS														
MEDICAL GENETICS	Medical Genetics	SGS/UKAS	Institute of Medical Genetics, UHW	05/11/2019	ISO 15189:2012	Executive Director of Therapies and Health Science	QSE Committee and Monthly Medical Genetics QSE Meeting	Peter Thompson	N/A	Action Mandatory x 14 Require Evidence to UKAS x 14 Action Recommended x 5	05/12/2019	Findings have been closed by UKAS		**C**
MEDICAL GENETICS	Institute of Medical Genetics	UKAS	Institute of Medical Genetics, UHW All Wales Genomics Laboratory	29/05/2020	ISO 15189	Executive Director of Therapies and Health Science	QSE CommitteeQSE Committee and Monthly Medical Genetics QSE Meeting	Lisa Grffiths	N/A	No findings/non-conformances were raised, so there is no improvement action report	TBC	**Regular updates are shared at the Medical Genetics QSE Meeting. A further more detailed update will be shared at the November 2021 Audit Committee**		**C**
MEDICAL GENETICS	Medical Genetics	UKAS	Institute of Medical Genetics, UHW All Wales Genomics Laboratory	05/11/2020 - 10/11/2020	ISO 15189	Executive Director of Therapies and Health Science	QSE Committee and Monthly Medical Genetics QSE Meeting	Lisa Grffiths	TBC	Mandatory findings x 49 Observations x 5 Extension to Scope (for new services) x 13	01/05/2021	Mandatory fingings 45 closed by UKAS. Evidence submitted to UKAS for further 4 but UKAS delayed in assessing evidence. Observation 5 closed Extension to Scope - 6 findings closed by UKAS. 2 findings on second cycle of evidence submitted. Evidence submitted to UKAS for further 5 but UKAS delayed in assessing evidence. All findings now closed by UKAS, new schedule of accreditation published.		**C**
MHRA														
CD&T	Pharmacy	MHRA	Pharmacy SMPU	TBC	Good manufacturing practice (GMP) and good distribution practice (GDP)	Executive Medical Director	QSE Committee	Darrel Baker	TBC	1 major 10 others	31/03/2021	Pharmacy Quality System recovery action plan developed and under weekly review by the Clinical Board. 5 oldest incidents, non-conformances and change controls now closed.		**PC**
CD&T	Pharmacy	MHRA	Pharmacy UHL	TBC	Good manufacturing practice (GMP) and good distribution practice (GDP)	Executive Medical Director	QSE Committee	Darrel Baker	TBC	3 majors 2 others	31/03/2020	Descalated from MHRA Inspection Action Group 1st July 2020 Outstanding Estates issues to resolve to meet requirements of the regulator		**PC**
NATURAL RESOURCES WALES														
OFFICE FOR NUCLEAR REGULATION														
QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES														
RESEARCH AND DEVELOPMENT														
UKAS														
Specialist Services	ALAS	SGS/UKAS	ALAS (CAV)	TBC	ISO 9001:2015	Executive Director of Therapies and Health Science	QSE Committee	Paul Rogers	N/A	2 x Minor Corrective Actions: Patient satisfaction/ feedback - we collect this but could do more to analyse the data Staff Competency and Awareness - Improve recording of non-CPD role competencies	01/10/2021	Positive Audit with 2 minor corrective actions that we were aware of. Have plans in motion to address both staff engagement/ recording of competencies and better analysis of patient feedback. Confident of completion of these before next audit review in 01/10/2021		**PC**
Surgery	Perioperative	SGS/UKAS	SSSU	TBC	ISO 13485:2016	Executive Director of Therapies and Health Science	QSE Committee	Clare Jacobs	N/A	3 minors	01/01/2020			**NA**
Surgery	Perioperative	SGS/UKAS	HSDU	TBC	ISO 13485:2016	Executive Director of Therapies and Health Science	QSE Committee	Mark Campbell	N/A	2 minors	15/07/2022	**Re-Validation Audit. Minor 1, was for audit of audits. We should have someone independent from HSDU audits to audit our audits. SSU Llandough will Audit HSDU and we will audit SSU. Minor 2, not currently registered to MHRA. HSDU is in the application process at the moment.**		NA
WELSH WATER														
WSAC														
Surgery	Audiology	WSAC	audiology - adults	TBC	audiology quality standards	Executive Director of Therapies and Health Science	QSE Committee	Lorraine Lewis	01/06/2022	compliant with 8 of 9 standards and meeting 85% target	01/01/2020	The one standard that was out of compliance around review appointments and individual management plans is now in compliance ready for next audit in 2022.		**C**
Surgery	Audiology	WSAC	Newborn hearing screeing wales	TBC	audiology quality standards	Executive Director of Therapies and Health Science	QSE Committee	Ellen Thomas/Razun Miah	01/11/2021	80% target met in all standards and 85% overall target met	01/11/2021	Audit delayed by 18 months due to covid		**NA**
Surgery	Audiology	WSAC	audiology - paediatrics	TBC	audiology quality standards	Executive Director of Therapies and Health Science	QSE Committee	Rhian Hughes/Ellen Thomas/Razun Miah	01/11/2021	80% target met in all standards and 85% overall target met	01/11/2021	Audit delayed by 18 months due to covid		**NA**
WEST MIDLANDS QRS														

Report Title:	**Internal Audit Recommendation Tracker Report**								
Meeting:	**Audit Committee**							**Meeting Date:**	**07/09/21**
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

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

The internal audit tracking report was first presented to the Audit Committee in September 2019 and approved by the Committee as an appropriate way forward to track the implementation of recommendations made by internal audit. Since the July 2021 Audit Committee, minor changes have been made to the format of the tracker in consultation with the Health Board's Internal Audit team.

The tracker continues to highlight progress made against previous years recommendations albeit in a more streamlined manner. The tracker attached to this report sets out the progress made against recommendations from 2019/20 and 2020/21. To date no reports have been approved for 2021/22 for inclusion in the tracker. The committee will recall that the remaining entries from 2018/19 were either completed or closed July's Committee meeting.

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

As can be seen from the attached summary tables the overall number of outstanding recommendations has reduced from 126 individual recommendations to 96 during the period July 2021 to September 2021. The reduction in recommendations can be attributed to the completion (60) and agreed removal (9) of 69 entries from the tracker following July's committee meeting. A further 39 entries have been added to the tracker. The audit reports added to the tracker on this occasion are:

1) Data Quality Performance Reporting (Single Cancer Pathway) (5 Recommendations made, 1 of which has completed)
2) Infrastructure and Network Management (5 recommendations)
3) Rostering in Community Children's Nursing (7 recommendations – 2 of which are complete and 6 of which are noted (Recommendation 5 completed prior to submission to committee))
4) Staff Recruitment (3 Recommendations, 2 of which have completed)
5) Wellbeing Hub at Maelfa (13 recommendations, 9 of which are complete)
6) Annual Planning Process (2 recommendations, 1 of which has been completed)

7) Engagement around service planning (5 recommendations)

Of the 96 recommendations listed 30 are recorded as completed, 57 are listed as partially complete and 9 are listed as having no action taken.

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

A review of all outstanding recommendations has been undertaken since the last meeting of the Audit Committee where the internal audit tracker was presented (July 2021). Each Executive Lead has been sent the recommendations made by Internal Audit which fall into their remits of work.

The table below shows the number of internal audits which have been undertaken between 2019/20 and 2021/22 (to date) and their overall assurance ratings.

	Substantial Assurance	Reasonable Assurance	Limited Assurance	Rating N/A - Advisory	Total
Internal Audits 2019/20	10	25	2	2	39
Internal Audits 2020/21	7	18	1	3	29
Internal Audits 2021/22	-	-	-	-	-

Attached at Appendix 1 are summary tables which provide an update on the July 2021 position.

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

Recommendation:

The Audit Committee Members are asked to:

(a) Note the tracking report for tracking audit recommendations made by Internal Audit.
(b) Note and be assured by the progress which has been made since the previous Audit and Assurance Committee Meeting in July 2021.

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

1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care	x

				sectors, making best use of our people and technology	
4.	Offer services that deliver the population health our citizens are entitled to expect	x	9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

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

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

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2019-20	01/07/2020	Medical Staff Study Leave - Reasonable	R1/6	Medium	The UHB Study Leave Procedure for Medical & Dental Staff should be reviewed and revised. The policy should more clearly specify: - roles and responsibilities – of Directorates, Managers, Consultants; - funding and budget guidance. - monitoring and compliance arrangements including KPIs; and - reporting arrangements. Once updated, the procedure flow chart that is appended should also be updated accordingly.	Director of People and Culture	Executive Director of Workforce and OD & Medical Director	PC	Medical Worforce Manager has met with the BMA and a further meeting is being aranged for August 2021 to finalise revisions to the Study Leave Procedure. It will then go to LNC for agreement and Strategy and Delivery Committee for approval.
2019-20	01/09/2020	Medical Staff Study Leave - Reasonable	R3/6	Medium	Directorate administrative arrangements should be reviewed and strengthened in line with the revised Health Board Procedure and as a part of producing local operational procedures, particularly the recording of clinical authorisation on Intrepid. Procedures should include the checking of core data on an annual or rolling basis	Director of People and Culture	Executive Director of Workforce and OD & Medical Director	C	This has been superceded by training provided by Medical Education
2019-20	01/09/2020	Medical Staff Study Leave - Reasonable	R4/6	Medium	The following arrangements are reviewed and strengthened:- - budget setting, monitoring and reporting; - payment of honorary staff expenses; and - ability to access Trust funds to support study leave budgets.	Director of People and Culture	Executive Director of Workforce and OD & Medical Director	PC	Budget setting discussed at LNC and a proposal reached which will mean there is an equitable amount available to each doctor. Figures to be worked through by finance before sign off and implementation.
2019-20	01/12/2020	Medical Staff Study Leave - Reasonable	R5/6	Medium	Assess and review the use of Intrepid as a tool for managing activities other than junior doctors and formulate a plan going forward.	Director of People and Culture	Executive Director of Workforce and OD & Medical Director	C	System was assessed and not suitable for job planning or eletronic rostering. We have procured Allocate for E-Job Plannign which is now 25% on system. Work ongoing throughout 2021. Scoping has been undertaken for UHB wide rostering system which is currently on hold until job planning embedded and IMTP annual business cycle.
2019-20	01/07/2020	Medical Staff Study Leave - Reasonable	R6/6	Medium	Develop the Intrepid User Group to co-incide with the introduction of the updated Health Board Procedure and local operational procedures. Besides regularising practices, the group could be a forum to identify development opportunities and good practice. The ability of the system to generate 'team views' and reports should be considered as well. Once updated, the authorisations should be checked annually. A Terms of Reference should be put in place and all meetings should have minutes and action plans.	Director of People and Culture	Assistant Medical Director (Workforce and Revalidation), Medical Workforce Manager and Medical Education Lead	C	This item was taken to Medical Workforce Advisory Group (MWAG) for discussion chaired by the Medical Director and Worforce Director. It was decided that a separate user group was not required but that this work would be integrated into other working groups, reporting into the MWAG.
2019-20	21/07/019	Freedom of Information	R7/7	Low	Foi certification or additional Foi training should be available for team members whose role involves processing and answering Foi requests	Director of Digital & Health Intelligence	Information Governance Manager	PC	Training providers have been contacted with delivery expected by Q4 2021/22
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R1/5	High	The UHB should ensure policies are reviewed and updated within appropriate timescales.	Director of Corporate Governance	Head of Corporate Governance	PC	The new Head of Corporate Governance commenced work with the team on 26 July. One of her priorities is to complete the worked identified by Inernal Audit on policies.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R2/5	Medium	Review the 'register' for completeness. Assess if all policies, procedures and other written control documents available on the intranet and internet are current and then ensure they are all recorded appropriately in the 'register'.	Director of Corporate Governance	Head of Corporate Governance	PC	The new Head of Corporate Governance commenced work with the team on 26 July. One of her priorities is to complete the worked identified by Inernal Audit on policies.

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2019-20	01/12/2020	Management of Health Board Policies and Procedures	R3/5	Medium	1. Review the readability of documents to make ways to write clearer, especially those available through internet to wider audience. From register, 372 out of 393, recorded as published on internet. 2. Correct and improve accessibility of documents. Review publishing process to ensure documents are circulated through correct location in internet and/or intranet sites. 3. A combined EHIA should be completed for all policies or where a Health Impact Assessment is not required this should be clearly stated. 4. The Corporate Governance Department should ensure the integrity of the 'Register', by reviewing accuracy of all key information.	Director of Corporate Governance	Head of Corporate Governance	PC	The new Head of Corporate Governance commenced work with the team on 26 July. One of her priorities is to complete the worked identified by Inernal Audit on policies.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R4/5	Low	Review of record keeping process for when a request is made to create new written control document; from receipt of request to create, to issue of draft for consultation. Review of record keeping process for the consultation process; from request made, publishing and any feedback received.	Director of Corporate Governance	Head of Corporate Governance	PC	The new Head of Corporate Governance commenced work with the team on 26 July. One of her priorities is to complete the worked identified by Inernal Audit on policies.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R5/5	Low	Review of record keeping process for notifying stakeholders of new, amended and exiting policies.	Director of Corporate Governance	Head of Corporate Governance	PC	The new Head of Corporate Governance commenced work with the team on 26 July. One of her priorities is to complete the worked identified by Inernal Audit on policies.
2019-20	N/A	Pre-employment Checks	R1/10	High	Temporary Staffing Management should revise their current pre-employmentchecks procedures. The following highlighted areas should be considered for revision: - All original Identification, Right to Work and Qualification documents should be brought to enrolment and photocopied by the Temporary Staffing Department. All copies should be signed and dated and then uploaded to Trac as evidence of proof of validity by the individual undertaking the checks. Online/downloaded documentation should not be accepted as proof of identification or right to work in the UK - References should cover the consecutive two year period of employment/education prior to the commencement of post. Reference dates should correctly correspond to the dates detailed on Trac; - Original Qualification Certificates/Proof of Registration (i.e. screenshot of nursing PIN) should be uploaded to Trac to evidence the individual meets the criteria of the role conditionally offered; and Management should inquire if 'Qualification Check' can be added to the Temporary Staffing Trac list of required pre-employment checks.	Executive Director of People and Culture	Executive Director of People and Culture	C	Complete
2019-20	N/A	Pre-employment Checks	R2/10	Medium	Health Board managers should be reminded that internal applicants cannot commence in post prior to pre-employment checks being fully completed. Managers should also be reminded to take notice of the weekly Trac update emails and the monthly escalation reports sent to them and regularly check on the progress of their applicants' pre-employment checks and take action as required to speed up the process. Managers should be encouraged to use Trac to keep up to date with progress of applications. The 'Managers Tips to Reduce Time to Hire' guidance should be circulated throughout the Health Board via email.	Executive Director of People and Culture	Executive Director of People and Culture	C	Complete
2019-20	N/A	Pre-employment Checks	R3/10	Medium	Temporary Staffing Department management to familiarise themselves with the NHS Employment Checks Standards and implement appropriate procedural guidance, ensuring it satisfies all requirements/criteria of the Standards.	Executive Director of People and Culture	Executive Director of People and Culture	C	Complete

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2019-20	N/A	Pre-employment Checks	R4/10	Medium	Management to review the process for Consultant reference checks to ensure it adheres to the relevant guidance.	Executive Director of People and Culture	Executive Director of People and Culture	C	Complete
2019-20	N/A	Pre-employment Checks	R5/10	Low	Management to review the Employment Services SLA.	Executive Director of People and Culture	Executive Director of People and Culture	C	NHS Shared Services Partnership are responsible for reviewing the SLA.
2019-20	N/A	Pre-employment Checks	R9/10	Low	Management should review all supporting policies/procedures listed in the CVU Recruitment Policy. Management should review and consider updating the Secondment Policy to include the requirement for pre-employment checks to be completed before an employee can commence in a secondment post. Management should review the Recruitment of Locum Doctors and Dentists Policy, ensuring all terminology is relevant.	Executive Director of People and Culture	Executive Director of People and Culture	PC	Currently under review.
2019-20	N/A	Pre-employment Checks	R10/10	Low	Temporary Staffing Department management to review the standard letter sent with the conditional offer and ensure it complies with the Identification Check NHS Standard.	Executive Director of People and Culture	Executive Director of People and Culture	PC	The Temporary staffing manager is currently reviewing the TSD documentation to reflect the wider organisational TRAC documention. This will take a few weeks to implement
2019-20	01/11/2020	Strategic Planning - IMTP	R4/4	Low	Management should ensure the ToR are reviewed and updated as required.	Director of Planning	Marie Davies	PC	BCAG will review ToR periodically going forward to ensure the role and function of group is updated if necessary.
2020-21	31/03/2021	Regional Partnership Board	R4/4	Low	Management should consider formal reporting on outcomes from the RPBs activities into the Health Board, to allow for effective scrutiny.	Director of Planning	Abigail Harris, Executive Director of Planning	NA	No update shared.
2020-21	31/03/2021	Environmental Sustainability Report	R1/2	Medium	Management should ensure a timetable is prepared annually and made available to all relevant staff prior to compiling the SDR. This should include the timeline for the first meeting of the task and finish group, data submission deadlines, the various stages of review and approval and submission to the Communications Team.	Director of Finance	Energy Manager/Head of Energy and Performance	C	For the report for 2020/21 the key relevant staff were informed of the timescales for the report including key deadlines.
2020-21	31/11/2020	Environmental Sustainability Report	R2/2	Medium	Evidence of the retrospective approval of the sustainability report by the Environmental Steering Group / Health & Safety Group and sign off by the Director of Capital Estates and Facilities should be provided to audit each year. The documented procedural guidance should be also updated to reflect the actual review and approval process currently in place.	Director of Finance	Energy Manager/Head of Energy and Performance	PC	The report for 2020/21 was presented / discussed at the Environmental Mangement Steering Group held on 6/7/21. The report was isued for comments and feedback. The procedural document will be updated to reflect this action.
2020-21	31/12/2020	Management of Serious Incidents	R3/6	Medium	Management should ensure that all outstanding actions are completed.	Executive Nurse Director	Assistant Director Patient Safety and Quality	NA	No update shared.
2020-21	31/11/2020	Management of Serious Incidents	R5/6	Low	Staff should be reminded to keep Datix as up to date as possible to ensure an effective audit trail.	Executive Nurse Director	Assistant Director Patient Safety and Quality	PC	The UHB is currently in the process of introducing the Once for Wales Concerns Management System and this wil lbe assoicated with the relavant training which wil linclude the requirement to keep the ssytem as up to date as possible.
2020-21	31/12/2020	Management of Serious Incidents	R6/6	Low	The review into the consistency of information supplied to Clinical Boards should be completed.	Executive Nurse Director	Assistant Director Patient Safety and Quality	PC	As above. Once the revised sytem is introduced will introduce a range of standardised reports for each Clincal Board.
2020-21	21/02/2020	Tentacle System Follow-up	R2/9	Medium	The level of recording of developments and changes to Tentacle should be improved. At a minimum the record should record what change was made, the date of testing, staff involved with UAT and a formal agreement of user acceptance.	Director of Digital & Health Intelligence	Service Improvement Manager, Cancer Services	C	CTM MVP testing record complete. Development program requests list and subsequent test list available on Cancer Services Teams channel. Release notes supplied to users.Formal process for agreement of user acceptance for changes has been produced.
2020-21	31/03/2021	Integrated Health Pathways	R1/6	Medium	Additionally, appropriate support should be put in place for the HealthPathways Project Lead that ensures effective cover for their role should they be away for a period of time or during long term sickness.	Executive Medical Director	Ruth Jordan 31/3/21	PC	The HealthPathways team were transferred to the management of the PCIC Clinical Board at the start of the 21/22 financial year to support operational stability. A review of structures and processes is currently under way
2020-21	10/02/2021	Integrated Health Pathways	R5/6	Medium	Whilst there are sound and accessible processes in place that allow GPs and Consultants to feedback issues and HealthPathways reports are in place that can monitor pathways in use, the review was not able to comprehensively establish user perceptions in this respect across Cardiff and the Vale of Glamorgan. UHB management should obtain further opinion and feedback from GPs to establish the level of current usage and current satisfaction with database functionality.	Executive Medical Director	Maria Dyban / ongoing Patricia Osborne / 10.02.21 Patricia Osborne / ongoing	C	The feedback facility on HP allows individuals to provide general feedback on the serviice/system and/or feedback on specific pathways. HPs is now being included in all GP training sessions that are supported by PCIC. These provide an opportunity for GPs to feed back on their experiences of using HPs. Monthly "priority" meetings are held with wider groups to ensure the most requested pathways are developed as quickly as possible and are also an opportunity for gathering feedback on the system

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2020-21	01/05/2021	Integrated Health Pathways	R6/6	Medium	Feedback provided by GPs and Consultants as to the effectiveness and worth fullness of the HealthPathways performance data should be reported within the organisation as a means of 'lessons learned' and continuous improvement.	Executive Medical Director	Maria Dyban & Patricia Osborne	C	A plan has been put in place to provide regular reports to PCIC SMYT and other relevant groups. A key indicator as to the usefulness of the service is considered to be how much it is used and regular usage data is provided by Google Analytics and is being reported. The number of pathways in place and the appropriacy of those pathways to GPs will impact on usage and this data is gathered from the HPs site with a growth plan is place. A member of staff has undertaken Signals for Noise training and is working with the team to provide internal data such as that relating from GPs to secondary care.
2020-21	30/09/2021	UHB Core Financial Systems	R1/3	Medium	Management should ensure the FCPs are updated as soon as possible.	Director of Finance	Helen Lawrence – Sept 2021	PC	FCPs are currently being reviwed to ensure up to date and reflective of current procedures.
2020-21	30/04/2021	UHB Core Financial Systems	R2/3	High	Management should ensure that the main Asset Register is updated to reflect the accurate position. The required Due process follow up should be commenced as soon as possible specifically for missing assets and all other applicable assets. For future verification exercise, it may be helpful if Finance provides a key with various categories (e.g. D- Disposal, A- Additions, M- Missing, O- others for unique issues: departments specifying on a separate column what O denotes etc). This can be forwarded at the point the initial email is sent out to the departments. This would help ensure standardization across the board, managing the time used in collating the information and help to analyse with ease if required.	Director of Finance	Helen Lawrence - March/April 2021	PC	A review of the asset register is currently underway. A verifiation key will be implemented for the annual verification process which will next take place in October 2021.
2020-21	01/05/2021	Risk Management	R1/5	Low	To demonstrate the periodic assessment of risk management maturity, future reviews of the BAF and RM Strategy should incorporate references and alignment to best practice guidance / risk management standards (See Appendix B).	Director of Corporate Governance	Head of Risk and Regulation / Risk and Regulation Officer May 2021	C	The UHB's updtaed Risk Management Strategy was approved at the July Board meeting which now incorporates references to best practive and risk management standards which will be adopted for future reviews of the BAF and RM Strategy.
2020-21	01/12/2021	Risk Management	R2/5	Medium	Continued efforts should be made to embed current processes for recording risks, which will facilitate the aggregated risk profile of the Health Board. To aid efficiency and effectiveness of current processes, consideration should be given to the means of capturing and recording risks, to facilitate greater aggregation and visibility	Director of Corporate Governance	Head of Risk and Regulation / Risk and Regulation Officer	C	Risk management training sessions continue to be delivered to Health Board employees to embed current processes. A check and challenge process has also been introduced to the Corporate Risk Register so that entries are verified prior to addition to the CRR which assists with the consistency and scoring of risk across all Clinical Boards and Corporate Directorates.
2020-21	01/12/2021	Risk Management	R4/5	Medium	To continue as planned to roll out the delivery of effective risk management systems and processes, as detailed in the BAF action plan to the Board on 28th January 2021.	Director of Corporate Governance	Head of Risk and Regulation	C	This process continues to run and further proposals for the development of this process and additional Board level training were agreed the July Board meeting.
2020-21	01/05/2021	Risk Management	R5/5	Low	Consideration should be given to utilising greater Microsoft Excel functionality, to enhance the maturity of the corporate risk register template. *(For example, data validation and conditional formatting functionality could be applied to the risk rating and assurance committee columns)*	Director of Corporate Governance	Head of Risk and Regulation	C	A revised Riosk register template was developed and approved at the Health Board's July Board meeting.
2020-21	01/03/2022	Consultant Job Planning 2nd Follow-up	R1/4	High	Clinical Boards must ensure that all consultants complete a job plan or have their existing job plan reviewed on an annual basis.	Executive Medical Director	Kirsten Mansfield	PC	A new job planning procedure and guidance that has been agreed with the BMA was approved by the Strategy and Delivery Committee in March 2021.

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2020-21	31/08/2021	Consultant Job Planning 2nd Follow-up	R2/4	High	The UHB job planning guidance should require consultants to use the standard Job Plan template contained within the guidance unless they can provide a valid reason for not doing so. Job Planning documentation should be completed in full and should include full details of the activities to be undertaken in each session. Line managers should ensure that the number and split of sessions recorded in ESR agrees to and is supported by a fully completed job plan.	Executive Medical Director	Kirsten Mansfield	**PC**	The implementation of the Allocate e-job planning system means that there is now a single, standardised job plan format in use that must be used by all Consultants and SAS Doctors.
2020-21	31/03/2022	Consultant Job Planning 2nd Follow-up	R3/4	High	Clinical Board management must ensure that all consultants complete the outcome measures template contained within the UHB Job Planning guidance as part of the job planning process.	Executive Medical Director	Kirsten Mansfield	**PC**	The revised job planning procedure and guidance issued in March 2021 requires job plans to include measurable outcomes. This includes a table of outcome measures against activities for all Supporting Professional Activities (SPA). The new electronic job planning system currently being implemented facilitates the recording of Health Board, Service and Personal outcome measures in a consistent format.
2020-21	31/03/2021	Consultant Job Planning 2nd Follow-up	R4/4	Medium	All completed job plans must be signed by the Consultant and the clinical manager responsible for agreeing them. The standard Job Plan documentation included in the UHB Job Planning guidance should be updated to incorporate the use of digital signatures.	Executive Medical Director	Kirsten Mansfield	**PC**	The Allocate e-job planning system has been purchased and continues to be rolled out across the UHB.
2020-21	30/06/2021	IM&T Control and Risk Assessment	R1/18	Not Rated	An IG Forum should be established for the IG leads from each clinical board to meet to discuss issues and to coordinate IG matters across the Health Board at an operational level.	Director of Digital & Health Intelligence	IG Manager by 30 June 2021	**PC**	We agree with the recommendation; the intention is for IG issues to be picked up at Clinical Board Q&S briefings but this will require additional capacity to ensure that the IG function is able to support the Clinical Boards. This will be reviewed as part of finalising the D&HI structure.
2020-21	31/05/2021	IM&T Control and Risk Assessment	R2/18	Not Rated	The revised governance framework for IM&T / digital should be implemented to ensure that there is a holistic structure for the organisation, with participation from Clinical Boards. Where control over aspects of IM&T has devolved to departments, the assurance flows to the DHIC should be clarified to ensure the committee can maintain oversight over the whole organisation.	Director of Digital & Health Intelligence	Director of Digital & Health Intelligence 31 May 2021	**PC**	The Digital Service Management Board, to include Clinical Board representation, will be re-established to meet on a regular quarterly basis, from 27 May 2021 onwards. As part of the DSMB function, alignment of informatics and ICT services that sit outside D&HI directorate will be mapped and included for completeness of oversight at UHB level.
2020-21	31/07/2021	IM&T Control and Risk Assessment	R3/18	Not Rated	A register of compliance requirements for all IM&T related legislation and standards should be developed along with a process for assessing status and reporting upwards to Committee.	Director of Digital & Health Intelligence	Director of Digital & Health Intelligence 31 July 2021	**PC**	Agreed. A register of compliance for all IM&T related legislation and standard will be developed to support the NIS Directive and data security standards, which will be managed through the Head of Digital Operations.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R4/18	Not Rated	Management should consider providing an annual report that identifies risks that have a low likelihood but have a severe worst-case scenario. This would ensure that executives are aware of the risks and worst cases that are being managed at a lower level, but hold the potential for severe adverse effects should they materialise. Management Response	Director of Digital & Health Intelligence	Director of D&HI 30 September 2021	**PC**	The D&HI directorate risk register is shared with the D&HI Committee at each meeting. An annual report to capture the low risk high impact risks will be produced and shared at the committee and with the Management Executive team.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R5/18	Not Rated	The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	Director of Digital & Health Intelligence	Head of Digital Operations 30 Sept 2021	**PC**	The risk identification process to support the event and problem management process will be developed and documented, for inclusion as part of the management or risk assurance documentation to be presented at the regular D&HI committee.
2020-21	31/05/2021	IM&T Control and Risk Assessment	R6/18	Not Rated	The Health Board should ensure greater links with clinical boards and the D&HI Directorate are developed using the DMB to ensure all decisions are aligned with the organisations digital strategy.	Director of Digital & Health Intelligence	Director of D&HI 31 May 2021	**PC**	The DSMB is being re-established to meet again from 27 May (each quarter) where decisions and actions relating to IM&T will be captured to ensure alignment with the UHB's digital strategy.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R7/18	Not Rated	Departmentally managed systems should comply with good practice for the management of digital. The D&HI Directorate should produce good practice guidance documentation for the health board overall as leaders of the digital services provision, with all departments required to comply for areas such as change control.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	**PC**	The D&HI directorate will produce updated good practice guidance documentation, based on ITIL and industry standards, for dissemination across all IM&T functions across the UHB.

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2020-21	30/09/2021	IM&T Control and Risk Assessment	R8/18	Not Rated	A review of the current strategic position of the Health Board in relation to its digital provision and maturity across all domains should be undertaken.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	**PC**	The D&HI directorate will undertake a complete baseline assessment against the digital maturity standards (HIMMS) to assist in determining the current position and help inform the digital strategy roadmap. This will be presented at D&HI committee.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R9/18	Not Rated	The roadmap should be fully defined in order to help deliver the Digital Strategy.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	**PC**	The current roadmap has been produced to align with the channel programme boards; a more detailed roadmap to include resources and dependencies will be developed for approval at D&HI committee.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R10/18	Not Rated	The Strategy should be available on the Health Board website, and flagged, with a communication plan to push awareness with all stakeholders	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	**PC**	The digital strategy is available as a public document and is accessible via the UHB's website. A communication plan for internal consumption is being developed. This will form the basis of a broader comms plan to share with all stakeholders.
2020-21	31/08/2021	IM&T Control and Risk Assessment	R11/18	Not Rated	The D&HI Directorate budget should be set to reflect the actual need of the organisation. The capital expenditure budget should be reviewed with the intent to providing a stable funding position to allow for delivery of the digital strategy.	Director of Digital & Health Intelligence	Director of D&HI 31 Aug 2021	**PC**	A Case for Investment has been produced and shared with the Management Executive team which sets out the capital and revenue requirements for the life of the digital strategy (2020-2025). Discussions on affordability and potential sources of funding are taking place with executive management. Decisions on funding are expected to be made during the second quarter of 2021/22
2020-21	30/09/2021	IM&T Control and Risk Assessment	R12/18	Not Rated	A full assessment of the current skills within the directorate, alongside the required resource and skills for the Digital Strategy should be undertaken. Once the gaps in skills have been identified a formal plan to upskill staff should be developed.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	**PC**	All staff within the D&HI directorate are expected to complete the PADR and objective setting process, which will identify current training and development needs. These will be compared with the known and expected requirements to deliver the digital strategy and will form the annual plan of training and development.
2020-21	31/07/2021	IM&T Control and Risk Assessment	R13/18	Not Rated	A formal cyber security workplan should be developed. This should be based on a formal assessment of the current position of the health board and define the actions needed to improve the position.	Director of Digital & Health Intelligence	Head of Digital Operations 31 July 2021	**PC**	A full cyber security work-plan, including NIS directive requirements will be completed as soon as the cyber team is in place. Recruitment is currently underway.
2020-21	30/06/2021	IM&T Control and Risk Assessment	R14/18	Not Rated	The national cyber security training should be mandated for all staff.	Director of Digital & Health Intelligence	Director of D&HI 30 June 2021	**PC**	Accepted. The national cyber resilience unit at Welsh Government has been approached for assistance in producing the training plan for staff across the UHB.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R15/18	Not Rated	Formal reporting on cyber security should be established, along with a suite of cyber security KPIs in order to show the status of cyber security and the progress of the team in managing issues.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	**PC**	A formal report on cyber security will form part of the suite of documents to be shared regularly at the D&HI committee.
2020-21	30/09/2021	IM&T Control and Risk Assessment	R16/18	Not Rated	Consideration should be given to developing a single register of assets and their configuration status for the Health Board. This should include a process for identifying critical assets and ensuring regular assessment of the need for replacement of these.	Director of Digital & Health Intelligence	Head of Digital Operations 30 Sept 2021	**PC**	The new IT portal and service desk solution procured in March 2021 will be populated to create a single register of all IM&T assets.
2020-21	31/07/2021	IM&T Control and Risk Assessment	R17/18	Not Rated	A patch management policy, and associate procedure should be developed.	Director of Digital & Health Intelligence	Head of Digital Operations 31 July 2021	**PC**	Agreed. A full patch management policy will be created to include all related procedures.

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2020-21	30/09/2021	IM&T Control and Risk Assessment	R18/18	Not Rated	The organisation should develop an overarching BCP / DR process. This should: • consider all the systems and use a business impact analysis to identify the business critical systems to prioritise for recovery; • departments with devolved control should feed into this process to ensure all system have appropriate plans and that the plans do not conflict; • RTO / RPO should be agreed for each system with the key stakeholders; and • The full position should be defined and agreed with executives to ensure that they accept the position and associated risks.	Director of Digital & Health Intelligence	Director of D&HI 30 Sept 2021	**PC**	Agreed. Working with colleagues in corporate planning, a full BCP/DR process will be developed and shared with Management Executive.
2020-21	30/09/2021	Data Quality Performance Reporting (Single Cancer Pathway) - Reasonable	R1/5	**Medium**	Management should continue as planned to finalise the review of the Data Quality Policy (UHB 298) (to reflect the General Data Protection Regulation framework), and the Data Quality Procedure (UHB 288). Once finalised, formal approval of the documents should be sought from the Board.	Chief Operating Officer	Director of Digital and Health Intelligence September 2021	PC	A review of the Data Quality Policy is now complete and a team from Information and Operations Performance have been tasked to complete a review of the Data Quality Procedure. Once complete, both documents will be presented to the Board for approval. Terms of Reference for group estalbished. Review of DQ procedure to be complted by end Qtr 3 (December 2021).
2020-21	30/09/2021	Data Quality Performance Reporting (Single Cancer Pathway) - Reasonable	R2/5	**Medium**	Operational procedures or guidance documents should be produced to ensure continuity and standardisation of the data quality processes.	Chief Operating Officer	Cancer Services Lead Manager, 30 September 2021	PC	The Operational procedures and guidance documents which were identified through the audit processes as being absent are now in a draft format. With the ongoing recruitment for key posts the intention is to have completed and signed off documents by the end of Quarter 2.
2020-21	20/07/2021	Data Quality Performance Reporting (Single Cancer Pathway) - Reasonable	R3/5	**Medium**	The Executive Cancer Board (ECB) should approve the Operational Cancer Group Terms of Reference, including the membership. Any issues of non-attendance going forward are to be escalated to the ECB.	Chief Operating Officer	Cancer Services Lead Manager, 20 July 2021	**C**	The terms of reference and the membership will be tabled for discussion and agreement at the next Cancer Operational Group to be held on 21st June 2021. The formal agreement of the Cancer Operational Group ToR will be tabled for the next meeting.
2020-21	30/09/2021	Data Quality Performance Reporting (Single Cancer Pathway) - Reasonable	R4/5	**Medium**	Management should ensure that stronger quality assurance checks are undertaken on the source data.	Chief Operating Officer	Cancer Services Lead Manager, 30 September 2021	PC	With the recruitment of key posts the audit and validation processes will be strengthened. A validation tool is being developed by DHCW which will be adapted and implemented within the Health Board. The timeframe for this improvement is by the end of Q2 in line with the CaNISC replacement programme
2020-21	30/09/2021	Data Quality Performance Reporting (Single Cancer Pathway) - Reasonable	R5/5	**Low**	Management should consider implementing an issues log to capture discrepancies in the data and help identify any negative trends.	Chief Operating Officer	Cancer Services Lead Manager, 30 September 2021	**NA**	With the recruitment of key posts an issues log will be established and maintained. This log will be used to raise technical concerns with the IT development team responsible for the main cancer tracking module. The log will also be used to identify individual and team training requirements. The time frame will be by end of Q2 in line with recruitment processes.
2020-21	31/10/2021	Infrastructure / Network Management	R1/5	**Medium**	Management should ensure that the Health Board's practical guide to engagement and associated flowchart is updated to reflect the current processes and made available on the HB intranet.	Director of Planning	Executive Director of Strategic Planning December 2021	**NA**	Agreed. The UHB will work with the South Glamorgan CHC to review and update the joint Flowchart to reflect current processes in the UHB and CHC, and the UHB will review and update the internal practical guide to engagement to address the issues identified above.
2020-21	30/11/2021	Infrastructure / Network Management	R2/5	**Medium**	In accordance with the Health Board's guidance on engagement, management should continue to ensure that the Community Health Council is engaged at the earliest opportunity, through the appropriate means as soon as a service change is recognised, and documentation is shared in a timely manner.	Director of Planning	Executive Director of Strategic Planning December 2021 - as part of the annual IMTP planning cycle	**NA**	Agreed. The importance of timely completion of a CHC Service Change Proforma for discussion with the CHC when service change proposals are being developed will be reinforced with Clinical Boards consideration given to building it into IMTP templates.
2020-21	31/12/2021	Infrastructure / Network Management	R3/5	**Low**	Consideration should be given to developing a process to formally capture lessons learned from stakeholder engagement, which has the potential to enhance future engagement.	Director of Planning	Executive Director of Strategic Planning December 2021	**NA**	Agreed. A template for capturing lessons learnt for completion by those actively involved in designing and running an engagement (including CHC colleagues) is being tested by the Shaping Our Future Clinical Services programme team following a recent piece of corporate engagement. The resulting proforma and recommendations on where the output is considered within the UHB governance structure will inform a roll out.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update
2020-21	31/12/2021	Infrastructure / Network Management	R4/5	Low	Consideration should be given to introducing a schedule of engagement activity to support service change / developments.	Director of Planning	Executive Director of Strategic Planning December 2021	NA	Agreed, there is potential value of a forward looking schedule of engagement based on information in the organisation's Annual Plan/IMTP.
2020-21	31/12/2021	Infrastructure / Network Management	R5/5	Low	In support of identified HB good practice, it would be beneficial for a common stakeholder mapping process to be adopted, to illustrate stakeholder selection by power and priority levels, to inform the engagement of service change / development.	Director of Planning	Executive Director of Strategic Planning December 2021	NA	Agreed. The Engagement Plan Template, included as a supporting resource for the internal UHB Practical Guide to Engagement, will be reviewed and updated to include stakeholder mapping advice based on current best practice.
2020-21	31/08/2021	Rostering in Community Children's Nursing	R1/7	Medium	The draft rostering desktop procedures should be reviewed by Team Leaders for accuracy and alignment with the objectives of the wider Health Board rostering procedure (UHB 339), thereafter they should be formally approved and adopted by CCNS. The approved rostering procedures should be disseminated to all CCNS nurses to formally advise them of the processes in place.	Chief Operating Officer	Alison Davies, Senior Nurse 30th June 2021 Operational Managers, CCNS Paula Cooper & Jayne Keddie 31st August 2021	PC	Draft rostering procedures currently being finalised by the CCNS Operational Managers. To be presented and ratified at Directorate and Clinical QSPE meetings in June 2021. Development of rostering guidelines for staff explaining the procedure will be drafted. The guidelines will discussed and disseminated via CCNS team meetings. Smaller team meetings will need to be held due to Covid restrictions, hence timescale needs to provide time for this.
2020-21	30/06/2021	Rostering in Community Children's Nursing Service	R2/7	Low	The draft desktop rostering procedures, developed through the course of the audit should be updated to include the management of under/over hours worked.	Chief Operating Officer	Alison Davies, Senior Nurse 30th June 2021	PC	The management of staff's annualised hours & balance will be included in the new rostering procedures. Version control will support this being regularly updated. To be prestned and ratified at Directorate and Clinical QSPE meetings in September 2021.
2020-21	31/12/2021	Rostering in Community Children's Nursing Service	R3/7	Medium	The Child Specific Needs Analysis, Staff Skills Matrix and Staff to Child Strengths and Weaknesses Map should be revised and updated by the Team Leaders to reflect current clinical need / requirements and subject to regular review to ensure accuracy of content. Additionally, these key documents should be incorporated into the rostering procedures for use during the monthly roster creation process.	Chief Operating Officer	Alison Davies, Senior Nurse 30th June 2021 Paula Davies, Lead Nurse Alison Davies, Senior Nurse December 2021	PC	These documents will be manually updated by the Operational Managers and Team leaders on a monthly basis at their Operational Management Meeting in collaboration with the Practice Educator. The OM's will provide assurance and a process for sign off so that there is an audit trail. This will be incorporated into the rostering procedures. The Directorate is currently exploring more advanced electronic rostering systems, which support community services and which may provide solutions to matching staff to patients which Rosterpro is unable to achieve. This would improve efficiency and patient safety.
2020-21	15/12/2021	Rostering in Community Children's Nursing Service	R4/7	Low	The CCNS Memorandum of Understanding: Home Based Continuing Care Packages should be updated, approved by senior management at both departmental and Clinical Board level for dissemination to parents / guardians as soon as is practicable so as to formalise mutual arrangements between the UHB and parent(s)/carers of children under the department's care.	Chief Operating Officer	Paula Davies, Lead Nurse Alison Davies, Senior Nurse 15th December 2021	PC	The Memorandum will be updated to include some recent requirements and rechecked by UHB Legal & Risk. Following this, we will provide opportunity for consultation with families and staff and disseminate.
2020-21	27/05/2021	Rostering in Community Children's Nursing Service	R6/7	Low	Each finalised rota should be formally signed-off by a Team Leader or the Administrative Operational Manager, prior to dissemination to CCNS nursing staff. The sign-off could take the form of an email to the Administrative Operational Manager stating approval and as such a stronger audit trail would be in place to close that period's rostering cycle.	Chief Operating Officer	Alison Davies, Senior Nurse Completed	C	Operational Managers and Team leaders have in place a process to capture written approval of completed rotas, and maintain an audit trail of this. Compliance with this will be checked.
2020-21	30/11/2021	Rostering in Community Children's Nursing Service	R7/7	Low	Management should continue as planned to ensure the gaps in staff training across CCNS are addressed.	Chief Operating Officer	Paula Cooper, Operational Manager Jayne Keddie, Operational Manager November 2021	PC	The service is usually compliant with mandatory training targets and has service specific training. The low compliance does correlate to COVID-19, increased staff absence and deployment during this period. An action plan for the service is in place to recover and improve compliance.
2020-21	31/07/2021	Staff Recruitment	R1/3	Low	Management should consider developing a system that is able to record key recruitment data for the different recruitment 'areas' for registered nurses in order to assess the effectiveness of each one.	Executive Nurse Director	Clinical Board Directors of Nursing are re-setting establishments in ESR by July 2021.	PC	Further changes made to draft in July 2021 based on latest position. Exective owner confirmed as Executive Director of People and Culture. Owever, potential for policy to be superseded or need further amendment due to recent guidance from Welsh Government on enhanced overtime / consultant payments linked to Recover Plan.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update
2020-21	30/09/2021	Staff Recruitment	R2/3	Low	Looking forward management should consider if there is a need to refresh the Project 95% and draw up specific plans for the nurse recruitment supply 'areas' once the pressures associated with the Covid pandemic and mass vaccinations centres have abated.	Director of People and Culture	Deputy Director of Workforce & OD, Clinical Board Nurse Director for Strategic Workforce, Nurse Resourcing Manager. September 2021	C	Recruitment Campaigns have restarted; with Children and Women and Mental Health Boards having run their own events during May 2021. Also a UHB wide event was held on 14.05.021 in the Lakeside Wing – aimed at engaging with students who will be qualifying this summer and attracting permanent registered nurses further afield. The event was well attended. We have received feedback that people want to attend face to face events; with social distancing measures in place. Further events will be planned for the Autumn.
2020-21	18/05/2021	Staff Recruitment	R3/3	Low	Management should consider formalising the monitoring and reporting process for nurse recruitment that addresses the frequency of the updates and the meetings that will receive the information. Management should also ensure that the reporting arrangements for the NPG are formalised.	Director of People and Culture	Executive Nurse Director; Clinical Board Directors of Nursing, Heads of Workforce & OD - ongoing	C	Further regular updating will be considered through NPG. Bi monthly meetings are held with representatives from the Clinical Boards, chaired by the Deputy Director of Workforce & OD. Monitoring of vacancies is undertaken at Clinical Board level within the Workforce Plan and via the CB Nurse Director and Heads of Workforce & OD.
2020-21	31/07/2021	Wellbeing Hub at Maelfa	R1/13	Low	Attendances at Project Team and Delivery Group should be reviewed, to ensure key parties are reminded of their responsibilities as members of these forums and are present where possible at relevant stages (O).	Director of Planning	Capital Planning Programme Support Manager (Strategic & Service Planning)	NA	Agreed. Attendances will be reviewed to ensure they are sufficient for the current stage and members reminded of their responsibilities. Whilst noting attendance issues by some parties, it is not considered to have impacted to date on critical decision making at key project development stages.
2020-21	31/07/2021	Wellbeing Hub at Maelfa	R2/13	low	It should be ensured that all parties reference the most up to date terms of reference for the Project Team and Delivery Group (O).	Director of Planning	Director of Capital, Estates & Facilities July 2021	C	The revised ToRs were presented at the project team meetingon 3/08/21
2020-21	31/07/2021	Wellbeing Hub at Maelfa	R3/13	Medium	The Project Team and Delivery Group should receive formal cost reporting at each meeting, including any over/underspend, and the balance of contingency funds (O).	Director of Planning	Director of Capital, Estates & Facilities July 2021	C	Project leads include financial information on their highlight reports submitted to project team members.
2020-21	31/07/2021	Wellbeing Hub at Maelfa	R4/13	Medium	Welsh Government Project Progress Reports should be shared with an appropriate forum (O).	Director of Planning	Director of Capital, Estates & Facilities July 2021	C	The project reports were included as part of the information pack considered by the Capital Management Group in June 2021. They will be inlcuded bi-monthly for future reference
2020-21	31/07/2021	Wellbeing Hub at Maelfa	R5/13	Low	The risk register should be updated to reflect current contractual issues (O).	Director of Planning	Director of Capital, Estates & Facilities July 2021	C	The risk register has been updated to reflect the contractural position at the time of the audit
2020-21	31/07/2021	Wellbeing Hub at Maelfa	R6/13	Medium	Confirmation Notice no. 2 should be finalised and executed as soon as possible (O).	Director of Planning	Director of Capital, Estates & Facilities July 2021	C	The relevant confirmation notice has been signed and sealed by both parties.
2020-21	31/07/2021	Wellbeing Hub at Maelfa	R7/13	Low	Management should continue to seek the early resolution of the Project Bank (O).	Director of Planning	Director of Capital, Estates & Facilities July 2021	PC	Discussions have been ongoing between Welsh Government and Lloyds Bank to agree the appropriate level of information to establish the Project Bank Account. This matter is being led by Welsh Government colleagues as it affects all health boards.
2020-21	31/07/2021	Wellbeing Hub at Maelfa	R8/13	Medium	Adviser agreements should be executed in a timely manner prior to duties commencing (O).	Director of Planning	Director of Capital, Estates & Facilities July 2021	PC	The SCP has submitted confirmation notice Nr 2 which has been duly completed by both parties. Confirmation notice nr 2 for the cost advisor has been submitted and is awaiting UHB completion. The UHB have written to the PM requesting the completed ocnfirmation Nr2 for execution.
2020-21	31/07/2021	Wellbeing Hub at Maelfa	R9/13	Medium	Payments should be made in accordance with the terms of the contract (O).	Director of Planning	Director of Capital, Estates & Facilities July 2021	PC	An order for the value of the contract sum has been uploaded onto oracle and issued to the SCP etc. This will allow prompt payment throughout the contract term.
2020-21	31/07/2021	Wellbeing Hub at Maelfa	R10/13	Medium	The UHB should implement improved monitoring and control arrangements to ensure Project Issue Forms are prepared and authorised in a timely manner following the Cost Adviser's assessment (O).	Director of Planning	Director of Capital, Estates & Facilities July 2021	C	The project leads have been instructed to ensure that all project issue forms are completed and approved prior to the issue of any project managers instructions

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update
2020-21	31/07/2021	Wellbeing Hub at Maelfa	R11/13	Low	The management of risks and contingency, including Covid-19 and other costs, should be consistently reported (D).	Director of Planning	Director of Capital, Estates & Facilities July 2021	C	The project highlight report will include the financial position with respect to the continugency and also details of numbers of project issues received pending and approved.
2020-21	31/07/2021	Wellbeing Hub at Maelfa	R12/13	Medium	Specific Covid funding risks, and its impact on project funding (as per Welsh Government requirements) will be highlighted and regularly reported to relevant forums (O).	Director of Planning	Director of Capital, Estates & Facilities July 2021	C	Covid costs are reported seperately as requested by Welsh Government. It is understood that WG will only consider additional funding for COVID if the porject is unable to contain the costs within the risk allowance.
2020-21	31/07/2021	Wellbeing Hub at Maelfa	R13/13	Low	The PEP should be updated accordingly and resonate with other supporting documentation (i.e. terms of reference).	Director of Planning	Director of Capital, Estates & Facilities July 2021	C	The PEP has been updated to reflect the construction phase arrangements.
2020-21	30/09/2021	Annual Planning Process - Substantial	R1/2	Low	The Terms of Reference and Operating Arrangements of the Strategy Development and Delivery Group should be reviewed, and where necessary updated, so that its role and powers remain appropriate for current circumstances.	Director of Planning	Marie Davies, Deputy Director Planning 30 September 2021 (Q2 21/22)	C	As part of understanding the most robust and proportional plan development and delivery arrangements a re-fresh of the UHBs internal planning governance arrangements are already being considered. This includes a revised term of reference being developed for SDDG. Terms pf Reference for the Strategy Development and Delivery Group (SDDG), have been reviewed, redrafted and signed off by teh group. This revised document clearly articularates the SDDG's role in teh annual plan / IMTP development.
2020-21	30/06/2021	Annual Planning Process - Substantial	R2/2	Low	Consideration should be given to the appropriate role of the Strategy and Delivery Committee in developing future Plans and this should be accurately reflected in the planning documents.	Director of Planning	Jonathan Watts, Head of Strategic Planning 30 June 2021 (Q2 21/22)	PC	The corporate planning cycle for 22-23 is currently being developed for sign off by the UHBs management executive group and Board (June 2021). This approach will include a clear articulation of the role and function of the Strategy and Delivery Committee. The role of the Strategy and Delivery Committee in the context of plan development has been reviewed and considered with it reiterated that the committee is a key forum through which emerging drafts of the UHBs plans can be tested, with, in particular, independent members. The timeline for delivery of a 22/23 plan will see the sub committee engaged twice during plan development.
2020-21	31/12/2021	Engagement Around Service Planning - Reasonable	R1/5	Medium	Management should ensure that the Health Board's practical guide to engagement and associated flowchart is updated to reflect the current processes and made available on the HB intranet.	Director of Planning	Executive Director of Strategic Planning December 2021	PC	Agreed. The UHB will work with the South Glamorgan CHC to review and update the joint Flowchart to reflect current processes in the UHB and CHC, and the UHB will review and update the internal practical guide to engagement to address the issues identified above. The first step is to review the Local Framework for Engagement and Consultation on Changes to Health Services that was agreed between the UHB and CHC in 2018, as this underpins the process illustrated in the flowchart. The Local Frameowrk has been reviewed and updated and is currently with the Exec Driector of Strategy and Planning for consideration before being shared for discussion with the CHC. Once agreed, the flowchart can be updated. The internal practical guide to engagement and associated suite of resources have also been reviewed and updated, they will be issued internally once the revised Local Framework has been agreed.
2020-21	31/12/2021	Engagement Around Service Planning - Reasonable	R2/5	Medium	In accordance with the Health Board's guidance on engagement, management should continue to ensure that the Community Health Council is engaged at the earliest opportunity, through the appropriate means as soon as a service change is recognised, and documentation is shared in a timely manner.	Director of Planning	Executive Director of Strategic Planning December 2021 - as part of the annual IMTP planning cycle	PC	Agreed. The importance of timely completion of a CHC Service Change Proforma for discussion with the CHC when service change proposals are being developed will be reinforced with Clinical Boards consideration given to building it into IMTP templates. The Service Change Proforma has been reviewed and updated, pending approval by the Exec Director of Strategy and Planning and discussion with the CHC. It forms a part of the Local Framework that has been reviewed as above will be reissued to Clinical Boards once agreed between the UHB and CHC.
2020-21	31/12/2021	Engagement Around Service Planning - Reasonable	R3/5	Low	Consideration should be given to developing a process to formally capture lessons learned from stakeholder engagement, which has the potential to enhance future engagement.	Director of Planning	Executive Director of Strategic Planning December 2021	PC	Agreed. A template for capturing lessons learnt for completion by those actively involved in designing and running an engagement (including CHC colleagues) is being tested by the Shaping Our Future Clinical Services programme team following a recent piece of corporate engagement. The resulting proforma and recommendations on where the output is considered within the UHB governance structure will inform a roll out. A template has been trailled in a lessons larnt exercise involving both UHB and CHC colleagues following the engagement on Shaping our Future Clinical Services. Once this is complete and the resulting report has been signed off following any amendments to the process, the proess will be adopated to support subsequent Lessons Learnt exercises from stakeholder engagement.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update
2020-21	31/12/2021	Engagement Around Service Planning - Reasonable	R4/5	Low	Consideration should be given to introducing a schedule of engagement activity to support service change / developments.	Director of Planning	Executive Director of Strategic Planning December 2021	PC	Agreed, there is potential value of a forward looking schedule of engagement based on information in the organisation's Annual Plan/IMTP. A service development tracker based on the Annual Plan, which includes a schedule of engagement, has been drafted and is currently being reviewed by Clinical Boards. Once signed off internally, the tracker and schedule will be discussed with the CHC to agree engagement requirements.
2020-21	31/12/2021	Engagement Around Service Planning - Reasonable	R5/5	Low	In support of identified HB good practice, it would be beneficial for a common stakeholder mapping process to be adopted, to illustrate stakeholder selection by power and priority levels, to inform the engagement of service change / development.	Director of Planning	Executive Director of Strategic Planning December 2021	PC	Agreed. The Engagement Plan Template, included as a supporting resource for the internal UHB Practical Guide to Engagement, will be reviewed and updated to include stakeholder mapping advice based on current best practice. The Engagement Plan template, included a ssuporting resource of the Internal Practical Guide to Engagement, has been reviewed and updated to include stakeholder mapping advice. Once the actions above have been complted, the Practical Guide and suporting resources will be re-issued to Clinical Boards and put on the UHB intranet.

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

	Update September 2021				Update September 2021				Update September 2021			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Overdue under 3 months	1	1				3			3	1	2	
Overdue by over 3 months under 6 months												
Overdue over 6 months under 12 months	1		1			2	3		3		3	
Overdue more than 12 months						1	1		1		1	
Superseded												
Total	**2**	1	1		**10**	6	4		**7**	1	6	

Total number of recommendations outstanding as of 26th August 2021 for financial year 2019/20 is 19 (8 of which have completed) compared to the position in July 2021 when a total of 33 outstanding recommendations were noted.

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

	Update September 2021				Update September 2021				Update September 2021			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached			3			2	8	2		2	5	4
Overdue under 3 months						1	2			4	1	1
Overdue by over 3 months under 6 months			1			9	1			4	3	1
Overdue over 6 months under 12 months							2				2	
Overdue more than 12 months								1				
Total	**4**		4		**28**	12	13	3	**27**	10	11	6

Total number of recommendations outstanding as of 27th August 2021 is 77(*) (22 of which are listed as complete) compared to the position in July 2021 when a total of 63 outstanding recommendations were noted.

* It should be noted that 18 recommendations from the IM&T Control and Risk Assessment review are not included in the above table as the report was not rated. All 18 entries are recorded as partially complete.

Report Title:	**Audit Wales Recommendation Tracking Report and Regulatory Tracker Report**								
Meeting:	**Audit and Assurance Committee**						**Meeting Date:**	**07/09/21**	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

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

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

19 External Audit Recommendations were brought forward from July's Audit Committee. This number includes an additional 5 recommendations relating to the Assessment of Progress Against Previous ICT Recommendations that were not added to the Tracker following April's committee meeting. 4 of these additional 5 entries are recorded as complete.

The External Audit tracker demonstrates that a further 9 recommendations have completed since July 2021, however, there are also 10 (of 19) recommendations that are partially complete.

4 recommendations are over 1 year overdue (2 of which are complete), 7 are over 3 months overdue (but less than 6 months), all of which have completed, and 8 are within 3 months of their implementation date.

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

A review of all outstanding recommendations has been undertaken with executive and operational leads for each recommendation since July 2021. This work will continue and be reported at each Audit and Assurance Committee to provide regular updates in the movement of recommendations.

The table at Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken in **18/19, 19/20, 20/21** and 21/22 as at 27th August 2021.

It should be noted that the remaining entry for 2018/19 has completed.

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

Recommendation:

The Audit Committee Members are asked to:

(a) Note and receive assurance from the progress which has been made in relation to the completion of Audit Wales recommendations.
(b) To note the continuing development of the Audit Wales Recommendation Tracker.

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

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

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

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update
2018-19	Oct-19	Structured Assessment 2018	R3d/11	d. Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date;	Chief Executive Officer	Head of Corporate Governance	C	ngoing
2019-20	No date specified	Clinical Coding Follow-up From 2014 not yet completed	R1	**Clinical Coding Resources:** Strengthen the management of the clinical coding team to ensure that good quality clinical coding data is produced. This should include: c) ensuring that there is capacity to allow band 4 coders to undertake mentoring and checking of coding of band 3 staff in line with job descriptions; d) revisiting the allocation of specialities across staff to ensure that there is sufficient flexibility within the existing capacity to cover periods of absence and succession planning is in place for staff who are due to retire in the next five to ten years; g) increasing levels of engagement between the different teams within the Health Board, to provide opportunities to raise issues, develop peer support arrangements and share knowledge; h) updating the clinical coding policy to reflect the current operational management arrangements; and k) increasing the range of validation and audit processes, including the consideration of the appointment of an accredited clinical coding auditor.	Director of Digital and Health Intelligence	James Webb	C	Vacancies are being recruited to. Additional Band 5 appointed to support with validation and audit.
2019-20	No date specified	Clinical Coding Follow-up From 2014 not yet completed	R2	**Medical Records:** R2 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include: a) reinforcing the Royal College of Physician (RCP) standards across the Health Board and developing a programme of audits which monitors compliance with the RCP standards; b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS); c) putting steps in place to ensure that notes that require coding are clearly identified at ward level and that clinical coding staff have early access to medical records, particularly at UHW; e) reducing the level of temporary medical records in circulation; f) considering the roll out of the digitalisation of health records to the Teenage Cancer Unit to allow easier access to clinical information for clinical coders; and g) revisiting the availability of training on the importance of good quality medical records to all staff.	Director of Digital and Health Intelligence	James Webb	PC	**b)**The UHB is developing mobile tracking technology which would support an audit programme designed to determine levels of tracking compliance across departments. **g)** Head of Coding to dicsuss with Medical Directors to establish the most appropriate platform
2019-20	Mar-20	Audit of Financial Statements Report Addendum - Recommendations	R4	4: the Phase 2 and Phase 3 continuing healthcare claims require concluding The Health Board should establish the reason for the ongoing delay with each of the remaining Phase 2 and Phase 3 claims and it should seek to conclude them promptly.	Director of Finance	Deputy Finance Director	PC	Phase 2 – all cases completed Phase 3 – 9 claims remain incomplete – all claims have been reviewed but these are not ready for completion yet due to requiring further meetings, negotiation, panels etc. Delays in finalising some claims during 20/21 due to the nurse assessors involved being redeployed to other areas during Covid crisis, and the inability to hold face-to-face meetings due to the pandemic.

2019-20	Annually	Implementing the Wellbeing of Future Generations Act	R1	**Long-term** Further enhance the profile of primary care by building upon the successes of existing promotional campaigns.	Director of Planning	Director of Operations, PCIC	PC	The Primary Choice campaign has covered the following primary care roles GP, nurse, dental, optometrist and receptionist. the sceond phase was paused due to Covid but work has now recommenced to include MH practitioner, physio, clinical practioner, pharmacist and roles within the OOHs service. In addition to this there has been significant comms as part of the CAV24/7 work around accessing primary care. **Nothing of note to add for September meeting**
2019-20	Dec-21	Implementing the Wellbeing of Future Generations Act	R2	2 Develop a campaign to educate the public about what types of services will be available at each of the centres and hubs.	Director of Planning	Director of Operations, PCIC	PC	Programme of business cases in development with engagement on design detail of services required to meet local needs taken forward as part of business case. First scheme (Maelfa) in constuction on track to be completed Dec 2021 and planning for Penarth and Ely hubs well underway. **Nothing of note to add at for September meeting**
2019-20	Annually	Implementing the Wellbeing of Future Generations Act	R5	**Prevention** 5 Undertake needs assessments on an ongoing basis and continually review services to ensure that centres and hubs remain current and fit for purpose.	Director of Planning	Director of Operations, PCIC	PC	Clusters plans are required and work is underway to update current plans. Work on Health and Wellbeing Centre had been paused due to Covid but has recently restarted. There will be clinical involvement from the clusters in this work. **Nothing of note to add at for September meeting**
2019-20	Nov-21	Implementing the Wellbeing of Future Generations Act	R6	6 Develop a clear plan to agree finances prior to centre and hub services commencing to prevent duplication of resources.	Director of Planning	Director of Operations, PCIC	PC	Operating model options and revenue consequences form part of each project scope are under active consideration by the SOFW in the community delivery board. **Nothing of note to add for September meeting**
2019-20	Oct-21	Implementing the Wellbeing of Future Generations Act	R9	**Involvement** 9 Explore the best vehicles to engage marginalised citizens both in terms of planning future centres and hubs and in ensuring they are accessible to all when in operation. For example, by finding community leaders to help roll out key messages and engage with these groups on an ongoing basis.	Director of Planning	Director of Operations, PCIC	PC	For each scheme, there is an engagement plan with the local community to ensure the detailed plans have been informed by both service views and views of those who will use the services. As part of the @home programme, C3SC has been commissioned by the RPB to develop an engagement framework. This is being prototyped with the CRI HWBC. **Nothing of note to add for September meeting**
2019-20	Apr-21	Audit of Accounts Report Addendum - Recommendations	R1	Some of the accounting processes and records need to be simplified, with far less use of manual adjustments to financial ledger outputs: The Health Board should reevaluate why so many manual adjustments are currently necessary and, in do so, liaise with us and consider engaging with a health boasrd that has the same finance system and avoids similar level of manual intervention	Director of Finance	Deputy Finance Director	C	The UHB has met with Audit Wales on 4th November 2020 in order to progress this. The finance department has redeployed additional resource to support improvements. This will now be rolled forward into 20/21 recommendations.
2019-20	Apr-21	Audit of Accounts Report Addendum - Recommendations	R2	The quality of some of the Health Board's underlying working papers requires further improvement: The Health Board should review and simplufy its supporting records for certain areas of its annual financial statemnets, including the inappropriate use of manual data entry (rather than formulas) within spreadsheets. To aid the review the Health Board should liaise with us to understand hjow some of hte documentation affects our audit.	Director of Finance	Deputy Finance Director	C	The UHB has met with Audit Wales on 4th November 2020 in order to progress this. The finance department has redeployed additional resource to support improvements. This will now be rolled forward into 20/21 recommendations.
2019-20	Apr-21	Audit of Accounts Report Addendum - Recommendations	R3	Related party declarations need to be signed and submitted after the end of each financial year: The Health Board shoud update it sannual related party declaration so that it specifies that the IM / SO must consider the whole financial year and therefore sign and submit it after 31 March, or on departure if that is relevant	Director of Finance	Deputy Finance Director	C	Please note that this is an end of year action and will not be completed until after the end of year as agreed by the imThis was actioned by the Corporate Governance team.plementation date
2020-21	Mar-22	Follow-up of Operating Theatres	R1	Ensure that momentum is maintained to deliver the benefits of the theatre improvement project which relate to process improvement, such as Day of Surgery Admission and pre-operative assessment: • prioritise the expansion of the pre-operative assessment service across specialties where doing so will achieve maximum benefit in improving quality and safety of care.	2019-20	Ceri Chinn	PC	We have bid for additional investment through recovery to increase POAC activity. This has been supported and staff are being appointed. We are also working to relocate this service in conjunction with estates and planning team

2020-21	Mar-22	Follow-up of Operating Theatres	R4	Create standards for professional management and leadership and ensure that team leaders meet that standard.	Chief Operating Officer	Ceri Chinn	PC	Agreed implementation date not yet reached. Good progress being made - Awaiting workforce manager input. The schemes of employee engagement continue and have been enhanced through the pandemic. A worforce manager post is being implemented in order to drive staff engagement and worforce redesign. Thispost will be central to achieving the goals of this recommendation and a full project approach will be implemented to monitor progress during 21/22. A development booklet for clinical leaders has been developed which outlines the professional standards for our clinical leaders. A development plan will be developed by the workforce programme mangaer to support clinical leaders to achieve these.
2020-21	Feb-21	Assessment of Progress Against Previous ICT Recommendations	R1/5	Include external audit recommendations, in addition to internal audit recommendations as part of the DHIC audit tracker	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	C	All audit recommendations, both internal and external are included within the DHIC audit tracker.
2020-21	Apr-20	Assessment of Progress Against Previous ICT Recommendations	R2/5	Ensure that appropriate arrangements are in place for the DHIC to have enough oversight and assurance over Information Governance	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	C	IG issues are reported and considred at each DHIC meeting (standing item)
2020-21	Sep-21	Assessment of Progress Against Previous ICT Recommendations	R3/5	Ensure that information asset owners are formally and regularly made aware of their role and responsibilities	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	C	IAOs are regularly written to remind them of their roles and responsibilities to maintain their respective IARs.
2020-21	Jun-21	Assessment of Progress Against Previous ICT Recommendations	R4/5	Rollout appropriate and regular offline information governance trainign to employees without PC access.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	An IG presentation has been produced that can be delivered by the individual service for staff who are unable to undertake online training. This has been circulated to those services with a dedicated training function.
2020-21	Feb-21	Assessment of Progress Against Previous ICT Recommendations	R5/5	The Board should regularly seek assurance that their critical systems would be recoverable in a disaster recovery scenario	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	C	The IT disaster recovery plan exists to ensure that systems are recoverable in the event of a disaster. These plans are subject to regular desk-top exercises, details of which are to be reported to DHIC and then to the Board. Hosting and back up documentation is in place for all critical Health Board systems and applications. The UHB has a documented IT Disaster Recovery Plan. All Clinical Boards have been made aware of their Disaster Recovery and Business Continuity responsibilities. Disaster Recovery arrangements have been validated on multiple occasions, including recent data restore actions and successful network disaster recovery alternative fall back routing arrangements.

Audit Wales Recommendations 2018/19 – 2021/22 (September 2021)

External Audit	Complete	No action	Partially complete	< 3 mths	> 3 mths	+6 mths	+ 1 year	Grand Total
Structured Assessment 2018	1	-	-	-	-	-	1	1
Clinical Coding Follow Up	1	-	1	-	-	-	2	2
Audit of Financial Statements	-	-	1	-	-	-	1	1
Implementation of the Wellbeing of Future Generations Act	-	-	5	5	-	-	-	5
Audit of Accounts Report Addendum - Recommendations	3	-	-	-	3	-	-	3
Follow Up of Operating Theatres	-	-	2	2	-	-	-	2
Assessment of Progress Against Previous ICT Recommendations	**4**	**-**	**1**	**1**	**4**			**5**
Total	**9**	**-**	**10**	**8**	**7**	**-**	**4**	**19**

From the above table it can be seen that since the last report to Committee in July 2021 a further 5 recommendations have been added to tracking report increasing the number of recommendations to 19. Of the 19 outstanding AW recommendations listed, 9 have been completed. It can also be seen that the remaining 10 recommendations are partially completed. 2outstanding actions are over 1 year overdue and 7 are over 3 months overdue.

Legislative, Regulatory & Alerts Compliance

Final Internal Audit Report

August 2021

Cardiff & Vale University Health Board

NWSSP Audit and Assurance Services

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

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Executive sign off:	Nikki Foreman – Executive Director Corporate Governance
Distribution:	Aaron Fowler – Head of Risk and Regulation Carol Evans – Assistant Director Patient Safety and Quality
Committee:	Audit & Assurance 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.

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Executive Summary

Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to Legislative, Regulatory and Alerts compliance, to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

Overview

Our overall assurance rating reflects the need to make enhancements to both the design and operation of the control environment, to provide greater assurance to the Health Board.

We acknowledge that resource pressures coupled with the impact of COVID-19 has limited the extent to which some areas have been able to progress. Our recommendations support the Health Board's recovery journey.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance **Low to moderate impact** on residual risk exposure until resolved	⇔ 2019/20

Assurance summary[1]

Assurance objectives		Assurance
1	The robustness of the 'Legislative and Regulatory Tracker'	Reasonable
2	The management of regulatory alerts, safety notices and other communications.	Reasonable

Matters Arising		Control Design or Operation	Recommendation Priority
1	Design of the Legislative and Regulatory Tracker	Design	Medium
2	Operating effectiveness of the Legislative and Regulatory Tracker	Operation	Medium
3	Assurance Report - Legislative and Regulatory Tracker	Operation	Low
4	Tracking and monitoring Welsh Health Circulars	Design	Medium
5	Assurance Reporting of Welsh Health Circulars	Design	Medium
6	Assurance Process for Patient Safety Alerts	Operation	Medium
7	Assurance Reporting for Patient Safety Alerts	Operation	Low
8	Safety Notices and Important Documents Management Policy & Procedure	Operation	Low

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulation the overall audit opinion

1. Introduction

The review of Legislative, Regulatory and Alerts Compliance was completed in line with the 2021/22 Internal Audit Plan for Cardiff and Vale University Health Board ("The Health Board").

The statutory obligations of the Health Board are wide ranging and complex, which include compliance with general law as well as NHS specific legislation. In addition, the Health Board is also subject to accreditation and review by several independent inspection and regulatory bodies. The Audit Committee regularly receives the 'Legislative and Regulatory Tracker Report', which offers assurance of the legislative / regulatory inspections and the progress of taking forward actions. This area had previously been audited in 2018/19 with limited assurance and followed up within 2019/20, with a move to reasonable assurance.

The NHS Wales Health and Care Standards requires organisations to act upon safety notices, alerts, and other such communications, as detailed within Standard 2.1, 'Managing Risk and Promoting Health and Safety'*.

As a consequence of the abolition of the National Patient Safety Agency (NPSA), the Welsh Government (WG) has taken over this role and identifies any significant risks / concerns and develops Patient Safety Solutions at a national level for issue to the NHS in Wales e.g. Patient Safety Alerts; that require prompt action within a specified implementation date in order to address high risk / significant safety problems; and, safety notices, which are issued to ensure that organisations and all relevant healthcare staff are made aware of potential patient safety issues at the earliest opportunity. WG also issue Welsh Health Circulars that need to be managed by the Health Board.

The Health Board also receives communications from several other bodies, including:

- Medicines and Healthcare Products Regulatory Agency (MHRA) for medical devices and pharmaceutical alerts;
- Health and Safety Executive (HSE) for health and safety alerts;
- Safety Alerts issued by the Department of Health (DH) Estates and Facilities;
- Safety Alerts issued by the NHS Wales Shared Services Partnership Facilities Services;
- Product recalls; and
- Field Safety Notices.

In most cases the communication is sent to all health boards and trusts for acting upon, depending on its relevance.

The executive lead for this review is the Executive Director of Corporate Governance.

Audit Risks

The potential risks considered in this review are as follows:

- Failure to meet licenced, statutory or regulatory requirements which may lead to patient harm, prosecution or loss of service;
- Reputational and financial loss due to non-compliance with the requirements of regulated activities; and

- A lack of clarity regarding staff responsibilities, resulting in poor coordination and response to legislative / regulatory requirements, safety alerts, continued exposure to risk and potential reproach by Welsh Government.

2. Detailed Audit Findings

Objective 1: The robustness of the 'Legislative and Regulatory Tracker' (The Tracker):

- A wide spectrum of regulatory bodies are included within the tracker, with no obvious omissions, such as the Health Inspectorate Wales and the Information Commissioner's Office.
- Regular reporting is undertaken of the tracker via the Audit Committee, and we have been informed by management that the structure and make-up of the tracker is under review.

The following matters arising were noted:

- The current design of the Tracker could be enhanced to provide a more meaningful assurance tool to the Audit Committee. Design issues result in a lack of clarity within the Tracker, which relate to RAG rating, the relevant assurance committee, the timeliness of updates and the nature of regulatory reports. *(Matter Arising 1 – Medium Priority)*
- There is extensive information supplied within the Tracker, but it is inconsistent in the assurance it offers when presented to the Audit Committee. Inconsistencies related to the way inspections / recommendations are detailed, in addition to the implementation dates and RAG ratings. *(Matter Arising 2 – High Priority)*
- The assurance report that accompanies the Tracker, when presented to the Audit Committee would also benefit from review, to provide greater analysis and ultimately assurance offered. Based on the information reported to the Audit Committee in July 2021 it is unclear how members of the committee can fulfil the recommendations, based on the current design and content of the tracker. *(Matter Arising 3 – Low Priority)*

Conclusion: Internal Audit last reviewed the Tracker in 2019/20 and although some progress has been made, further work is required to enhance the Tracker as an effective assurance tool, rather than an information report to the Audit Committee that inspections are being undertaken. We note that resource pressures within the team, coupled with the impact of the COVID-19 pandemic has impacted the development of the tracker. *(Reasonable Assurance).*

Objective 2: The management of regulatory alerts, safety notices and other communications, in accordance with the NHS Wales Health and Care Standard 2.1, 'Managing Risk and Promoting Health and Safety'*.

In accordance with the audit brief, we reviewed a sample of Patient Safety Alerts (PSA) at the request of the Executive Director of Nursing. The audit sample also extended to Welsh Health Circulars (WHC).

- The Health Board has in place 'Safety Notices and Important Documents Management Policy (UHB 069 v2) and a subsequent Procedure' (UHB 377 v1.1). The procedure was last reviewed in July 2021, where updates on the liaison officers and process map were noted.
- WHC can be received by a variety of sources within the Health Board, depending on the nature of the circular, however, all WHC are included on the Welsh Governments website.
- The process for managing PSA is undertaken by the Patient Safety Team in line with the agreed procedure (noted above, UHB 377).
- The NHS Wales Delivery Unit issue and administer the PSA process on behalf of Welsh Government.
- The Patient Safety Team have a dedicated email, to where PSA are received and distributed to Clinical Boards.

The following matters arising were noted:

- The process surrounding the management and recording of WHC has been subject to recent improvement but requires embedding to ensure that sufficient assurance is being gained that actions have been completed. *(Matter Arising 4 –Medium Priority)*
- No routine assurance reporting of WHC has been identified, that would give continuing assurance that actions are being monitored and completed. *(Matter Arising 5 – Medium Assurance)*
- Our sample of PSA identified weaknesses in the monitoring processes of actions taken to address alerts and subsequent audit trails. *(Matter Arising 6 – Medium Priority)*
- Assurance reporting on PSA did not take place during 2020/21 (due to COVID-19), however reporting on Patient Safety Solutions which encompasses PSA is on the forward plan for the Quality, Safety and Experience Committee (2021/22*). (Matter Arising 7 – Low Priority)*
- The Safety Notices and Important documents Management Procedure (UHB 069) does not explicitly mention Welsh Health Circulars, and the overarching Policy (UHB 377) requires review. *(Matter Arising 8 – Low Priority)*

Conclusion: An increased focus is needed on assuring that actions arising from WHC and PSA have been fully completed, with an effective feedback loop from the Clinical Boards being embedded. We note that resource pressures within the teams, coupled with the impact of the COVID-19 pandemic has impacted on gaining this assurance, although recent improvements have been made to the process for tracking WHC. We are also aware that a business case is currently being developed, which highlights the issue of resource pressures and the limitations of current processes, in the absence of an electronic solution to provide greater oversight of patient safety, comparable to the solutions being used by other Health Boards in Wales (*Reasonable Assurance).*

Appendix A: Management Action Plan

Matter Arising 1 – Design of the Legislative and Regulatory Tracker (Control Design)	**Risk**
The design of the Legislative and Regulatory Tracker could be enhanced by addressing the following weaknesses: • There is a lack of clarity of how the 'RAG Rating' column is to be determined and whether there is any correlation between the RAG rating and 'Confirm if completed tab'. • The 'Assurance Committee' column does not clarify what assurance is being offered to the Audit Committee, other than a named committee. • The Tracker does not facilitate the opportunity to note when updates were last provided i.e., how is the Audit Committee satisfied that the assuring committees are regularly updated on progress, or specifically the Audit Committee for items within their remit. • The format of the Tracker does not capture the focus or titles of regulatory reports, e.g., within the Information Commissioner's Office section there is no reference to data protection or cyber security elements of the 2020 report.	Failure to meet licenced, statutory or regulatory requirements which may lead to patient harm, prosecution or loss of service.

Recommendation 1	**Priority level**
The design of the Legislative and Regulatory Tracker should be reviewed through the lens of an assurance tool, to provide greater clarity to the Audit Committee.	**Medium**

Agreed Management Action 1	**Target date**	**Responsible Officer/ Deadline**
Action agreed the tracker will be improved to pick up on the weaknesses identified in this matter. Initial amendments will be made immediately and reported to Audit Committee in September with any outstanding issues resolved by Audit Committee in November.	9th November 21	Head of Risk and Regulation

Matter Arising 2 - Operational effectiveness of the Legislative and Regulatory Tracker (Operating Effectiveness)	Risk
There is extensive information supplied within the Legislative and Regulatory Tracker, but it is inconsistent in the assurance it offers when presented to the Audit Committee, specifically: • There are inconsistencies in the way different regulatory body inspection recommendations are being presented, for instance: - There are details on individual recommendations for the Information Commissioner's Office section; however, the assurance committee for these reports is not the Audit Committee. Assurance is not being given to the Audit Committee on the number and status of these recommendations from the original reports, or when the noted assurance committee was last updated on progress. - In areas where the assurance committee is the Audit Committee e.g., the Community Health Council section; there is no information on what the recommendations are and the status of the individual recommendations. • In conjunction with the point regarding RAG rating in matters arising one, the application of the RAG rating is unclear e.g., within three of the reports concerning food hygiene the "confirm if completed tab" was annotated as "NA" (No Action) but the RAG rating is amber. The 'Management Response / Update' column includes narrative around the suspension of inspections; however, it is unclear if any original recommendations have been completed. • Implementation dates for when actions are due were also completed on an inconsistent basis throughout the tracker.	Failure to meet licenced, statutory or regulatory requirements which may lead to patient harm, prosecution or loss of service.

Recommendation 2	Priority level
The Legislative and Regulatory Tracker should be reviewed, to ensure consistency in approach arising from regulatory inspections, to offer comparable assurance to the Audit Committee.	Medium

Agreed Management Action 2	Target date	Responsible Officer/ Deadline
Action agreed the tracker will be improved to pick up on the weaknesses identified in this matter. Initial amendments will be made immediately and reported to Audit Committee in September with any outstanding issues resolved by Audit Committee in November.	9th November 21	Head of Risk and Regulation

Matter Arising 3 – Assurance Report - Legislative and Regulatory Tracker (Operating effectiveness)	Risk
We reviewed the report that accompanied the Legislative and Regulatory Tracker for the 6th July 2021 Audit Committee, and we identified the following: • The agenda for the July Audit committee notes the Tracker under items for 'approval and ratification' but the tone of the recommendations are for noting. • Based on the format of the Legislative and Regulatory Tracker in its current form, it is unclear how members of the committee can fulfil the recommendations that are laid out, as noted, *"Note the inspections which have taken place since the last meeting of the Audit Committee in April 2020 and their respective outcomes."* There is little information surrounding outcomes, with no analysis noted in the cover paper. The committee should also be drawn to items that they are the assuring committee for, to potentially approve the progress that has been achieved.	Failure to meet licenced, statutory or regulatory requirements which may lead to patient harm, prosecution or loss of service.

Recommendation 3	Priority level
Consideration should be given to the ask of the Audit Committee based upon the information they are presented within the Legislative and Regulatory Tracker and whether they are able to fulfil their responsibilities.	Low

Agreed Management Action 3	Target date	Responsible Officer/ Deadline
Action agreed the AC report for the Legislative tracker will be improved to pick up on the weaknesses identified in this matter.	7th September	Head of Risk and Regulation

Matter Arising 4 – Tracking and monitoring Welsh Health Circulars (Control design)	Risk
We reviewed a sample of five WHC over the period 1st February 2020 – 30th April 2021 to establish if appropriate mechanisms were in place that gives assurance that actions arising have been completed. Our review highlighted the following: • At the time of testing, there was an outline tracker being maintained by the Corporate Governance team, however, one of our sample was not documented within this tracker. There were also some substantial gaps in the data that was recorded for the remaining four entries. e.g. there was no operational leads named, limited updates were recorded, no mention of any monitoring groups / committees for the actions. • There was also no clear evidence of compliance to aspects of the *"Safety Notices and Important Documents Management Procedure"* e.g. the issue of the 'Safety Notices / Important Documents Compliance form'. Also, the audit tool requires 10% or a minimum of five Welsh Health Circulars to be reviewed each financial year by the appropriate Health Board Liaison Officer; we found no evidence that this had taken place during the financial year 2020/21. • There was also little evidence of effective linkage with the Clinical Boards that would allow for a robust follow up process to gain assurance that actions from WHC have been completed. We have been informed by the Head of Risk and Regulation that the corporate tracking mechanism for WHC are being revised for 2021/22. Following completion of the audit testing, we were provided with an updated version of the WHC tracker which demonstrated an improved coverage and increased level of commentary to confirm actions taken. This has addressed some of the issues identified within the first bullet point above. It is also planned that the revised mechanism will include utilising the Safety Notices/Important Document Compliance Form to gain assurance that	A lack of clarity regarding staff responsibilities, resulting in poor coordination and response to legislative / regulatory requirements, safety alerts, continued exposure to risk and potential reproach by Welsh Government.

any actions arising have been implemented. We have taken account of these developments in determining the priority level for this matter arising.

Recommendation 4	Priority level	
The following should be taken forward to enhance the oversight of Welsh Health Circulars: a) The tracker should be regularly reconciled to the Welsh Government website to ensure no gaps are identified. b) The tracker should be regularly updated to ensure meaningful information is collected. c) An effective follow up process should be embedded so that assurance can be gained that actions are being completed.	**Medium**	
Agreed Management Action 4	**Target date**	**Responsible Officer/ Deadline**
Agreed to the matters identified in relation to the Healthcare Circulars tracker. Initial amendments will be made immediately and reported to Audit Committee in September with any outstanding issues resolved by Audit Committee in November.	9th November 21	Head of Risk and Regulation

Matter Arising 5 - Assurance Reporting of Welsh Health Circulars (Control Design)	**Risk**
Welsh Health Circulars have been reported as part of the Corporate Governance Statement, contained within the Health Board's Annual Report 2020-2021. However, for three WHC there was no commentary around what actions were taken to demonstrate implementation. For the majority of the remaining WHC there was a standard comment: *"circulated to key staff and managers and discussed at appropriate meeting."* From this statement it is unclear how the Audit Committee and Board can take assurance that any actions arising from WHC have been implemented. In terms of the reporting arrangements, prior to the release of the Annual Governance Statement contained within the Annual Report, we did not identify any regular assurance reporting within the Health Board during 2020/21. We acknowledge that the COVID-19 pandemic would have had an impact on monitoring arrangements, however a forward plan is needed for 2021/22.	A lack of clarity regarding staff responsibilities, resulting in poor coordination and response to legislative / regulatory requirements, safety alerts, continued exposure to risk and potential reproach by Welsh Government.

Recommendation 5	**Priority level**	
Regular assurance reporting should be established for Welsh Health Circulars.	**Medium**	
Agreed Management Action 5	**Target date**	**Responsible Officer/ Deadline**
Agreed to the matters identified in relation to the Healthcare Circulars tracker and reporting which will be reported to Audit Committee going forward.	9th November 21	Head of Risk and Regulation

Matter Arising 6 – Assurance Process for Patient Safety Alerts (Operating effectiveness)	**Risk**
Patient Safety Alerts are recorded and monitored through an excel spreadsheet that includes monitoring information, such as, date notified, responses due and date compliance declared (split by Clinical Board). We reviewed the monitoring arrangements for a sample of five Patient Safety Alerts over the period January – December 2020, to ascertain if we could determine progress, allowing for a period of implementation and we noted the following: • There was no evidence of the distribution and completion/return of the compliance form (that is stated in the approved procedure UHB 377) for any of our sample. This has led to ad-hoc emails and other documents being received as evidence from a variety of sources within the Health Board. Due to this and the evidence not being fully retained in a central repository, it has proven difficult to gain assurance that actions arising from PSA have been fully implemented across all relevant Clinical Boards. • Significant gaps have also been identified within the tracker (excel spreadsheet mentioned above) e.g. the date of receipt from the clinical boards to confirm compliance were blank (for all clinical boards), for four of the PSA sampled. We note that the tracker is a relatively new instrument (introduced during 2021) and a proportion of the sample would not have used this when being monitored. We were able to verify the enhancements made to the monitoring of PSA by the Patient Safety Team, through the support of a temporary resource. We are also aware that there is an aspiration to move to an electronic solution, where PSA could be tracked with greater efficiency and effectiveness, in addition to addressing further patient safety matters. A business case was being drafted at the time of the audit.	A lack of clarity regarding staff responsibilities, resulting in ineffective coordination and response to legislative / regulatory requirements, safety alerts, continued exposure to risk and potential reproach by Welsh Government.

Recommendation 6	Priority level	
In support of the steps taken to enhance the oversight of Patient Safety Alerts, the following should be taken forward: a) Management should ensure the distribution of the compliance form in line with agreed procedure for each Patient Safety Alert received (UHB 377). b) An effective feedback loop should be implemented between the Patient Safety Team and the Clinical Boards that gives assurance all actions arising from Patient Safety Alerts are fully implemented. c) A complete audit trail should be maintained in a centralised repository to ensure completeness of each PSA.	**Medium**	
Agreed Management Action 6	**Target date**	**Responsible Officer/ Deadline**
A business case (BC) has been developed to increase the resource necessary to meet these recommendations. The BC proposes funding for a 1WTE Band 7 member of staff to manage all processes related to Patient Safety Alerts. Secure investment for the implementation of AMAT a clinical effectiveness/governance system which will introduce an improved web based system which can be used for the monitoring and implementation of Patient Safety Alerts. This will introduce an effective feedback loop and a complete audit trail in a centralised repository.	Agreement of investment - end September 2021	Assistant Director Patient Safety and Quality.

Matter Arising 7 - Assurance Reporting for Patient Safety Alerts (Operating Effectiveness)	**Risk**
In terms of reporting arrangements for PSA, we did not identify any assurance reports to the Quality, Safety and Experience (QSE) Committee during 2020/21. We have been informed by management that this is due to the COVID -19 pandemic, however, Patient Safety Solutions do appear on the forward plan for the QSE Committee during 2021/22. Audit also notes that prior to the pandemic the QSE Committee did receive assurance reports. We also note that there have been revisions to the governance arrangements which underpin the QSE Committee to include a Clinical Effectiveness Committee, which receive updates on specific PSA that are of concern.	A lack of clarity regarding staff responsibilities, resulting in poor coordination and response to legislative / regulatory requirements, safety alerts, continued exposure to risk and potential reproach by Welsh Government.

Recommendation 7	**Priority level**
Assurance reports regarding Patient Safety Alerts should be provided to the Quality, Safety and Experience Committee or appropriate group during 2021/22.	**Low**

Agreed Management Action 7	**Target date**	**Responsible Officer/ Deadline**
Agreement of future reporting arrangements for PSAs within the revised QSE Committee structure.	End September 2021	Assistant Director Patient Safety and Quality
Agreement of a regular schedule of reporting for PSAs	End September 2021	Assistant Director Patient Safety and Quality

Matter Arising 8 - Safety Notices and Important Documents Management Policy & Procedure (Operating Effectiveness)	**Risk**
The Health Board has in place a high-level 'Safety Notices and Important Documents Management Policy' (UHB 069) that sets the strategic context. The date of next review is marked as 6th December 2020, although management have noted that an initial review has highlighted no areas that require update. Supporting the policy is the 'Safety Notices and Important documents Management Procedure' (UHB 377). The procedure was last reviewed in July 2021 where updates on the liaison officers and process map were noted. Audit reviewed this document and noted that there was no explicit mention of Welsh Health Circulares. Also, within the audit tool (appendix 4), there was no indication that evidence would be verified of the actions taken.	A lack of clarity regarding staff responsibilities, resulting in poor coordination and response to legislative / regulatory requirements, safety alerts, continued exposure to risk and potential reproach by Welsh Government.

Recommendation 8	**Priority level**
The 'Safety Notices and Important Documents Management Policy' (UHB 069) is to be formally reviewed. Consideration should be given to explicitly mentioning Welsh Health Circulars within the current procedure (UHB 377) and to incorporate evidence checks as part of the audit tool.	**Low**

Agreed Management Action 8	**Target date**	**Responsible Officer/ Deadline**
Agree to action to ensure that WHCs are managed via this policy in future along with appropriate evidence checks.	9th November	Head of Risk and Regulation

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Healthy Eating Standards - Hospital Restaurant & Retail Outlets

Final Internal Audit Report

August 2021

Cardiff and Vale University Health Board

NWSSP Audit and Assurance

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Contents

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Auditors:	Olubanke Ajayi-Olaoye, Principal Auditor Wendy Wright, Deputy Head of Internal Audit
Executive sign-off:	Fiona Kinghorn, Executive Director of Public Health
Distribution:	Rhianon Urquart, Principal Health Promotion Specialist Helen Griffith, Senior Health Promotion Specialist Chloe Barrell, Public Health Practitioner
Committee:	Audit & Assurance 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.

Executive Summary

Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the University Health Board (UHB) in relation to the Healthy Eating Standards for Restaurant and Retail Outlets, in order to provide assurance to the UHB's Audit Committee that risks material to the achievement of the systems objectives were managed appropriately.

Overview

We identified no significant issues for reporting in our review.

Matters arising identify minor weaknesses in system design, or are of an advisory nature, which if taken forward would assist in raising the profile and position of the Standards.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	The Standards are clearly documented	Substantial
2	Governance arrangements provide effective oversight of the Standards	Reasonable
3	The audit outputs of the UHB's Public Health Team are effectively reported and acted upon	Reasonable

Matters Arising

		Control Design or Operation	Recommendation Priority
1	Design and standing of the Healthy Eating Standards	Design	Low
2	Lack of clarity of governance arrangements	Design	Medium
3	Refinement of audit process and associated outputs	Operation	Medium

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulation the overall audit opinion

1. Introduction

The review of the 'Healthy Eating Standards for Hospital Restaurant and Retail Outlets' was completed in line with the 2021/22 Internal Audit Plan, and at the request of the Health Board's Public Health Team. In 2015, the Health Board adopted the Healthy Eating Standards for Restaurant and Retail Outlets (the Standards) as a guide to provide a healthy choice for customers, including staff, patients and visitors.

The Standards are underpinned by two key frameworks:

- Food Standards Agency - Guidance for determining whether products are low (green), medium (amber) or high (red) (From Annex 3 Guidance for nutritional labelling, 2016); and
- Welsh Government - Health Promoting Hospital Vending Guidance, 2012.

The Standards cover the UHB's restaurants, cafes, retail outlets, trolleys and vending machines. There are approximately 20 restaurant and retail outlets. Products are audited based on the Food Standards Agency guidance for determining whether products are low (green), medium (amber) or high (red). The audits typically cover hot and cold food, drinks, snacks and confectionary.

A paper to the Strategy and Delivery Committee on 12th January 2021 noted, *"We are the first Health Board in Wales to adopt this approach, whereby a minimum of 75% of the food and drink on offer in our restaurants and retail outlets are classed as healthier options, and this has been noted as best practice by the Healthy Weight Healthy Wales Implementation Board".*

The paper also highlighted the impact of COVID-19 and the revised food service offer, in addition to the suspension of the development of the concourse at UHW. Initial contact had been made with prospective external / commercial providers, which asked them to *"… identify the impact of the Standards on their profit margin. As a direct result of COVID-19, the Expression of Interests (EOI) process was unable to be completed."*

The executive lead for this review is the Executive Director of Public Health.

Audit Risks

The potential risks considered in this review were as follows:

- There is a lack of clarity through poor design of the Standards;
- Levels of non-compliance with the Standards are high, resulting in unhealthy food choices being made within the Health Board's restaurant and retail outlets;
- The Public Health audit process is inefficient and ineffective; and
- Inadequate monitoring and reporting of the Standards fails to encourage a healthy environment.

2. Detailed Audit Findings

Objective 1: The Health Board Standards are clearly documented and provide clear guidance for restaurant and retail outlets to follow

- The Standards provide clear guidance for restaurant and retail outlets to apply, and the use of colourful pictorial illustrations make the Standards engaging and easy to understand.

The following matter arising was noted:

- On review of the Standards it was noted that there were instances where references to legislation and strategic priorities could be more explicit; the reference links contained within require review for robustness; and, there was a lack of clarity of which governance forum had endorsed the Standards. *(Matter Arising 1 – Low Priority)*

Conclusion: The recommendation made under this objective is of low priority, and if taken forward may assist in raising the profile and standing of the Standards, for completeness and clarity. (Substantial Assurance)

Objective 2: There are appropriate governance arrangements in place, which provide effective oversight of the Standards and their implementation

The following areas of good practice were noted for this objective:

- The 'Steering Group: Cardiff & Vale UHB Healthy Eating Standards for Hospital, Restaurants & Retail Outlets' has oversight of compliance, monitoring, promotion and development of the Standards. The forum meets three times a year and following the resumption of audits upholds an action plan to provide focus for the meetings.
- The UHB's Public Health Team has a standing agenda item on the UHB Nutrition and Catering Steering Group, which meets three times a year, with a primary focus on patient nutrition. The group is updated on the outcomes of audits and thus compliance with the Standards, in addition to further updates relating to the Standards.

The following matter arising was noted for this objective:

- Further clarity is needed of the governance arrangements to support and direct the application and reporting of the Standards, including the means of escalation from the Steering Group. The Terms of Reference for the Steering Group remains in draft. *(Matter Arising 2 – Medium Priority)*

Conclusion: A review of governance arrangements including the finalisation of governance documents would enhance current arrangements. (Reasonable Assurance)

Objective 3: Cardiff and Vale Local Public Health Team audit process outputs are effectively reported and acted upon in the organisation

- There is an audit schedule which specifies the audits to be undertaken for the year.
- The results from each audit are recorded on a spreadsheet, which has the nutritional content of the items sold. Following the audit, the catering team are informed of the compliance results, and an update is given at the next Steering Group.
- A consistent audit checklist is used to ensure that the audited area adheres to the requirements outlined within the Standards.
- Nutritional information and contents used to audit the compliance rates to the Healthy Eating Standards are obtained from supplier information.
- Where restaurant and retail outlets are selected for audit, full assurance is undertaken of the product offering.
- To enhance the communication of audit results, the Public Health Team are currently developing a traffic light dashboard, with the support of Medical Illustration within the UHB.

The following matter arising was noted for this objective:

- Opportunities to enhance the audit process and associated outputs have been identified, which relate to the scheduling of audits, the checklist used to support the audit process, the arrangements for documenting follow ups and the means of sharing good practice. *(Matter Arising 3 – Medium Priority)*

Conclusion: The recommendation made under this objective would enhance the current audit processes and associated reporting of outputs. (Reasonable Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Design and standing of the Healthy Eating Standards (Control Design)		**Impact**
The following observations were made on review of the Standards: • The Standards provide helpful references, but it was found that some of the links were inactive or broken. • It was not evident from reviewing the Standards which governance forum had endorsed the Standards. • The vision, as set out in the Standards refers to the Wellbeing of Future Generations but does not explicitly refer to the Well-being of Future Generations (Wales) Act 2015. • Similarly, the vision also refers to the Shaping our Future Wellbeing Strategy but does not directly reference the strategic change programmes that are being established, such as the Shaping our Future Population Health.		Potential risk of: There is a lack of clarity through poor design of the Standards.
Recommendation 1		**Priority**
At the next review of the Standards consideration should be given to the following, which may also assist in raising the profile: • Testing the reference links to ensure they are still live and current; • Noting the governance forum which endorsed the Standards on the cover sheet; • Direct reference to the Well-being of Future Generations (Wales) Act 2015; and • Reference to Strategic change programmes, which underpin the Shaping our Future Wellbeing Strategy, such as Shaping our Future Population Health.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
1) Review and update all paperwork 2) Confirm governance arrangements with Executive Director of Public Health 3) Ensure referencing to strategic drivers are incorporated in the documentation.	End of September 2021	Rhianon Urquhart, Principal Health Promotion Specialist

Matter Arising 2: Lack of clarity of governance arrangements (Control Design)	**Impact**
The following observations of the governance arrangements were noted: • As noted in finding one, the Standards do not specify the governance forum which endorsed the Standards. • It was noted that the Standards were presented to the Quality, Safety and Experience Committee in December 2019, the following is an extract from the minutes, *"The Committee resolved that: a) Progress of the policy be noted; and b) A revised policy be brought back at a later date".* There has been no further submission to the Committee, the COVID-19 pandemic will have impacted progress. The auditor was advised that the Management Executive has since approved the continuation of the Standards in 2020. • In January 2021, the Strategy and Delivery Committee received an update on the current position of the Standards and the results from audits undertaken, including changes that have occurred due to the COVID-19 pandemic and plans going forward on addressing this. The Strategy and Delivery Committee has not been included as a part of the Standard's governance arrangements as documented within the Draft Steering Group Terms of Reference. • The 'Steering Group: Cardiff & Vale UHB Healthy Eating Standards for Hospital, Restaurants & Retail Outlets' Terms of Reference is currently in draft status and under review at the time of the audit. The	Potential risk of: Levels of non-compliance with the Standards are high, resulting in unhealthy food choices being made within the Health Board's restaurant and retail outlets.

Recommendation 2	**Priority**
To enhance the governance arrangements currently in place to support and direct the Standards, the governance arrangements should be reviewed, and draft governance documents finalised and approved to provide clarity.	**Medium**

Agreed Management Action 2	**Target Date**	**Responsible Officer**
1. Review governance and reporting mechanisms to ensure the standards are implemented and applied in accordance with UHB governance processes.	October 2021	Rhianon Urquhart, Principal Health Promotion Specialist

Matter Arising 3: Refinement of Audit Process and Associated Outputs (Operational Control)	**Impact**
The following observations were noted of the audit process and associated outputs: • Audits are scheduled in advance and audited areas are notified weeks in advance. Whilst this promotes a collaborative approach, it is questionable whether this always presents a true representation of compliance with the Standards. • An audit checklist is used to facilitate the audit process, the following is noted in the Standards, but does not form part of the audit checklist, "The nutritional information of all products to be displayed to the customer, as per the FSA traffic light system". • A follow up visit is usually arranged where a restaurant or retail outlet falls below the compliance rate of 75%. The follow up process is a visual observation, thus, there is no documentation to evidence the visit. • There is currently no formal process in place for the capturing and sharing of good practice.	Potential risk of: The Public Health audit process is inefficient and ineffective; and Inadequate monitoring and reporting of the Standards fails to encourage a healthy environment.
Recommendation 3	**Priority**
Consideration should be given to taking forward the following to enhance the audit process and associated outputs: • To reflect on the system of scheduling audits, weighing the benefits and possible value added by performing some unannounced spot checks; • Follow up visits should be documented to determine if there is a noted improvement, or if compliance issues remain; • To develop a process for capturing and sharing good practice; and • The audit checklist should be updated to reflect the requirement of the Standards to incorporate the display of the traffic light system.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
1) Revise audit schedule to include unannounced spot checks in addition to scheduled audit visits. 2) Audit documentation revised to ensure audit results , in particular non-compliance, is highlighted and appropriate actions identified to improve compliance. 3) Develop communication tools to highlight examples of good practice, for example, newsletters, performance dashboards etc. 4) Include traffic light system in audit documentation.	October 2021	Helen Griffith, Senior Health Promotion Specialist Chloe Barrell, Public Health Practitioner

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
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 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Cancellation of Outpatient Clinics Follow-up (Mental Health Clinical Board):

Final Internal Audit Report

August 2021

Cardiff & Vale University Health Board

NWSSP Audit and Assurance Services

Contents

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Auditors:	Geoffrey Woolley, Principal Internal Auditor Wendy Wright, Deputy Head of Internal Audit
Executive sign off:	Steve Curry, Chief Operating Officer
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	Mark Jones, Directorate Manager, Adult Mental Health
	Joanne Wilson, Directorate Manager, Mental Health Services for Older People
	Simon McDonald, Digital Lead for Mental Health
Committee:	Audit & Assurance 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

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1. Introduction and Background

The follow-up review of Cancellation of Outpatient Clinics was completed in line with the 2021/22 Internal Audit Plan. The opinion provided through this review is a key component, which will inform the Head of Internal Audit's Annual Opinion.

This was a follow-up review of the original report that was issued in January 2021, which identified five issues and resulted in an overall assurance rating of 'Limited Assurance'.

The Lead Executive Director for this review was the Chief Operating Officer.

2. Scope and Objectives

The overall objective of this review was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the Cancellation of Outpatient Clinics audit that was undertaken as part of our 2020/21 work programme.

The scope of this follow up review **does not** aim to provide assurance against the full scope and objectives of the original audit. The 'follow up review opinion' provides an assurance level against the implementation of the agreed action plan only.

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

- Appropriate progress has been made with the implementation of the agreed management responses within the agreed timescales;
- Adequate evidence is available to support the level of progress that has been made; and
- The actions implemented have effectively addressed the issues highlighted during the original audit.

3. Associated Risks

The potential risks considered in this review are as follows:

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

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The review did not aim to provide assurance against the full scope and objectives of the original audit. The 'follow-up' opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

Rating	Indicator	Definition
Reasonable Assurance		All high level recommendations implemented and progress on the medium and low level recommendations.

Significant work has been undertaken towards implementing the recommendations in the original audit report, which is demonstrated by a move in assurance rating from Limited to Reasonable. The rationale for holding reasonable assurance is largely drawn from our ability to verify the design of controls, but the implementation of the controls requires a further period to become embedded. Our follow up recommendations raised in this review support an upward trajectory of enhanced assurance.

A detailed written procedure has been developed which includes a comprehensive proforma form to be used and covers all the issues identified as requiring attention. Namely consideration of all available options before clinics are cancelled; senior level authorisation for the cancellation of clinics; and regular monitoring of the number and reasons for clinic cancellations. This should aid implementation of an improved and consistent approach to outpatient clinic cancellations going forward.

Looking ahead, it is inevitable that further work and time will be required to fully embed the procedure, whilst being tried and tested by the Clinical Board.

A monthly cancellation report has been developed which has been automatically run and issued from April 2021, to each clinic for their area and the Clinical Board Director (for all areas). The report shows the total number of cancellations and rebooked appointments in the month, analysed by clinic, reason and subsequent outcome, which is supported by detailed information for each clinician and each patient affected.

We acknowledge the report is in its infancy and whilst it begins to tell a story which is clinically useful, when we reviewed the reports, we highlighted issues which require addressing to support the further development of the report. Specifically, how the report accumulates and presents some information, and the quality of earlier underlying data which is prone to inconsistency across the Directorates.

5. Summary of Audit Findings

Progress against the original recommendations to be implemented is as follows:

Priority rating	Number of management responses to be implemented	Fully actioned	Partially actioned	Not actioned
High	2	2	0	0
Medium	3	1	2	0
Total	**5**	**3**	**2**	**0**

Follow Up Recommendations raised through this review:

Priority rating	Follow up recommendations
High	0
Medium	3
Low	1
Total	**4**

The action plan within Appendix A provides full details of the findings, priority ratings and management responses from the original review, along with details of the current position, as verified by our follow-up work. To support the UHB's ongoing development in this area, follow up recommendations and priority ratings are included where necessary.

Appendix A: Management Action Plan

Original Finding 1 – Written procedures (Control design)	**Risk**
There were no written procedures / guidance available for staff regarding the operation of Mental Health Outpatient Clinic Cancellations.	A lack of up-to-date written procedures may lead to uncertainty regarding action required and inconsistency between the various teams.

Original Recommendation 1	**Priority level**
Written procedures / guidance should be developed and distributed to all staff regarding the operation of Mental Health Outpatient Clinic Cancellations.	**High**

Original Management Response 1	**Responsible Officer/ Deadline**
The clinical board are leading on an Outpatient Transformation project currently. It is envisaged that as part of this working group output would be a written procedures / guidelines for the operational streamlining and consistent working of mental health outpatient clinics across Cardiff and Vale UHB. In the interim, the clinical board will urgently source operating procedures from elsewhere in the UHB. MHCB local guidance will be produced in draft for their January 2021 meeting and approved through the transformation project steering group in March/April 2021. Completion date April 21st 2021.	Dr. Neil Jones – Dep CBD Jo Wilson – Directorate Manager MHSOP Dr. Mark Jones – Directorate Manager Adult Services Ian Wile – Director of Ops April 2021

Current Position 1
A written procedure covering the Cancellation of Outpatient Clinics has been developed following input from across the Mental Health Directorates. It is detailed and comprehensive, 8 pages long, and includes consideration of all issues identified in the original audit report as requiring attention. Namely consideration of all available options before clinics are cancelled, senior level authorisation for the cancellation of clinics and regular monitoring of the number and reasons for clinic cancellations. Furthermore, it specifies the responsible author, the Clinical Board Director, and includes a comprehensive proforma form to be completed for outpatient clinic cancellations, a detailed flowchart indicating the procedures to be followed for outpatient clinic

cancellations and guidance regarding the PARIS computerised reporting mechanism which has been developed.

Therefore, it should aid implementation of an improved and consistent approach to outpatient clinic cancellations going forward.

We consider this recommendation **fully implemented.**

However, one minor finding was identified. While the written procedure includes the version reference and date produced, it does not specify a review date or the approving forum. To raise the profile and standing of the procedures it would be beneficial to incorporate this information.

Follow-up Recommendation 1	**Priority level**
Clarification of the approving forum and next review date should be added to the written procedure for the Cancellation of Outpatient Clinics.	**Low**
Follow-up Management Response 1	**Responsible Officer/ Deadline**
Document to be formatted to usual UHB standard, with version control, date, authorising body.	Neil Jones, Clinical Board Director

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

It is acknowledged that the Clinicians are likely to be considering these issues before cancelling clinics but there is currently no evidence to support this.

Original Recommendation 2	Priority level
Management must ensure that sufficient evidence is retained to confirm that all available options have been effectively considered before clinics are cancelled.	Medium

Management Response 2	Responsible Officer/ Deadline
Following reaching an agreement to the operational workings of outpatient clinics from the Outpatient Transformation project, consistent Paris cancellation lists can be generated and inputted onto the system by working closely with the Paris lead manager. This record will contain a fuller explanation for the cancellation, alternatives considered, and if these were not used, why not. In the interim, manual operating processes will be drafted for discussion and implementation in the January 21 meet of the steering group for implementation from February 21 onwards until PARIS accommodates this. Completion date April 21st 2021.	Dr. Neil Jones – Dep CBD Michelle Lewis – Information Lead - MH Jo Wilson – DM MHSOP Dr. Mark Jones – DM Adult Dr Tracey Tye – Locality Lead North Dr. Rakesh Pankajakshan – Locality Lead Vale Dr. Bhushan Vaidya – Locality Lead – South April 2021

Current Position 2

The current version of the Outpatient Clinic Cancellation Form in the Mental Health Clinical Board developed procedure includes boxes for:

- *"Have you considered alternative solutions, if so, please specify. Yes/No/Notes.*
- *Have you considered alternative HCPs (Nurse/Nurse prescriber or Pharmacist led clinic). Yes/No/Notes."*

However, Outpatient Clinic Cancellation Forms have not been completed for cancellations to date for Adult Mental Health Services and these boxes had not been completed for the forms completed for cancellations to date for Mental Health Services for Older People.

We consider this recommendation **partially implemented**.

Khan Raj
08/31/2021 16:26:13

Follow-up Recommendation 2	Priority level
The boxes for consideration of alternative solutions and alternative HCPs should be completed for each Outpatient Clinic Cancellation as evidence that all available options have been effectively considered before clinics are cancelled.	Medium
Follow-up Management Response 2	**Responsible Officer/ Deadline**
The guidelines have been updated, and the pro forma for completion includes clear instruction for staff cancelling, and those authorising that form should be completed in FULL. Amendment to protocol advising to escalate any concern about non-completion of forms, any performance variations or concerns about utility of processes.	Neil Jones, Clinical Board Director

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

authorised by the relevant locality medical lead in working age adult services and the Clinical Director in Older Peoples Services. These arrangements will be finalised on 6th January 2021.	Dr. Mark Jones – DM Adult Dr Tracey Tye – Locality Lead North Dr. Rakesh Pankajakshan – Locality Lead Vale Dr. Bhushan Vaidya – Locality Lead – South Dr. Paul Cantrell – CD Adult Dr. Arpita Charabharti – CD MHSOP January 2021

Current Position 3
The current version of the Outpatient Clinic Cancellation Form in the Mental Health Clinical Board developed procedure includes a section headed "Request for cancellation of six weeks or less must be authorised by either Clinical Director (or deputy), Lead Nurse, Directorate Manager, before cancellation will be administered" followed by boxes for Authorised by, Date, Authorised Yes/No and Reason for decision. However, while these boxes have generally been completed for cancellations to date for Mental Health Services for Older People, cancellation forms have not been completed to date for Adult Mental Health Services cancellations. We consider this recommendation **partially implemented**.

Follow-up Recommendation 3	**Priority level**
All authorisation boxes should be completed for each Outpatient Clinic Cancellation as evidence of senior level authorisation.	**Medium**

Follow-up Management Response 3	**Responsible Officer/ Deadline**
As a Clinical Board – we have taken a decision to prioritise senior sign off (and thus scrutiny) on the less than six week cancellation – which have the most profound affect on waiting patients. We have not MANDATED clinic sign off for more routine clinics. E.g. a directorate with 20 consultants with two clinics per week – would be expected to sign off – 240 paper forms per year. Our clinics are almost entirely organised through PARIS and we have developed reports – which are able to show us all cancellations and the given reason. We feel scrutiny of these reports gives a more meaningful result. We will keep this approach under review – and will of course mandate IF directed to do so.	Neil Jones, Clinical Board Director

Original Finding 4 – PARIS is used inconsistently between Mental Health Directorates (Control design)	**Risk**
The PARIS Patient Management System is currently used inconsistently between the Mental Health Directorates. The Community Mental Health Teams use the PARIS Booking system to control Outpatient Clinic appointments whereas Mental Health Services for Older People initially control Outpatient Clinic appointments using manual bound books at each location. They then subsequently update the details for each patient in the PARIS Referral Module which is different / separate to the PARIS Booking Module. We were informed that the intention is to move to using the Booking module at some stage in the future.	Inefficiencies and inconsistencies may occur from using different PARIS modules in different Directorates within Mental Health.

Original Recommendation 4	**Priority level**
Mental Health Services for Older People should fulfil its intention of moving to using the PARIS Booking Module as soon as possible so that consistent systems apply throughout Mental Health.	**Medium**

Management Response 4	**Responsible Officer/ Deadline**
Following reaching an agreement to the operational workings of outpatient clinics from the Outpatient Transformation project, consistent Paris usage across the clinical board will be achieved. The Directorate Manager for MHSOP has further explored with the Information lead, timescales for achieving this and in mid-January 21 their South Locality will commence use, with the Vale and North localities following in February 2021.	Michelle Lewis – Information Lead – MH Jo Wilson – DM MHSOP Dr. Arpita Chakrabharti February 2021

Current Position 4
Following training in February and March 2021, Mental Health Services for Older People successfully moved to using the PARIS Booking Module from April 2021 and so consistent systems are now in place throughout Mental Health. We consider this recommendation **fully implemented**.

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

Original Recommendation 5	**Priority level**
1. Monthly reporting which covers Outpatient Clinic Cancellations should be developed which covers as a minimum the total monthly number and percentage of Mental Health Outpatient Clinic Cancellations and the equivalent results for the year to date. Where poor results are reported, the reasons should also be identified. Consideration should also be given to whether additional drill down of the results should be included. For example Directorate or clinic level. 2. All relevant staff should be reminded of the existence of the cancellation reports in the PARIS reports module including instructions how to locate and use them.	**High**

Management Response 5	Responsible Officer/ Deadline
Following reaching an agreement to the operational workings of outpatient clinics from the Outpatient Transformation project, consistent Paris recording and production of robust reports can be generated by working closely with the Paris lead manager in the medium term. In the short term monthly reporting on numbers of cancellations and number as a percentage of the total will be collated monthly following a baseline assessment in early January 2021. This activity will be discussed within the Directorate performance meets with the MHCB as well as in local directorate meetings with their teams. Internal performance monitoring processes for completion date April 21st 2021.	Dr. Neil Jones – Dep CBD Michelle Lewis – Information Lead – MH Jo Wilson – DM MHSOP Dr. Mark Jones – DM Adult Ian Wile – Director of Operations April 2021

Current Position 5
A monthly cancellation report has been developed which has been automatically run and issued from April 2021 to each clinic for their area and the Mental Health Clinical Board Director for all areas. Furthermore, relevant staff are aware that additional ad hoc reports can be run if required. The report shows the total number of cancellations and rebooked appointments in the month analysed by clinic, reason and subsequent outcome and is supported by detailed information for each clinician and each patient affected and so begins to tell a story which is clinically useful. We consider this recommendation **fully implemented**. However, we noted that some queries remained regarding how the report accumulates and presents some information. Also, the quality of earlier underlying data which is prone to inconsistency across the Directorates.

Follow-up Recommendation 4	Priority level
1. A continued period of testing, bedding in and fine tuning of the cancellation report should be undertaken so that outstanding data accumulation and presentation issues can be identified and cleared. This should involve input from all recipients of the report. 2. Any further changes which need to be made in connection with the monthly cancellation report should be reflected in the Cancellation of Outpatient Clinics written procedures.	**Medium**

Follow-up Management Response 4	Responsible Officer/ Deadline
Each Directorate has a 6 weekly scheduled performance meeting. The O/P cancellation procedure will be a recurrent agenda item until the iterative process is satisfied by the time of the 3 year procedure review. This is reflected in the procedure.	Daniel Crossland, Deputy Director of Operations and Delivery

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 in place 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.

Follow up - No action taken to implement recommendations.

Assurance not applicable

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

Ultrasound Governance

(Clinical Diagnostics and Therapeutics Clinical Board)

Final Internal Audit Report

August 2021

Cardiff and Vale University Health Board

NWSSP Audit and Assurance

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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Executive sign-off:	Dr Fiona Jenkins, Executive Director of Therapies and Health Science Steve Curry, Chief Operating Officer
Distribution:	Matthew Temby, Director of Operations, Clinical Diagnostics and Therapeutics Clinical Board Sue Bailey, Director for Quality, Clinical Diagnostics and Therapeutics Clive Morgan, Assistant Director of Therapies, Clinical Diagnostics and Therapeutics Clinical Board Dr Kate Bryant, Consultant Clinical Scientist, Head of Non-Ionising Radiation, Medical Physics Dr Paul Williams, Principal Clinical Scientist, Ultrasound Quality Assurance Lead, Medical Physics
Committee:	Audit & Assurance 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.

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Executive Summary

Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to ultrasound 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.

Overview

This report provides limited assurance for Ultrasound Governance arrangements, which stems from issues relating to the design and implementation of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2).

Governance arrangements were found to be lacking and require review to effectively direct and oversee the implementation of the requirements prescribed by the revised policy and procedure.

Two high priority recommendations are proposed, which fall under the scope of objectives one and two.

Report Classification

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	-

Assurance summary[1]

	Assurance objectives	Assurance
1	Design and implementation of ultrasound governance arrangements	Limited
2	Roles and responsibilities	Limited
3	Servicing, maintenance, repair and quality assurance	Substantial
4	Procurement of diagnostic and therapeutic ultrasound equipment	Substantial
5	Ultrasound training	Reasonable

Matters Arising

		Control Design or Operation	Recommendation Priority
1	Lack of communication of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2)	Operation	High
2	Absence of Clinical Board assurance to the Executive Director of Therapies and Health Science	Operation	Medium
3	Design and feedback of the Medical Ultrasound Risk Management Procedure	Design	Medium
4	Ultrasound governance arrangements require review	Operation	High
5	Roles and responsibilities outlined by procedure require formalisation	Operation	Medium

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulation the overall audit opinion

1. Introduction

The review of Ultrasound Governance was deferred in 2020/21 and carried forward to the 2021/22 Internal Audit Plan. The Clinical Diagnostics and Therapeutics Clinical Board proposed the review for inclusion in the plan.

The Health Board's Medical Ultrasound Risk Management Policy (UHB 322 v.2) was updated in 2020 and approved by the Quality, Safety and Experience Committee. The policy notes, "Cardiff and Vale UHB is committed to providing uniform, high quality diagnostic and therapeutic ultrasound services which consistently meet as a minimum all national evidence-based standards".

The lead executives for the review are Steve Curry, Chief Operating Officer and Dr Fiona Jenkins, Executive Director of Therapies and Health Science.

Audit Risks

The potential risks considered in this review are as follows:

- There is no effective clinical governance framework;
- Equipment is poorly specified or maintained;
- Examinations are undertaken or interpreted by untrained or poorly trained individuals;
- Inadequate monitoring of performance and scrutiny of outcomes.

The following policy commitment will be outside of the scope of this audit, *"Provide a robust framework for the documentation of ultrasound referrals, examinations and procedures, and the secure storage of images, to ensure data is recorded accurately and consistently, and stored safely across the UHB".* (To be considered as a discrete audit for future audit plans).

2. Detailed Audit Findings

Objective 1: The design and implementation of ultrasound governance arrangements outlined within the Health Board's Ultrasound Risk Management Policy and Procedure.

Medical Ultrasound Risk Management Policy & Procedure (UHB 322 v2)

- The Quality, Safety and Experience Committee approved the revised Policy and Procedure on 20 July 2020. The accountable executive is the Executive Director of Therapies and Health Science.
- Both documents are available on the UHB's intranet site.

The following matters arising were noted:

- Audit testing identified that there was a lack of awareness of the revised Medical Ultrasound Risk Management Policy and Procedure, which was published in February 2021. *(Matters Arising 1 – High Priority)*
- Further consideration is required of how Clinical Boards are to provide assurance to the Executive Director of Therapies and Health Science that medical ultrasound is managed in compliance with the UHB's policy and procedure. *(Matters Arising 2 – Medium Priority)*

- Feedback during the audit highlighted the comprehensive nature of the procedure but an abridged version would be welcomed. Also, the naming of the policy and procedure suggests a focus on risk management, but the content is of ensuring sound structure and processes for ultrasound governance. *(Matters Arising 3 – Medium Priority)*

Medical Ultrasound Governance Arrangements

- There is an Ultrasound Clinical Governance Group (UCGG) in place.
- The acting Chair of the UCGG has had opportunity to raise concerns through the Medical Equipment Group and Quality Safety and Experience sub-committee in 2019.

The following matters arising were noted:

- The Ultrasound Clinical Governance Group Terms of Reference is out of date (2015) and has not been reviewed in tandem with the revised Medical Ultrasound Risk Management Policy and Procedure.
- Whilst the outdated terms of reference suggests a formal means of escalation beyond the group, we were unable to evidence routine or embedded reporting arrangements.
- The current chairing arrangements of the UCGG meetings falls short of the terms of reference, with reduced authority in the UHB, which has impacted the ability of the group to guide and direct matters of ultrasound governance.
- Poor attendance of the UCGG has been an issue, which was highlighted by the sampled audit areas and the acting chair of the UCGG.

  (Matters Arising 4 – High Priority)

Conclusion: To support the implementation of the updated Medical Ultrasound Risk Management Policy and Procedure the governance arrangements require review to provide sound oversight and direction. (Limited Assurance)

Objective 2: Roles and responsibilities in the management of diagnostic and therapeutic ultrasound services.

- The revised policy and procedure requires three key ultrasound governance roles to be allocated within Clinical Boards; Clinical Lead User, Speciality Lead User, and Educational Supervisor / Training Supervisor.
- Whilst these roles may have been nominally allocated, we were unable to formally evidence the allocation of these roles within Obstetrics & Gynaecology, Cardiology Directorates, and the Medical Physics Doppler Ultrasound Service. *(Matters Arising 5 – Medium Priority)*

Conclusion: The three key roles in the management of diagnostic and therapeutic ultrasound services require formal adoption by Clinical Boards. (Limited Assurance)

Objective 3: Servicing, maintenance, repair and quality assurance of diagnostic and therapeutic ultrasound equipment, in addition to decommissioning.

- For the sampled audit areas, all ultrasound equipment in use within the Obstetrics & Gynaecology, Cardiology Directorates, and Medical Physics Doppler Ultrasound Service are covered by formal UHB-wide contractual managed service agreements.
- Regular meetings are held between managed service agreement providers and key ultrasound user representatives within the UHB. Reports are provided that cover asset support given, a report of current equipment in place, issues/faults/repairs reported, and action and training provided to users in the period.
- All three areas held records of regular servicing and maintenance of their ultrasound equipment and that of call-outs for issues/faults/repairs.
- Daily quality assurance safety checks are performed by the clinical and medical users on ultrasound equipment within the Directorates as a matter of course before the equipment is put into use.

Conclusion: There are no matters arising in respect of this Objective. (Substantial Assurance)

Objective 4: Procurement of diagnostic and therapeutic ultrasound equipment.

- Purchases of new ultrasound equipment made by the Cardiology Directorate were done so in compliance with the requirements of the Medical Equipment Management Procedure prior to the publication of the revised Medical Ultrasound Risk Management Procedure.
- There are no items of ultrasound equipment on loan, trial or hire within any of the three areas at the time of the audit as confirmed by the respective Directorate Managers and the Lead Clinical Scientist of the Non-Ionising Radiation Team.

NB: We were advised that there have been no purchases of ultrasound equipment in any of the tested areas since the publication of the Ultrasound Risk Management Procedure in February 2021.

Conclusion: There are no matters arising in respect of this Objective. (Substantial Assurance)

Objective 5: Training and competence for the use of diagnostic and therapeutic ultrasound.

In accordance with Section 4 of the Medical Ultrasound Risk Management Procedure, all clinical and medical staff working with ultrasound equipment within the Obstetrics & Gynaecology, Cardiology Directorates, and the Medical Physics Doppler Ultrasound Service held evidence of:

- Up to date records of statutory registration status in respect of their professional bodies/institutions.
- Up to date records of all ultrasound users' relevant qualifications and the awarding institution.

Beyond the above training requirements of the Procedure which were satisfied, section 4.1, Ultrasound Equipment Training, is nuanced to the training requirements of specific equipment, and section 4.2, Ultrasound Safety Training, to general requirements of safe management of medical ultrasound equipment. Our testing did not extend to requirements 4.1 and 4.2 given

the lack of awareness of the procedure. In accordance with 'Matters Arising 2' of this report, further consideration is required of how Clinical Boards are to provide assurance to the Executive Director of Therapies and Health Science that medical ultrasound is managed in compliance with the UHB's policy and procedure.

The Non-Ionising Radiation Team have acknowledged that for greater oversight of ultrasound safety training an e-learning module is currently in development, with the intention of linking to ESR, which will provide a means of monitoring compliance and fulfilment of section 4.2 of the procedure.

Conclusion: Whilst no recommendations are made under this objective, the fulfilment of recommendation two of this report will provide greater assurance to the Executive Director of Therapies and Health Science on the requirements of 4.1 and 4.2 of the procedure. In addition to the introduction of an e-learning tool to provide greater oversight of general ultrasound safety training across the UHB. (Reasonable Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Lack of communication of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2) (Control Operation)	**Impact**
It was evident through audit testing that there was a lack of awareness of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2), although both were available on the UHB intranet site. For the sampled areas, none of the directorate management, clinical or medical ultrasound users in Obstetrics & Gynaecology and Cardiology Directorates were aware of the existence of the finalised policy and procedure. The Ultrasound Clinical Governance Group in July 2020 reviewed draft iterations of the policy and procedure, and both directorates had representatives who attended. Once the policy and procedure had been formally ratified by the UHB Quality, Safety and Experience Committee in July 2020, there was no evidence of communication to all UHB Directorate Managers or the membership body of the Ultrasound Clinical Governance Group.	Potential risk of there being no effective clinical ultrasound governance framework in place.
Recommendation 1	**Priority**
The Executive Director of Therapies and Health Science should be provided with assurance that the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2) has been adequately communicated within the Health Board.	**High**

Agreed Management Action	**Target Date**	**Responsible Officer**
The Policy and Procedure will be promoted through the Medical Equipment Group, Medical Device Safety Officer's group, Clinical Board operational teams as well as through the Clinical Executive's Office of Professional Leadership.	October 2021	Assistant Director of Therapies and Health Science

Matter Arising 2: Absence of Clinical Board assurance to the Executive Director of Therapies and Health Science (Control Operation)	**Impact**
The Medical Ultrasound Risk Management Procedure provides direction to Clinical Boards regards required assurance to the Executive Director of Therapies and Health Science, which notes, *"The Clinical Board Heads of Operations and Delivery are responsible for:* *Providing assurance to the Executive Director of Therapies and Health Science that medical ultrasound is managed in compliance with the UHB's policies and procedures."* Given the further findings within this report relating to ultrasound governance (finding 4), it is unclear how the required assurance is determined and how it is communicated.	Potential risk of there being no effective clinical ultrasound governance framework in place.

Recommendation 2	**Priority**
Consideration should be given to the mechanisms for Clinical Boards to provide assurance to the Executive Director of Therapies and Health Science, to satisfy the assurance responsibilities set out within the Medical Ultrasound Risk Management Procedure (UHB 322).	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
An annual audit template will be developed by the membership of the UCGG to include a balanced range of performance indicators on the effective management of U/S devices including training, competence and maintenance as part of the U/S governance framework.	March 2022	Assistant Director of Therapies and Health Science
Opportunities to develop a digital audit tool will be explored with corporate IM&T teams.	March 2022	Assistant Director of Therapies and Health Science

Matter Arising 3: Design and feedback of the Ultrasound Risk Management Procedure (Control Design)	**Impact**
The audit provided opportunity to disseminate the procedure and obtain feedback from those that engaged with the audit. The following observations were noted: • Whilst the procedure is comprehensive, it is a lengthy document (23 pages of text) which covers an extensive depth of content to read and retain. • An abridged version of the procedure would be welcomed, capturing key themes and requirements, summarised into two or three pages, underpinned by the full procedure for clarification when required. • The naming of the policy and procedure suggests a focus on risk management, but the content is of ensuring sound structure and processes for ultrasound governance.	Potential risk of the design and implementation of ultrasound governance arrangements outlined within the Health Board's Ultrasound Risk Management Policy and Procedure.
Recommendation 3	**Priority**
Following feedback through the course of the review, consideration should be given to: • Producing an abridged version of the Medical Ultrasound Risk Management Procedure, summarising key themes, to underpin the full procedure; and • The renaming of the procedure to reflect the actual content of Ultrasound Governance and to align with the role of the Ultrasound Clinical Governance Group.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
Provide an abridged version of the procedure, about 2 or 3 pages. Rename the policy and procedures to reflect more closely what they contain. Khan Raj 08/31/2021 16:26:13	26th August 2021	Paul Williams, Principal Clinical Scientist

Matter Arising 4: Ultrasound governance arrangements require review (Control Operation)	**Impact**
The following observations were noted regarding the ultrasound governance arrangements and were prevalent pre-COVID: • There is an Ultrasound Clinical Governance Group (UCGG) in place, with a formal terms of reference, dated April 2015. • The UCGG terms of reference has not been reviewed in tandem with the revised policy and procedure (published 17 February 2021). • The terms of reference for the UCGG notes the following roles: Chair, Deputy Chief Operating Officer, and Vice Chair, Assistant Director of Therapies and Health Science. The auditor was advised that neither positions have chaired the group since 2018. Acting chairpersons have been assigned but hold reduced authority in the UHB. • The auditor was advised by the sampled areas that attendance at the UCGG has been poor. There were no records of attendance held, and thus quorate arrangements were uncertain. Due to the lack of documentation, we were unable to validate the strength of the UCGG. • The terms of reference for the UCGG refers to 'relationships and accountabilities with the Board and its committees/groups', specifically referencing the Medical Equipment Group (MEG) and the Decontamination Group. Minutes of the MEG and Quality Safety and Experience sub-committee (Clinical Diagnostics and Therapeutics Clinical Board) did evidence the raising of ultrasound clinical governance concerns in 2019 by the acting Chair. • There is no evidence of routine reporting to and from the UCGG. • The auditor was advised that the acting Chair and Vice Chair of the UCGG do attend the Quality, Safety and Experience Committee, with opportunity to raise concerns, as outlined within the UCGG terms of reference, but it was unclear if there are any embedded reporting arrangements of a more formal nature.	Potential risk of no effective clinical ultrasound governance framework.

Recommendation 4		Priority
Ultrasound governance arrangements should be reviewed as follows: • The placing of the Ultrasound Clinical Governance Group (UCGG) within the Health Board's governance structures. • The appointment of appropriate person(s) to Chair the UCGG meetings with sufficient seniority to escalate issues as they arise. • The reporting mechanisms to facilitate the escalation and cascade of ultrasound governance. • Membership of the UCGG should be sourced from all ultrasound using Directorates. • Actions and attendance (including quorum) are recorded for the meetings. On completion of review, the governance arrangements should be revised and formalised through an updated Terms of Reference.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**
The UCGG ToR will be formally reviewed to ensure that it has appropriate governance arrangements. The UCGG will formally report through the Medical Equipment Group (MEG) which is chaired by the Executive Director of Therapies and Health Science. The MEG will receive minutes and a written report. The TORs for UCGG and MEG will be amended accordingly.	October 2021	UCGG / Assistant Director of Therapies and Health Science
The membership of the UCGG will be signed off by the Executive Director of Therapies and Health Science. Communication on expected attendance from clinical areas at the UCGG will be disseminated through the operational Clinical Board structures and the Office of Professional Leadership.	November 2021	Assistant Director of Therapies and Health Science

Matter Arising 5: Roles and responsibilities outlined by procedure require formalisation (Control Operation)		**Impact**
So as to appropriately focus, organise and stratify areas of ultrasound governance at Directorate / Departmental level, the UHB Ultrasound Risk Management Procedure has adopted three key roles based upon areas of expertise that allow this to be undertaken effectively; these are, Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor. Since the publication of the revised procedure, we were unable to evidence the formal adoption of the roles outlined within the procedure, for the three sampled areas. It is noted that within the Obstetrics & Gynaecology Directorate, and the Medical Physics Doppler Ultrasound Service that these roles had been identified, but not formalised.		Potential risk of poor training and competence for the use of diagnostic and therapeutic ultrasound.
Recommendation 5		**Priority**
In accordance with Sections 2 and 3 of the UHB Ultrasound Risk Management Procedure, the three key roles of Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor should be formalised within the sampled audit areas.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
The three key roles of Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor have been formalised within Medical Physics.	Complete	
The O&G Directorate is setting up a quarterly formal ultrasound governance meeting, the first of which is starting in September. Within this we will be formalising roles and working through each aspect of the policy inc: roles and responsibilities and communication plan around this.	30th September 2021	Mark Denbow, Directorate Ultrasound Governance Lead

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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