Audit & Assurance Committee Meeting

Tue 07 November 2023, 09:00 - 11:15

MS Teams

Agenda

09:00 - 09:10
10 min

1. Preliminaries

1.1. Welcome & Introductions

John Union

1.2. Apologies for Absence

John Union

1.3. Declarations of Interest

John Union

1.4. Minutes of the Committee meeting held: 05.09.23

John Union

1.4 Draft Audit Minutes 05.09.2023 - Public.pdf (10 pages)

1.5. Action Log following meeting held: 05.09.23

John Union

1.5 Audit Public Action Log November.pdf (2 pages)

1.6. Any Other Urgent Business

John Union

09:10 - 11:15
125 min

2. Items for Review & Assurance

2.1. Internal Audit Progress Report

30 minutes *Ian Virgil*

2.1 A&A Progress Report November 23 cover.pdf (3 pages)
2.1a A&A Progress Report November 23.pdf (21 pages)

2.2. CD&T Clinical Board Medical Records Tracking Update

5 minutes *Sarah Lloyd / Sion O'Keefe*

2.2 Medical Records Tracking - Progress Update Sep 2023v3.pdf (5 pages)

2.3. Updated Policies Plan

5 minutes *Matt Phillips*

2.3 Audit Committee_Policies.pdf (3 pages)

2.4. Audit Wales Update

10 minutes *Wales Audit*

- 2.4 CVUHB Audit Committee Update (November 2023).pdf (14 pages)

2.5. BREAK – 10 minutes

2.6. Internal Audit Recommendation Tracker Report

5 minutes *Matt Phillips*

- 2.6 Internal Audit Tracking Report - Nov 2023.pdf (4 pages)
- 2.6a Internal Audit Summary Tables - Nov 2023.pdf (4 pages)
- 2.6b Internal Audit Tracker - November 2023 v3.pdf (14 pages)

2.7. Audit Wales Recommendation Tracking Report

5 minutes *Matt Phillips*

- 2.7 Audit Wales Recommendation Tracking Report - Nov 2023.pdf (2 pages)
- 2.7a Audit Wales Recommendation Table - Nov 2023.pdf (1 pages)
- 2.7b Audit Wales Tracker - November 2023 v2.pdf (5 pages)

2.8. Regulatory Compliance Tracking Report

5 minutes *Matt Phillips*

- 2.8 Regulatory Compliance Tracking Report Nov 2023.pdf (3 pages)
- 2.8a Reg Tracker for Committee November 2023.pdf (4 pages)

2.9. Procurement Compliance Report – Chair's Action Review

5 minutes *Catherine Phillips / Claire Salisbury*

- 2.9 Procurement Chair's Action Appendix.pdf (4 pages)

2.10. Procurement Compliance Report / Single Tender Actions

10 minutes *Catherine Phillips / Claire Salisbury*

- 2.10 Procurement Audit Committee Board Report - Oct 2023 v1.pdf (8 pages)
- 2.10a Procurement Compliance Report Single Tender Actions.pdf (3 pages)

2.11. Annual Clinical Audit Plan

10 minutes *Jason Roberts / Meriel Jenney*

- 2.11 Clinincal audit forward plan October 2023.pdf (3 pages)
- 2.11a Appendix 1.pdf (6 pages)
- 2.11b Appendix 2.pdf (3 pages)
- 2.11c Appendix 3.pdf (4 pages)
- 2.11d Appendix 4.pdf (2 pages)
- 2.11e Appendix 5.pdf (2 pages)
- 2.11f Appendix 6.pdf (5 pages)
- 2.11g Appendix 7.pdf (8 pages)

2.12. Counter Fraud Progress Report / Review the effectiveness of Counter Fraud Specialist

15 minutes *Catherine Phillips / Gareth Lavington*

- 2.12 COUNTER FRAUD PROGRESS _ PUBLIC _ COVER SHEET.pdf (2 pages)
- 2.12a COUNTER FRAUD PROGRESS REPORT - CAVUHB PUBLIC.pdf (10 pages)

11:15 - 11:15 ## 3. Items for Approval/Ratification

0 min

No Items

11:15 - 11:15
0 min

4. Items for Noting & Information

4.1. Internal Audit Reports for information:

Ian Virgil

- Refresh of the Health Board's Strategy (Substantial Assurance)
- Urgent and Emergency Care – Welsh Government Six Goals Programme (Substantial Assurance)
- PARIS System (Reasonable Assurance)
- Follow-up: Chemocare IT System (Reasonable Assurance)
- Surgery CB - Consultant Job Plans (Limited Assurance)
- Leadership and Management Training and Development (Advisory)
- Quality, Safety & Experience Governance (Advisory)

- 4.1 A&A Internal Audit Reports for Information cover.pdf (2 pages)
- 4.1a Refresh of the Health Board's Strategy Final Internal Audit Report_.pdf (12 pages)
- 4.1b WG Six Goals Programme Final Internal Audit Report_.pdf (12 pages)
- 4.1c PARIS Final Internal Audit Report (002).pdf (18 pages)
- 4.1d Chemocare Follow Up final IA Report.pdf (9 pages)
- 4.1e Surgery CB Consultant Job Plans Final Internal Audit Report.pdf (24 pages)
- 4.1f Leadership and Management Training and Development Final Internal Audit Report (Advisory).pdf (30 pages)
- 4.1g QSE Governance Advisory Final Internal Audit Report.pdf (12 pages)

4.2. Review of Draft Charitable Funds Annual Report and Accounts

Catherine Phillips

- 4.2 Report on the draft annual accounts 202223.pdf (3 pages)
- 4.2a C&V HC Annual Report & Accounts - v1 1.pdf (51 pages)
- 4.2b Audit enquiries letter - CVUHB Charity 2022-23 Responses back to Mark Jones 11 Oct 2023.pdf (23 pages)

11:15 - 11:15
0 min

5. Agenda for Private Audit and Assurance Committee

i. *Audit of Accounts Report Addendum – Recommendations (Confidential Discussion)*
ii. *Pentyrch Advisory Internal Audit Report (Confidential Discussion)*
iii. *Future Hospitals Internal Audit Report (Confidential Discussion)*
iv. *Cyber Security Update (verbal)*
v. *Counter Fraud Progress Update (Confidential – ongoing investigations*
vi. *Overpayments of Salary (Confidential Discussion)*
vii. *Procurement Improvement Plan Update*

11:15 - 11:15
0 min

6. Any Other Business

11:15 - 11:15
0 min

7. Review & Final Closure

7.1. Items to deferred to the Board / Committees

John Union

7.2. Date and Time of the next Committee meeting:

Tuesday 6th February 2024 at 9am via MS Teams

11:15 - 11:15
0 min

8. Declaration

John Union

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].

Confirmed Minutes of the Public Audit & Assurance Committee Meeting
Held On 5th September 2023 at 9:00am
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance and Committee Chair (CC)
Present:		
Mike Jones	MJ	Independent Member for Trade Union
Ceri Phillips	CP	UHB Vice Chair
Rhian Thomas	RT	Independent Member for Capital and Estates (IM-CE)
Charles Janczewski	CJ	UHB Chair
In Attendance:		
Lucy Jugessur	WW	Interim Deputy Head of Internal Audit (IDHIA)
Gareth Lavington	GL	Lead Local Counter Fraud Specialist (LLCFS)
Catherine Phillips	CP	Executive Director of Finance (EDF)
Matt Phillips	MP	Director of Corporate Governance (DCG)
Matt Temby	MT	Managing Director of Planned Care (MDPC)
Ian Virgil	IV	Head of Internal Audit (HIA)
Urvisha Perez	UP	Audit Wales
Lianne Morse	LM	Deputy Director of People & Culture (DDPC)
Andrew Partridge	AP	Corporate Archivist and Records Management Manager (CARMM)
Rob Mahoney	RM	Deputy Director of Finance – Operational (DDF-O)
Observers:		
Secretariat:		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Rachel Gidman	RG	Executive Director of People and Culture

Item No	Agenda Item	Action
AAC 5/9/23/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 5/9/23/002	**Apologies for Absence** Apologies for absence were received. **The Committee resolved that:** a) Apologies were noted.	
AAC 5/9/23/003	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	
AAC 5/9/23/004	**Minutes of the Meeting Held on 4th July 2023 and 25th July 2023** The Minutes of the Meeting Held on the 4th July 2023 and 25th July 2023 were received.	

	4th July 2023 Public Minutes - Last action on Page 2 should read the Charitable Funds Audit would go to the CFC. 2th July 2023 Special Minutes - True and accurate record. **The Committee resolved that:** a) The draft minutes of the meetings held on 4th July 2023 and 25th July 2023, were held to be a true and accurate record of the meeting.	
AAC 5/9/23/005	**Action Log – Following Meeting held on 11th May 2023** The Action Log was received. **The Committee resolved that:** a) The Action Log was discussed and noted.	
AAC 5/9/23/006	**Any Other Urgent Business** **The Committee resolved that:** a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 5/9/23/007	**Internal Audit Progress Report** The Head of Internal Audit (HIA) presented the Internal Audit Progress Report and highlighted the following: - 6 out of the 7 audits which were to be presented had not met the deadline due to various delays in the process of formulating the reports; - However, they were making good progress in delivering the plan; - If these reports were not brought regularly through the Committee as planned, it may create a potential backlog to delivery; - An update report would be brought to the Committee in November. The UHB Chair noted concern around the lack of management response, and asked whether the original timescales were reasonable, whether they were resource short, or if the work had not been planned efficiently. The HIA responded that the delays in the reporting process were mostly due to staff being on annual leave over the summer. Action: 1. For Internal Audit/Director of Corporate Governance to follow up and understand why management responses to the reports had been delayed. The CC asked if the Estates Internal Audit would be carried out for every Health Board across Wales. The HIA confirmed that this was correct, and explained that this had also contributed to the delay in the reporting process in the attempt to get a consistent message across NHS Wales. The UHB Chair commented that 'Limited' would be the only likely outcome for Estates across all of the Welsh Health Boards, and he explained that they had	

strict limitations on their capital spend and their ability to deliver high-quality facilities. The UHB Chair highlighted the major backlog in terms of maintenance, and he hoped this would be reflected in the report.

The UHB Vice Chair asked whether the issue around RAAC concrete would need attention.

The HIA responded that this had been highlighted as a potential area of risk across Wales during planning discussions held in January. He confirmed that it would likely feature in the following year's audit reviews.

The EDF added that the Specialist Estates team, on behalf of Welsh Government (WG), were undertaking a review across all of Wales. She provided assurance that CAVUHB were not in a bad position, and that they would not be looking to Internal Audit to do any work at this stage.

The HIA stated that the Recommendation Tracking Audit report had been finalised, and clarified that the assurance rating should read 'Substantial'.

The HIA explained that the graph highlighted the current progress with the delivery of the 2023/24 Internal Audit Plan, and summarised the following:

- One audit had been finalised, and the other four had reached the draft report stage;
- A further 8 audits were in progress, and 13 were at the planning stage and were ready to start work over the next few months;
- Full details of the current year's audit plan were included in Appendix A of the report.

The HIA stated that there had been several changes to the 2023/24 Plan since the previous Committee in July, and highlighted that:

- An advisory piece of work had been requested by the Chief Executive and the UHB Chair around GP Site Evaluation Process. This work was nearly finished, and an update could be provided in the private session;
- Two items were identified for removal and deferral – the ISO Accreditation within ALAC, and the Medicine CB Acute Model / Same Day Emergency Care respectively.

Regarding the Recommendations Tracker Audit, the IDHIA highlighted that:

- The audit was issued with substantial assurance, as substantial work had been undertaken regarding managing the recommendations;
- The Medium finding related to the lack of supporting narrative to close Internal and External Audit recommendations;
- There were two Low findings.

The UHB Chair highlighted in the report that there were discrepancies in the outcomes of completed audit reviews for recommendation, and the IDHIA explained that this was an error and that they should read 'substantial'.

The CC and UHB Chair praised the work undertaken to get to a 'substantial' rating.

The CC commented that they needed further assurance on the draft report on Consultant Job Plans which had a 'Limited' assurance rating, however that this would be discussed in the November A&A Committee.

	The HIA responded that the Surgery Clinical Board had challenged the report, and that they were awaiting sign off from the Clinical Board following discussions. **The Committee resolved that:** 1. The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit report, was considered; 2. The proposed adjustments to the 2023/24 plan were approved.	
AAC 5/9/23/008	**CD&T Clinical Board Update** This item was deferred to the November Committee.	
AAC 5/9/23/009	**Audit Wales Update** Urvisha Perez (UP) presented the Audit Wales Update and highlighted the following: - <u>Financial Audit Work</u> – • 2023/23 Accountability Report and Financial Statements – complete • Audit of Accounts Report Addendum – in progress • 2022/23 Charitable Funds Accounts – planned to start in November 2023 - <u>Performance Audit Update</u> – • Part One of the Unscheduled Care Review and the Review of Workforce Planning Arrangements – both reports were being drafted • Primary Care Services Follow-up Review – in the latter stages of fieldwork • Structured Assessment for 2023 – fieldwork was underway, and interviews would be held throughout September • This year's structured assessment included an examination of the Health Board's wellbeing objectives • Part Two of the Unscheduled Care Review would start shortly • The Deep Dive into Digital, the Planned Care Review, and local work (Follow-up of 2019 Clinical Coding) were in the planning stages. The UHB Chair asked whether UP had received full cooperation from colleagues in the structured assessment interviews. UP confirmed that the interviews were going well. **The Committee resolved that:** a) The Audit Wales Update was noted.	
AAC 5/9/23/010	**Audit Wales Orthopaedic Report and Management Response** UP introduced the report, and highlighted the following: - The local Health Board specific report on tackling the Orthopaedic waiting list backlog had been discussed in the July Audit Committee; - The National report on the Orthopaedic services across Wales was included in the meeting papers; - A completed management response had not been ready for the July Committee;	

- The All Wales summary report made two recommendations for WG, and three for Health Boards. Additionally, the Health Board's local report included suggested Board Member questions.

The MDPC highlighted the three main themes, and summarised that:

- Progress to date on Getting It Right First Time included –
    - Reconfiguration of some elements within the Orthopaedics service post-pandemic was needed to implement all of the GIRFT recommendations - this was now complete.
    - The one outstanding reconfiguration element was the PACU provision at UHL, as the cardiothoracic move back to UHW had been delayed until April 2024. However, a plan had been funded through the Planned Care Response to provide an enhanced recovery area to give PACU provision for Ortho patients in UHL.
    - The GIRFT recommendations formed part of a standard governance process which sat within the individual Directorate for Orthopaedics;
- Progress to date on the Musculoskeletal Service included –
    - A lot of work was required to ensure a standardised approach to physiotherapy and other therapy representations within the sub-sets of Orthopaedics
    - Work was ongoing to develop their health pathways.
    - They needed to finalise putting the MSK Steering Group in place, and it would form a sub-set of the Planned Care Board within the governance structure;
- Progress to date on Patient Outcomes included –
    - A lot of work was being done in the region - their Multi-Disciplinary Teams were in place, the Orthopaedic Infection Lead was in post, work was underway in terms of the Keeping Patients Well workstream (which was being managed through the Planned Care Board), and they had a regular validation process in place post-pandemic.

The IM-CE noted that most of the Health Board's complaints centred around communication, and she asked how well C&V were managing their communication with the patients on the waiting lists.

The MDPC responded that within Orthopaedics they had good systems in place, for example the Keeping Me Well piece and the validation of waiting lists, and that they were continually making improvements.

The IM-CE asked whether they had the resources to support the communication piece.

The MDPC responded that he was confident that within Orthopaedics, that they had sufficient resources to allow for effective communication. However, he stated that he did not know the situation for other waiting lists.

The MDPC added that the following Finance & Performance Committee would include a Deep Dive into the Orthopaedics Waiting List.

The Committee resolved that:

a) The Audit Wales Orthopaedic Report and Management Response was noted.

AAC 5/9/23/011	**Declarations of Interest, Gifts and Hospitality Report** The CARMM introduced the report and highlighted the following: - The previous year, a decision was made to move the Declarations of Interest, Gifts and Hospitality onto ESR – since then, they had seen an increased number of employees responding; - At the time of the report, they had received 4267 declarations, and as at 01.09.2023, the number had increased by 175; - This was due to the targeted emails sent to Bands 8-9 who were perceived to be decision-makers – they saw a 50-60% return rate on Declarations, and the percentage of those who had not responded previously had reduced from 21% to 12%; - There was still work to do on other bandings – 63% of Bands 7s had not made a Declaration, and this would continue as a work in progress. The IM-TU highlighted a lack of access or opportunity to log onto ESR via computers at work, and he asked what the plan was around tackling this. The CARMM responded that Comms had been sent out, and that staff who accessed their payslips via ESR would be able to submit a Declaration. He highlighted that it would be important to communicate to staff that the process took a matter of seconds. The CC and the IM-TU commented that many staff within the lower bands did not access their payslips via ESR, and so it would be beneficial to have an alternative format to submit Declarations. The CC asked what other Health Boards were doing to tackle the barriers to lower bands submitting Declarations. The CARMM explained that they had focused on the higher bands due to them being deemed as decision-makers which would impact the care of a patient. The UHB Chair asked whether the submission of a Declaration was a requirement through their governance standing orders for all staff, or whether they should just target their efforts on specific staff. The DCG added that there was no standing order or financial instruction requirement, however broader policies were involved. He added that he would look into how to tackle this effectively. The DDPC offered the support of the ESR team, and added that there was an access and understanding/education issue amongst staff. The CARMM presented a table to the Committee which illustrated all of the Declarations made by staff to date. **The Committee resolved that:** a) The ongoing work being undertaken within Standards of Behaviour was noted; b) The proposals to improve Declaration of Interest reporting across the Health Board was noted.	
AAC 5/9/23/012	**Single Tender Actions** The EDF presented the report, and summarised the following:	

	- The table on Breach activity year-on-year was highlighted, and that the breaches were commensurate with the work undertaken on the Improvement Plan; - They would continue to have breaches whilst they work through what was eligible for procurement onto the Procurement system – Claire Salisbury would provide an update at the following Committee on progress with their Improvement Programme; - The number of STA/SQA's by Department had started to reduce; - They hoped that they had reached the peak of their non-compliant activity, and that activity would settle at a new lower level. The CC asked what "the service did not engage with Procurement" meant, when given as a reason for non-compliance. The EDF responded that there were a variety of reasons as to why a service did not engage. She explained that their Improvement Programme would identify learning and issues around the procurement process, it would ensure that they used the catalogues available, and that they bought at scale. The IM-CE asked how straightforward the process was for a service to engage with Procurement. The EDF responded that she did not think that resource constraints were the issue, and that the system and process usually worked really well. The UHB Vice Chair asked for assurance about the carbon footprint sustainability issue within procurement. The EDF responded that foundation economy and decarbonisation formed part of the decision-making process routinely pulled into Procurement. She highlighted that Claire Salisbury, who was their Head of Procurement and National Lead, also worked on these areas on behalf of Shared Services and WG. She added that where there were opportunities to source products and work with companies more locally, they would do so if it made sense financially. The UHB Chair asked if they used their scheme of delegation appropriately. The EDF suggested that more training and education needed to be done around the procurement process. She highlighted that the reason behind the large number of STA/SQA's for Clinical, Diagnostics and Therapies was that they did not always consider the maintenance and consumables within the purchase of big equipment – however, they had started Whole-Life Procurement which should reduce the number of STA's over time. **The Committee resolved that:** 1. The contents of the Report was noted; 2. The contents of the Report was approved/agreed.	
AAC 5/9/23/013 	**Counter Fraud Progress Report** The LLCFS introduced the report for the period of 17.06.2023 to 18.08.2023, and summarised the following: - Work continued on Promotion and Awareness and Educational Activity – • Their first Corporate induction event would take place in October • The webinar events continued	

	• The E-Learning package went live in April – up until the end of July, 15 staff from C&V had completed the module, largely due to the fact that this training was not mandatory. They continued to explore how this could be improved; - There had been a high level of referrals received – • 25 total referrals were received during this period, of which 15 were promoted to a formal investigation. • They continued to receive a high volume of salary-overpayments that fit within the criteria of those reported to counter-fraud • It was positive that people were aware of the Counter-Fraud team - Work continued on the National Fraud Initiative, and they had not yet found any matches of concern to the organisation; - 3 Fraud Risk Assessments related to the dishonest retention of salary overpayments, working elsewhere (remote/agile working), and a specific incident which related to a post-investigation on an automated medicine cabinet in a GP OOH. Detail for these incidents would be provided in the Private Committee session. Regarding salary overpayments, the CC asked whether non-fraud recovery meant that a full repayment had been made to the Health Board. The LLCFS responded that this was relatively new and that it was protocol from the Counter-Fraud Authority (CFA). He noted that if an employee agreed to repay the monies it would be treated as a civil recovery/non-fraud recovery, which still had to be reported to the CFA. The CC asked for a piece of work to be undertaken to identify the number of salary-overpayment incidents which occur, which could be presented to the Public Audit & Assurance Committee. <u>Action:</u> 1. To provide information on how many salary overpayments had come through to the Counter Fraud team (GL) The DDF-O highlighted that this was a sub-set of the overpayments, and that the vast majority of overpayments were administrative errors and were recovered through normal processes. **The Committee resolved that:** a) The Counter Fraud Progress Report was noted.	
AAC 5/9/23/014	**Overpayment of Health Board Salaries** The DDPC introduced the report, and highlighted the following: - They worked closely with finance colleagues, and they had established that approx. 80% of the overpayments were recovered over an agreed period of time - The focus of the team was on prevention - They had sent out communications on a regular basis to managers to remind them of their requirements in filling out termination forms, staff changes, and recording staff sickness. - They had spoken with Clinical Boards to ensure individuals had the right support - Shared Services had recently launched a live dashboard to track month-on-month where overpayments were happening, and what the cost was. They wished to track the improved progress throughout the year.	

	- The DDPC anticipated that within the next month they could bring data into the Private A&A Committee. The UHB Chair commented that figures were needed in the report to provide assurance to the Board that they were managing the situation. The DDF-O responded that they had only recently started to receive data from the dashboard, and that more time was needed to decipher a trend. He added that broadly the trend was around £1.8m of overpayments, of which they recovered around 85-90% of that. The EDF suggested that they needed to monitor the recovery of the old historic overpayments, as well as to monitor the new. The UHB Chair noted caution around data protection and the sharing of names of staff within the dashboard. However, he suggested that they could create a separate version of the dashboard for the public session. The DDF-O confirmed that the dashboard did share individual's information, and so it would have to be shared in a future Private Committee session. **The Committee resolved that:** a) The contents of the Overpayment of Salary Update report was noted.	
	Items for Approval / Ratification	
AAC 5/9/23/015	No items for approval or ratification.	
	Items for Information and Noting	
AAC 5/9/23/016	**Internal Audit reports for information:** The CC highlighted the two papers for noting: i) Internal Audit Reports for Information ii) Recommendation Tracking – Substantial Assurance **The Committee resolved that:** a) The final Internal Audit reports were noted.	
AAC 5/9/23/017	**National Fraud Initiative Self-Appraisal Checklist 2020-21 report** UP explained that the checklist had been completed and that the paper was just for information. **The Committee resolved that:** a) The National Fraud Initiative Self-Appraisal Checklist 2020-21 report was noted.	
AAC 5/9/23/018	**Agenda for Private Audit and Assurance Committee** *i. Counter-Fraud Progress Update (Confidential – ongoing investigations)*	
AAC 5/9/23/019	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	

AAC 5/9/23/020	**Items to be deferred to Board / Committee** No items were deferred to Board / Committees.	
AAC 5/9/23/021	**Date and time of next committee meeting** Tuesday 7th November at 2pm via MS Teams	

Public Action Log
Following Audit & Assurance Committee Meeting
5 September 2023
(Updated for the Meeting 7 November 2023)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
AAC 4/7/23/010	Declarations of Interest, Gifts and Hospitality Report	Essential to ensure that the decision makers provided nil returns in order to have assurance of their interests.	Aaron Fowler	**September 2023**	**COMPLETED** Updates continue to be shared at each committee meeting with a focus on all decision makers at band 8a and above.
AAC 4/7/23/011	Internal Audit Recommendation Tracker Report	A detailed review of the internal tracking process was being completed.	Internal Audit	**September 2023**	**COMPLETED Updated in September**
AAC 4/7/23/009	Audit Wales Orthopaedic Report	The extent to which patients were managed whilst on the waiting list could influence outcomes and should be factored into the report and considered.	Audit Wales	**November 2023**	**COMPLETED** Audit Wales Recommendation Tracker
AAC 5/9/23/007	Internal Audit Progress Report	To follow up and understand why management responses have been delayed.	Matt Phillips/ Internal Audit	**November 2023**	**COMPLETED Update in November 2023**
Actions in Progress					
AAC 7/2/23/007	Internal Audit Progress Report	Follow up audit report in relation to the Medical Records Tracking (CD&T Clinical Board) to be brought to Committee at a later date.	Internal Audit	**TBC (awaiting response from Internal Audit)**	**Emailed Internal Audit to request a date when this will be brought to the Committee.**

AAC 4/7/23/007	Follow up Audits	To build in-between projects to ensure that they have followed all the right governance.	Ian Virgil	**November 2023**	**Update in November 2023**
AAC 4/7/23/014	Updated Policies Plan	Update on the Plan be brought to the Committee.	Matt Phillips	**November 2023**	**Update in November 2023**
AAC 5/9/23/014	Counter Fraud Progress Report	To provide information on how many salary overpayments have come through to the Counter Fraud team.	Gareth Lavington	**November 2023**	**Update in November 2023**
Actions referred to Board / Committees					
AAC 4/7/23/009	Deep Dive Orthopaedics Waiting Lists	Deep dive on how patients are managed whilst on the Orthopaedics Waiting List.	Paul Bostock	**September 2023**	**COMPLETED** *Added to Finance and Performance (F&P) Action log F&P Committee updated on 20.09.23*
AAC 4/7/23/013	Regulatory Compliance Tracking Report	Some of the Patient Safety Solutions had been on the tracker for some time and should be taken to a future Quality, Safety & Experience (QSE) Committee meeting to provide assurance.	Aaron Fowler	**October 2023**	**Added to QSE Action Log**

Report Title:	**Internal Audit Progress Report**					Agenda Item no.	2.1
Meeting:	Audit & Assurance Committee		Public	X		Meeting Date:	07/11/23
			Private				
Status *(please tick one only):*	Assurance	X	Approval			Information	
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Head of Internal Audit						

Main Report

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 the Audit & Assurance Service is in accordance with its annual plan, which is prepared following a detailed planning process, including consultation with the Executive Directors, and is subject to Audit & Assurance 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 engagement process established with the UHB.

The 2023/24 plan was formally approved by the Audit Committee at its April 23 meeting.

The progress report provides the Audit & Assurance 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.

Appendix A of the progress report sets out the Internal Audit plan as agreed by the committee, including commentary as to progress with the delivery of assignments.

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

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

The following reports have been finalised since the September 23 meeting:

- Refresh of the Health Board's Strategy - (Substantial Assurance)
- Urgent and Emergency Care – Welsh Government Six Goals Programme – (Substantial Assurance)
- PARIS System – (Reasonable Assurance)
- Follow-up: Chemocare IT System – (Reasonable Assurance)
- Surgery CB - Consultant Job Plans – (Limited Assurance)
- Leadership and Management Training and Development (Advisory)
- Quality, Safety & Experience Governance (Advisory)

Recommendation:

Saunders.Nathan 06/11/2023 11:21:06

The Audit & Assurance Committee are requested to:

- **Consider** the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit report.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	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	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term	X	Integration	x	Collaboration	x	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/~~No~~
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.
Safety: Yes/~~No~~
The progress report provides an update on the delivery of the Internal Audit plan for 2022/23, which includes an audit that provides assurance around controls and processes relating to patient safety.
Financial: ~~Yes~~/No
Workforce: Yes/~~No~~
The progress report provides an update on the delivery of the Internal Audit plan for 2022/23, which includes audits that provide assurance around controls and processes relating to workforce.
Legal: ~~Yes~~/No
Reputational: Yes/~~No~~
The progress report provides an update on the delivery of the Internal Audit plan for 2022/23, which includes a final audit which provides assurance around reputational risks.
Socio Economic: Yes/~~No~~

The progress report provides an update on the delivery of the Internal Audit plan for 2022/23, which includes an audit which provides assurance around socio economic issues.	
Equality and Health: ~~Yes~~/No	
Decarbonisation: ~~Yes~~/No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee November 2023

NWSSP 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 2023/24 Internal Audit plan.

The report includes details of the progress made to date against individual assignments along with details regarding the delivery of the plan and any required updates.

The plan for 2023/24 was agreed by the Audit & Assurance Committee in April 2023 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 November Audit Committee but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
Estates Assurance – Estate Condition	Draft Report	Limited	Delay in agreeing draft report and receiving management responses.
Shaping Our Future Wellbeing – Future Hospitals Programme	Draft Report	Advisory	Delay in agreeing draft report and receiving management responses.
Implementation of Health Roster System	Draft Report	Limited	Requirement for additional fieldwork. Draft being reviewed by management.
Mental Health Clinical Board Governance	Draft Report	Reasonable	Delay in agreeing scope and meeting management to progress fieldwork.
Mortality Reviews	Fieldwork		Delay in agreeing scope and meeting management to progress fieldwork.
Alcohol Standards	Fieldwork		Delay in progressing fieldwork.

3. Outcomes from Completed Audit Reviews

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

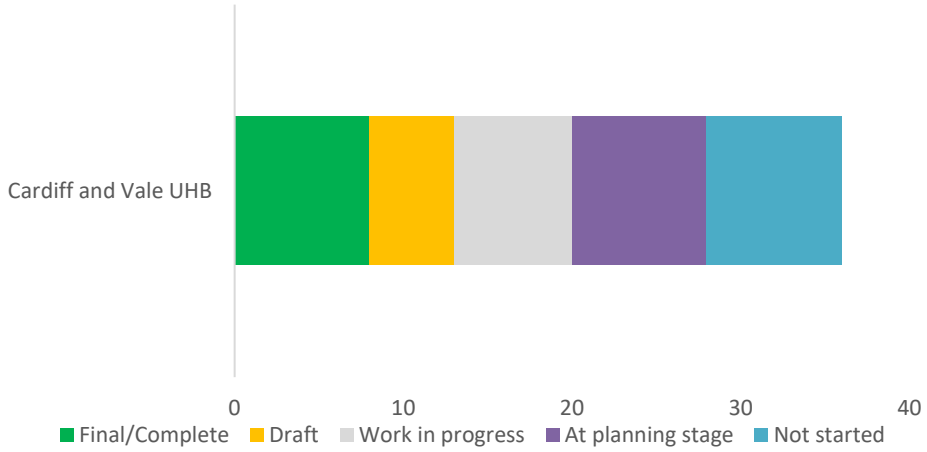
The Executive Summaries from seven of the final reports are provided in Section six. The full reports are included separately within the Audit Committee agenda for information.

The final report for the advisory audit of the Pentyrch Surgery Development – Site Evaluation Process is included within the private committee papers due to the sensitive nature of the subject matter.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Refresh of the Health Board's Strategy	Substantial	
Urgent and Emergency Care – Welsh Government Six Goals Programme		
PARIS System	Reasonable	
Follow-up: Chemocare IT System		
Surgery CB - Consultant Job Plans	Limited	
Pentyrch Surgery Development – Site Evaluation Process	Advisory	
Leadership and Management Training and Development		
Quality, Safety & Experience Governance		

4. Delivery of the 2023/24 Internal Audit Plan

There are a total of 36 reviews within the 2023/24 Internal Audit Plan, and overall progress at this stage of the year is summarised below.



The graph above illustrates that eight audits from the 2023/24 plan have been finalised so far this year and five others have reached the draft report stage.

In addition, there are seven audits that are currently work in progress with a further eight 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 A also includes details of the three audits from the 2022/23 plan that had not been sufficiently progressed to be included within the Head of Internal Audit Opinion for 2022/23. The outcomes from these audits will feed into the 2023/24 Opinion.

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 (KPI).

5. Final Report Summaries

6.1 Refresh of the Health Board's Strategy

Purpose

Review of the Health Board's approach in undertaking engagement with all stakeholders to inform the development of the refreshed 10-year strategy.

Overview

We have issued substantial assurance on this area.

The matter requiring management attention include:

- The risk register did not have the required fields completed and updates were not reflected within it.

Report Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Assurance summary

	Objectives	Assurance
1	There is a Health Board framework which sets out the approach in ensuring the application of good and effective public engagement practice	Substantial
2	A stakeholder engagement programme plan is in place which sets out the approach for how the engagement is to be conducted and a timetable for the refresh of the Health Board's Strategy	Substantial
3	Key stakeholders have been adequately identified and continuously involved in the engagement process of refreshing the Health Board Strategy	Substantial
4	Results/ outcomes of public engagements undertaken are assessed and incorporated to inform the refreshed Health Board's Strategy	Substantial
5	There are appropriate governance arrangements, which provide effective oversight of the stakeholder engagement process for the refresh of the Health Board's Strategy	Substantial
6	Risks relating to stakeholder engagement are appropriately considered and monitored	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Format and updating of the risk register	6	Operation	Medium

6.2 Urgent and Emergency Care – Welsh Government Six Goals Programme

Purpose

The overall objective of our audit was to review the development of controls and actions relating to the governance arrangements for the implementation of the Welsh Government 'Six Goals for Urgent and Emergency Care' Programme.

Overview

We have issued substantial assurance on this area.

The Health Board has developed robust governance arrangements around the on-going implementation of the Six Goals Programme, including an overarching Delivery Board and four Workstream Project Groups.

The governance arrangements facilitate effective and regular monitoring and reporting of progress towards delivery of the Programme, and management and mitigation of key Programme risks.

We have identified two low priority recommendations which are detailed within Section 2 and Appendix A of the report.

Report Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Assurance summary[1]

	Objectives	Assurance
1	The Health Board's four Workstreams effectively align with the aims of the Welsh Government's 'Six Goals for Urgent and Emergency Care'	Substantial
2	The Health Board has appropriate governance arrangements in place for the four Workstreams	Substantial
3	Active monitoring and reporting on progress delivery for the stated priorities within each Workstream	Substantial
4	Sharing of progress and learning is being undertaken between the four Workstreams	Substantial
5	Risks in relation to delivery of the four workstreams have been identified and are being monitored	Substantial

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

6.3 Paris System

Purpose

The overall objective of the audit was to provide the Health Board with assurance that data held within the system is accurate, secure from unauthorised access and loss, and that the system fits the needs of the service.

Overview

We have issued reasonable assurance on this area. The matters requiring management attention include:

- The Civica Service Report is not fully developed or being received regularly.
- The monthly leavers report from the IT Security team is no longer being received.
- The criteria for locking down dormant accounts is in need of review.
- System back-ups are presently being stored with the servers.

Other recommendations / advisory points are contained within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Governance & change management	Reasonable
2	Database controls	Substantial
3	Application controls	Reasonable
4	Data input	Substantial
5	Outputs, alerts, reports & interfaces	Reasonable
6	Audit log	Substantial
7	BCP and disaster recovery	Limited

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Civica Service Report	1	Operation	Medium
2	Dormant Accounts	3	Operation	Medium
3	Leavers Report	3	Operation	Medium
6	System Back-ups	7	Operation	High

6.4 Follow-up: Chemocare IT System

Purpose

To provide the Health Board with assurance regarding the implementation of the agreed management actions from the Chemocare IT system (2122-21) review that was reported as part of our 2021/22 work programme.

Overview of findings

Good progress has been made in addressing the recommendations contained within the original report.

The system has been upgraded to version 6, and as part of this the database and servers have been upgraded to a newer, more secure version.

There are enhanced controls in place for user access and training is fully recorded.

We note that two items are still in progress. The first relates to the development of a Business Continuity plan, which by necessity required the upgrade to be completed and changes to operating procedures made first. The second relates to implementing an automated alert process in the event of interface failures.

The two on-going recommendations will be monitored via the Health Board's Internal Audit Recommendation Tracker until fully complete.

Saunders.Nathan 06/11/2023 11:21:06

Follow-up Report Classification

		Trend
Reasonable 	**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.	⇧

Progress Summary

	Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Performance Monitoring	Medium	⇧	Closed
2	Database Security	High	⇧	Closed
3	User Training Logs	Low	⇧	Closed
4	User Management	Medium	⇧	Closed
5	Password Controls	Medium	⇧	Closed
6	Interface Failure Alerts	Medium	⇔	Medium
7	Hosting and Backup Agreements	Medium	⇧	Closed
8	Business Continuity Plan	Medium	⇔	Medium

6.5 Surgery CB - Consultant Job Plans

Purpose

The purpose of our audit is to provide assurance to the Board that there are effective arrangements in place to manage the risks associated with consultant job planning within selected areas of the Surgery Clinical Board.

Overview

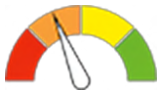
We have issued limited assurance on this area. The significant matters which require management attention include:

- Not all job plans were on the Allocate e-job planning system.
- All job plans were out of date or not agreed and fully signed off.
- No evidence to confirm additional approval of job plans with over 12 sessions per week.
- Personal outcomes were not being recorded.
- The monitoring of the delivery of agreed sessions is not being done, or not being evidenced.
- Annual reviews are not being undertaken when due.

Further matters arising concerning the areas for refinement and further development have also been noted in Appendix A.

Report Opinion

Limited



More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	All consultants have up to date, agreed job plans in place	Limited
2	Job plans include personal outcomes that are linked to the HB's objectives	Limited
3	There is effective monitoring to ensure planned sessions are being delivered	Reasonable
4	Job Plans are reviewed annually or more frequently if circumstances change	Limited
5	Team job plans are used where appropriate	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Job plans not on Allocate for all consultants	1	Operation	Medium
2	Job Plans out of date or not signed off	1	Operation	High
3	Approval of Additional Sessions	1	Operation	Medium
4	Recording of Personal outcomes	2	Operation	High
5	Monitoring of delivery of agreed sessions	3	Operation	Medium
6	Annual Reviews	4	Operation	High

6.6 Leadership and Management Training and Development

Purpose

An advisory review of the on-going work to develop leadership and management training and development within the Health Board.

Overview

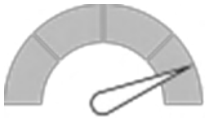
This is an advisory review to support management, rather than an assurance report, we therefore offer no assurance rating.

In contrast to internal audit recommendations, which address the design and operation of the control environment we propose opportunities that the Health Board may wish to take forward. The opportunities outlined in this report (see Appendix A), if taken forward will help to enable the Health Board to further the strategic and managerial oversight and delivery of leadership and management training and development across the Health Board.

Whilst there are strategic intentions in place to support the delivery of leadership and management training and development, these are not fully formalised. Once finalised they should be actualised and delivered through a formal project management-based approach that engages with Clinical Boards and is sufficiently resourced accordingly.

Report Classification

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.

Advisory Audit Objectives

Our review sought to ascertain and evaluate if:

1	The Health Board develops a Leadership Development Framework following engagement with staff and management.
2	Project management processes and plans are in place for the design, instigation and delivery of Leadership Development and Management Programmes, in line with the Leadership and Culture Plan 2022-2025 and principles of compassionate leadership.
3	Suitable resources have been identified to ensure delivery of the Programmes.
4	Engagement and planning is undertaken with Clinical Board senior management to ensure awareness of Leadership and Management Programmes.
5	There are appropriate completion rates of the Programmes and attendees are providing user feedback.
6	The Leadership and Management Programmes are being appropriately evaluated to ensure their aims and objectives are being achieved.
7	Monitoring and Progress Reporting to the People and Culture Committee and Board.

Opportunities:		Audit Objective
1	Leadership Framework outlines the leadership and management training strategic objectives in alignment with Health Board IMTP.	1

2	Future Programmes should be planned and implemented via a project management methodology ensuring engagement across all Clinical Boards.	2
3	Future leadership and management programmes are appropriately funded to attract qualified and experienced staff and expedite effective course delivery.	3
4	Clinical Boards should be engaged with regularly to ascertain what future courses/programmes can be provided based upon their respective staff needs.	4
5	The level of uptake of Programmes across the Clinical Board's Directorates should be identified and used to target areas to maximise awareness and promotion of the leadership and management courses available.	4
6	When Education, Culture & Organisational Development (ECOD) staff capacity allows, student progress updates should be periodically submitted to line management.	5
7	Consideration should be given to introducing measures to improve student feedback returns and reasonably implementing suggestions and any identified 'lessons learned'.	5
8	Implement a teaching checklist that assists in ensuring that each programme set of learning objectives are being met, and periodically evaluate current programme objectives to ensure that they meet student needs.	6
9	Continuation of benchmarking with other Health Bodies to ascertain other approaches and practices and adopt shared learning of best practice where appropriate and applicable.	6
10	Progress reporting to the People and Culture Committee relating to the work being undertaken on the Leadership Framework and the Leadership/ Management training programmes should be provided.	7

6.7 Quality, Safety & Experience Governance

Purpose

This was an advisory review of the Health Boards Quality & Safety Governance arrangements and any supporting implementation programmes to ensure compliance with the requirements set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Overview

This is an advisory review to support management, rather than an assurance report, and no assurance rating is provided.

In contrast to internal audit recommendations, which address the design and operation of the control environment we propose opportunities that the Health Board may wish to take forward. The opportunities outlined in this report (see Appendix A), if taken forward will help to enable the Health Board to further embed the Quality, Safety and Experience Framework across the Health Board.

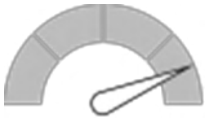
The Quality and Engagement Act came into force on the 1st April 2023 which placed a Duty of Quality on all Welsh Health Boards and included a requirement to report on this duty, at least annually.

To support their compliance with this Act the Health Board adopted a Quality safety and Experience Framework 2021 – 2026 in September 2021.

We consider that good progress has been made in implementing the QSEF and placing quality at the heart of patient care but acknowledge that quality processes and controls will always be subject to opportunities for improvement and evolutionary change.

Report Opinion

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.

Advisory Audit Objectives

Our review sought to ascertain and evaluate if:

1	The 'Quality Governance Priority' set out within the Quality, Safety and Experience Framework (2021 – 2026) is being taken forward by the Health Board.
2	The Quality, Safety and Experience Committee is kept informed of progress of implementing the Quality, Safety and Experience Framework (2021 – 2026) and any issues are highlighted for scrutiny.

Opportunities:		Audit Objective
1	Establishment of the Organisational Learning Committee	1
2	Reviewing and updating the Clinical Effectiveness Committee and Clinical Safety Group TOR	1

ASSIGNMENT STATUS SCHEDULE

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2022/23 Plan							
Surgery CB - Consultant Job Plans		COO			Final Report	Limited	November
Shaping Our Future Wellbeing – Future Hospitals Programme		*Finance*			*Draft Report*	*Advisory*	*February*
Medical Staff Additional Sessions		Medical			Planning (Final brief issued)		February
2023/24 Plan							
Recommendation Tracking	6	Corporate Governance	Q1		Final Report	Substantial	September
Leadership and Management Training and Development (Advisory)	10	People & Culture	Q1		Final Report	Advisory	November
Refresh of the Health Board's Strategy	18	Strategic Planning	Q1		Final Report	Substantial	November
Quality, Safety &Experience Governance (Advisory)	28	Nursing / Medical	Q1		Final Report	Advisory	November
ChemoCare IT System Follow-up	36	Digital & Health Intelligence	Q1		Final Report	Reasonable	November
Paris System	12	Digital & Health Intelligence	Q2		Final Report	Reasonable	November
Urgent and Emergency Care – Welsh Government Six Goals Programme	22	COO	Q2		Final Report	Substantial	November
Pentyrch Surgery Development – Site Evaluation Process	37	Chief Executive	Q2		Final Report	Advisory	November

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Estates Assurance – Estate Condition	4	Finance	Q1		Draft Report	Limited	February
Mental Health Clinical Board Governance	24	COO	Q1		Draft Report	Reasonable	February
Capital Systems	3	Finance	Q2		Draft Report	Reasonable	February
Implementation of Health Roster System	9	People & Culture	Q2/3		Draft Report	Limited	February
Financial Management within Clinical Boards	2	Finance	Q2		Work in Progress		February
Technical Continuity	13	Digital & Health Intelligence	Q2		Work in Progress		February
Alcohol Standards	21	Public Health	Q2		Work in Progress		February
PCIC CB Governance	25	COO	Q2		Work in Progress		February
Patient Safety Incident Management	29	Nursing	Q2		Work in Progress		February
Mortality Reviews	33	Medical	Q2		Work in Progress		February
Core Financial Systems	1	Finance	Q2/3		Planning (Final brief issued)		February
Information Governance	14	Digital & Health Intelligence	Q3		Planning (Final brief issued)		February
Payroll Costs	7	People & Culture / Finance	Q3		Planning (Draft brief issued)		April
Cyber Security Follow-up	15	Digital & Health Intelligence	Q3		Planning		April

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
IMTP Development Process	16	Strategic Planning	Q3		Planning		April
Business Continuity Planning	17	Strategic Planning	Q3		Planning		April
Cancer Services	23	COO	Q3		Planning (Final brief issued)		April
Medical Records Tracking (CD&T) Follow-up	27	COO	Q3		Planning (Draft brief issued)		April
Infection Prevention & Control	30	Nursing	Q3		Work in Progress		April
Risk Management / Board Assurance Framework	5	Corporate Governance	Q4				April
Implementation of People & Culture Plan	8	People & Culture	Q4				April
Performance Reporting	11	Digital & Health Intelligence	Q4				April
Maternity Care – Ockenden Review	31	Nursing	Q4				April
Management of Health Board Policies Follow-up	35	Nursing	Q4				April
Decarbonisation	19	Strategic Planning	TBC				TBC
Shaping Our Future Hospitals Programme	20	Strategic Planning	TBC				TBC
Development of Integrated Audit Plans:							
• *UHL – Endoscopy Unit Development*	*34*	*Strategic Planning*	*Q2*		*Draft Report*	*Reasonable*	*February*
• *UHW – Vascular Hybrid Theatre & MTC Theatre*	*37*	*Strategic Planning*	*TBC*				*TBC*

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Reviews removed from the plan							
ISO Accreditation within ALAC	32	Therapies	~~Q1~~	Q2	The external accreditation review has been completed with a positive outcome, so no value in completing our planned audit. Removal agreed with the Director of Therapies and Health Science. To be agreed by September AC.		
Medicine CB – Acute Model / Same Day Emergency Care	26	COO	Q3		The COO requested deferral to Q1 of the 24/25 plan to allow further time for the developments to be embedded. To be agreed by September AC.		

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Recommendation Tracking	Substantial	Final	25/07/23	15/08/23	11/08/23	11/08/23	G
Pentyrch Surgery Development – Site Evaluation Process	Advisory	Final	08/09/23	29/09/23	21/09/23	21/09/23	G
Leadership and Management Training and Development	Advisory	Final	21/09/23	12/10/23	02/10/23	03/10/23	G
Refresh of the Health Board's Strategy	Limited	Final	29/09/23	20/10/23	06/10/23	09/10/23	G
PARIS System	Reasonable	Final	28/09/23	19/10/23	02/10/23	09/10/23	G
Quality, Safety & Experience Governance	Advisory	Final	17/08/23	8/09/23	12/10/23	13/10/23	R
Urgent and Emergency Care – Welsh Government Six Goals Programme	Substantial	Final	12/10/23	22/11/23	19/10/23	19/10/23	G
Follow-up: Chemocare IT System	Reasonable	Final	26/09/23	17/10/23	23/10/23	24/10/23	R

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2023/24	G	April 2023	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 2023/24	A	86% 12 from 14	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	92% 11 from 12	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	75% 6 from 8	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 8 from 8	80%	v>20%	10%<v< 20%	v<10%

Assurance Ratings

	**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.

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Maes y Coed Road
Cardiff
CF14 4HH.

Contact details
Ian Virgill (Head of Internal Audit) - ian.virgil@wales.nhs.uk

Report Title:	Progress Report: Audit Report on Medical Records Tracking					Agenda Item no.	2.2
Meeting:	Audit & Assurance Meeting		Public	X		Meeting Date:	07/11/2023
			Private				
Status *(please tick one only):*	**Assurance**	**Y**	Approval			Information	
Lead Executive:	Chief Operating Officer						
Report Author (Title):	Head of Business Development, CD&T						

Main Report
Background and current situation:

In January 2023, the Internal Audit Report on Medical Records Tracking was finalized. It concluded that there was 'Limited Assurance' with regards the effectiveness of the mechanisms for tracking medical records; within and external to the Health Records department.

The audit outlined seven recommendations. There has been significant progress undertaken against these. Of the four **'High'** priority recommendations, two have been completed, with two in progress. Further details are provided below:

Recommendation R1/ 7: The Health Board's Records Management Policy (UHB 142 v3) and Procedure (UHB 326 v2) require review.

Priority: High

Agreed Management Action: *Review of The Health Board's Records Management Policy (UHB 142 v3) and Procedure (UHB 326 v2) will be undertaken to reflect subsequent changes in national and local legislation and guidance, as well as operational practice, with view to updated versions being approved and available to Health Board teams and employees.*

Status: COMPLETED

Assurance: The Health Board's Records Management Policy has been updated and taken to the Digital & Health Intelligence Committee (15.08.23). The Records Management Policy was ratified and the supporting procedure approved.

Recommendation R3/ 7: Management should consider viable options to address the issues identified through our observations of security and storage arrangements of Health Records.

Priority: High

Agreed Management Action: *The department will develop a Security and Storage action plan addressing all points outlined. The plan will detail which elements the department is responsible for delivering and those requiring Clinical Board or Health Board support e.g. those requiring capital works. It will be submitted to the Clinical Diagnostics & Therapeutics Clinical Board, with review, support and oversight through its Quality, Safety and Patient Experience Sub-Committee programme.*

Status: COMPLETED

Assurance: A 'Security & Storage' action plan relating to the Health Records department has been developed and approved by CD&T Clinical Board.(15.03.23). Almost all actions have been completed or progressed, including key improvements resulting in the restricted access of all filing libraries except to designated departmental staff, and the acquisition of additional off-site storage capacity. The latter has enabled the department to move more of its areas to Location Based Filing

and stand up plans for full transition to this storage approach. Furthermore, daily environment audits have been instituted, ensuring key security and operational requirements are met and sustained; in turn addressing several of the actions outlined. Key maintenance and estate issues have been identified, with work either completed or planned.

Recommendation R5/7: Management should ensure staff are reminded of their responsibilities to return health records once used and the importance of updating PMS or PARIS following a change in location.

Priority: **High**

Agreed Management Action: *This will be taken forward as part of Agreed Management Action 4, specifically in relation to point 4 of Matters Arising 4. Departmental (Health Records), reinforcement of correct processes and good practice related to storage of medical records, will be undertaken prior to this.*

Status: **IN PROGRESS**

Assurance: The reinforcement of correct processes and good practice related to the storage of medical records within the Health Records department has been undertaken by the Head of Health Records, forming a key part of R4/7. As part of an impact assessment of delivering fully restricted filing libraries - which will include an accompanying customer survey - the importance of tracking records at all points of delivery and transfer will be highlighted. The impact assessment will also include internal and external tracking audits; on a sample basis. The results will be shared with Clinical Boards and for onward discussion at QSE meetings.

Recommendation R2/7: In alignment with the review of the Records Management Policy and Procedure, the governance arrangements should be redesigned to provide effective oversight of the tracking of health records, to ensure there is a line of sight to the accountable executive of the policy and procedure.

Priority: **High**

Agreed Management Action: *The Health Board has a monthly Information Governance Sub-group chaired by the SIRO and attended by senior leaders including the Medical Director. Matters relating to the tracking of medical records can be escalated there. The group is linked to the Digital and Health Intelligence Committee (formerly the Information Governance Sub-Committee), and as such relevant points and actions will be raised accordingly at organisational governance fora. It is acknowledged that the mechanism for receiving points of escalation is often responsive in nature. Review of current governance arrangements related to medical records management will be undertaken with recommendations made, and subsequently enacted, to ensure a clearer line of sight to the accountable executive of related policy and procedures and related Heath Board.*

Status: **IN PROGRESS**

Assurance: The redesign of governance arrangements for effective oversight of the tracking of medical records, led through the Information Governance Sub-group, will see an adapted version of the Medical Records management Group (MRMG) reinstated and chaired by the Medical Director. This is now anticipated to recommence in quarter 4 of 2023/24.

Recommendation R4/7: Management should formally track progress of taking forward lessons learnt to mitigate the risk of known issues recurring and to assist in identifying barriers that can be escalated for resolution.

Priority: Medium

Agreed Management Action: *A Health Board 'Tracking of Medical Record Learning and Improvement Proposal' will be developed. This will incorporate the points outlined in the Ombudsman response November 2021. Learning and progress on improvement will be assessed through Clinical Board's Quality, Safety & Patient Experience meetings, with further oversight via the Health Board's Patient Experience function and governance structures, as well as the enhanced governance structures subsequently clarified through the delivery of recommendation 2.*

Status: IN PROGRESS

Assurance: Formally tracking lessons learnt and the metrics related to them will align within QSE agendas, with specific oversight via the proposed MRMG. Implementation of the scanning of medical records related to concerns and the full restriction of access to Health Records filing library staff only (05.6.23), outlines demonstrable actions taken to address issues identified through learning exercises

Recommendation R6/7: Management should consider enhancing the operational efficiency and effectiveness to track medical records, based on our findings associated with the alternative filing systems in use, the indexing of records, the inconsistencies between UHL and UHW, and random spot checks on locations

Priority: Medium

Agreed Management Action: *The department will revise its related local Standard Operating Procedures to ensure consistency of practice across sites, particularly in relation to the points outlined. Emphasis will be placed on regular sample location and tracking checks and hierarchy of actions depending on findings. A specific plan to complete the progress made towards a universal filing system (location-based tracking), will be developed. This will link to the Security and Storage action plan aligned to Recommendation 3.*

Status: IN PROGRESS

Assurance: Operational efficiency and effectiveness has been improved via the sharing of tracking techniques, with standard operating procedures being revised accordingly. With the full restriction of Health Records filing libraries achieved, work has begun to switch the remaining areas to Location Based Filing; Filing Library 4 UHW and the adjacent overflow room. As a part of this transition, filing library staff have access to more hardware to track records in-situ, significantly reducing filing time and reducing the risk of tracking errors. Sample tracking audits (spot checks), will form part of the impact assessment related to fully restricted filing libraries and be part of audit cycles.

Recommendation R7/7: Following the implementation of recommendations 1 and 2 within this report, consideration should be given by management and the relevant governance forums of how the known barriers to digitisation can be addressed, if the Health Board aspires to digitise Health Records.

Priority: Low

Agreed Management Action: *An assessment and proposal document will be created outlining known and potential barriers to digitisation and how they can be addressed, linking to current Health Board strategies and programmes, and specifically to national and organisational Digital work plans and schemes.*

Status: IN PROGRESS

Assurance: The digitisation of records is incorporated into the digital strategy roadmap, reviewed through the newly established Digital Advisory Board, with oversight through Senior Leadership Board. In recent months, the Board have been provided by the Director of Digital & Health Intelligence, with an overview of Digital & Health Intelligence plans; this following various updates to Management Executive and Senior Leadership Board meetings. An Internal investment case is to be submitted in quarter 4 of 2023/24. This is a 3 to 5 year investment case of which digitsation forms a key element as a benefit driver for electronic clinical notes, specifically a digital integrated care record. In the interim, review of internal and Welsh Health Board mechanisms will continue to incrementally improve the current breadth and depth of the digital record platforms available. This will enable a surer foundation should the investment and resource needed be secured.

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

Recommendation:

The Board / Committee are requested to:

Note the contents of the report and progress made against recommendations

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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**	**Y**
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

Prevention		Long term		Integration		**Collaboration**	**Y**	Involvement	

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes/**No**

Safety: Yes/**No**

Financial: Yes/**No**

Workforce: Yes/**No**

Legal: Yes/**No**

Saunders.Nathan 03/11/2023 11:21:06

Reputational: Yes/**No**
Socio Economic: Yes/**No**
Equality and Health: Yes/**No**
Decarbonisation: Yes/**No**

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
06/11/2023 11:21:06

Report Title:	Policy Plan Update				Agenda Item no.	2.3
Meeting:	Audit and Assurance		Public	X	Meeting Date:	7 Nov 23
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Director of Corporate Governance					
Report Author (Title):	Director of Corporate Governance					

Main Report
Background and current situation:

In May 23 Internal Audit reported on a review of CAV's Policy framework.

The outcome was a Limited Assurance. The principal issue was the number of out-of-date policies or procedures and 8 other key matters were identified.

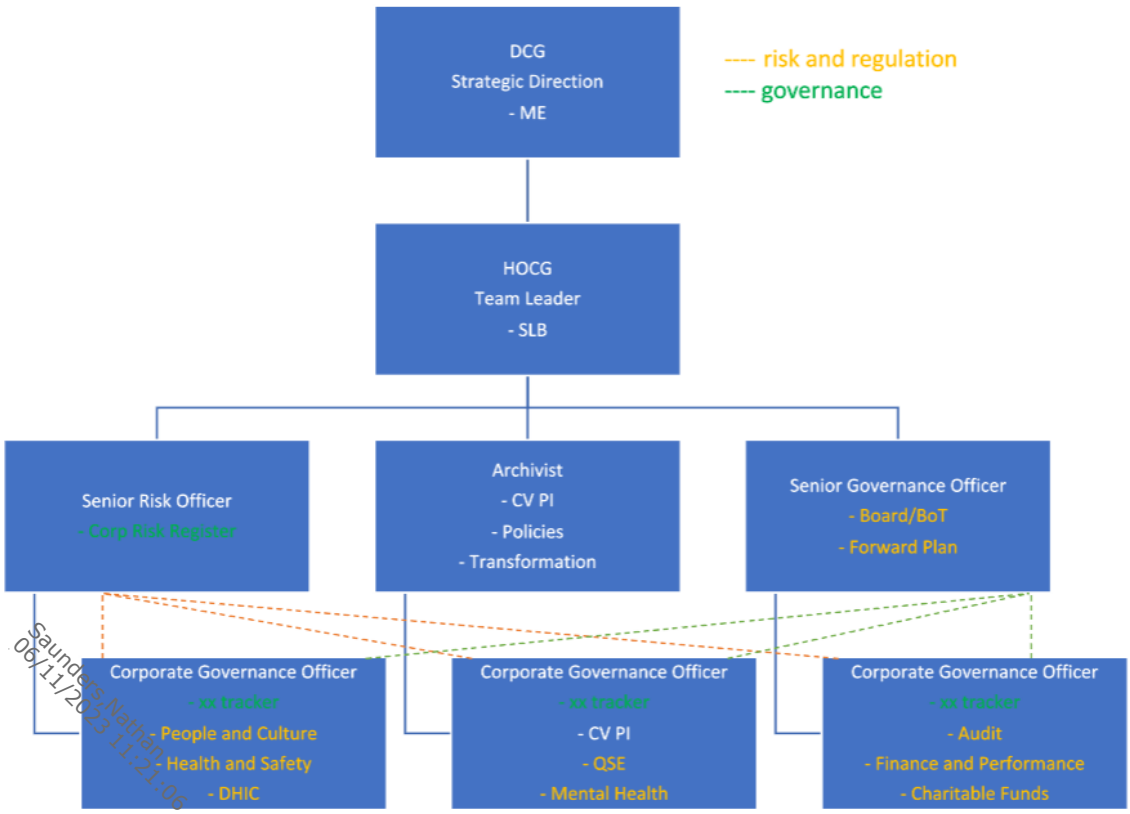
This report is intended as an update to the action being taken.

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

It is sensible to recognise that there has been a significant amount of change in the small Corporate Governance team since the audit was carried out. The Director of Corporate Governance joined in Aug 23 and Head of Corporate Governance in Oct 23. The Head of Risk and Regulation and Head of Corporate Business roles are vacant until further notice and a number of changes to the remaining team have been carried out. Of the team of 7, 2 are currently absent through sickness.

The person previously responsible for Policies and the Audit Management Action Plan left CAV in the Summer.

The new Corporate Governance Structure is below:



The changes mean there is now a dedicated Policy lead within the team – Andrew Partridge, Archivist.

Following the audit report, work was done to baseline the entire catalogue of policies in CAV to identify which were out of date and owned by who. Each policy owner has been contacted and asked to review their policy.

However, rather than seek to update a management system that requires a lot of transactional work, an alternative system that automates these processes has been researched.

The intention is to make use of the Audit Management and Tracking platform (AMaT) that is currently used by a number of Clinical Boards for Audits, Inspections and Projects. AMaT will allow us to host the whole policy catalogue, all relevant information on ownership, version control etc. and automate notification reminders to policy owners regarding upcoming expiry dates.

Internal Audit will review this in Q4, by which time the remaining policy owners and authors would have been identified and the works to transfer each policy to AMaT in progress, allowing for full demonstration of the increased controls, transparency, access and ownership.

Recommendation:

The Committee is requested to:

- **Note** the update and the intended Course of action.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	ü	Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Safety: Yes
Financial: No
Workforce: Yes

Legal: Yes	
Reputational: Yes	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Executive Directors	Provided to Execs through Management Executive

Archwilio Cymru
Audit Wales

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

Date issued: November 2023

Document reference: 3461A2023

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

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

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

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

Contents

Audit and Assurance Committee Update

About this document

1 This document provides the Audit and Assurance Committee with an update on our current and planned accounts and performance audit work at Cardiff and Vale University Health Board.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Auditor General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Financial audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of Accounts Report Addendum – recommendations	Executive Director of Finance	To set out our audit recommendations, and management responses, arising from our audit of the Health Board's 2022-23 financial statements.	Complete	The Committee will consider the report on 7 November.

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the 2022-23 Charitable Funds Accounts	Executive Director of Finance	To provide an audit opinion on the Health Board's Charitable Funds Accounts.	To start in November.	We expect Trustee Members to consider the audited account and our audit report in late January 2024. We expect to certify by 31 January 2024.

Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of Unscheduled Care	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. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).	Blog and data tool published in April 2022 Part 1 – Regional report being drafted Part 2 – Review due to start in October 2023	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All-Wales thematic on workforce planning arrangements	Executive Director of People and Culture	This work will examine the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Draft report to be issued for clearance in November.	February 2024
Primary Care Services - Follow-up Review (2022 Local Work)	Chief Operating Officer	In 2018, we conducted a review of primary care services, specifically considering whether the Health Board was well placed to deliver the national vision for primary care as set out in the national plan. We made a number of recommendations to the Health Board. This work will follow-up progress against these recommendations.	Draft report to be issued for clearance in November.	February 2024
Structured Assessment 2023 – Core	Director of Corporate Governance	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2023 Structured Assessment work will review:	Report drafting	February 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		• Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.		
Structured Assessment 2023 – Deep Dive	To be confirmed	We had previously indicated an intention to undertake deeper dive work to examine digital arrangements. However, given the significantly challenging financial position across NHS Wales, we are now looking at replacing the work on digital with focused work examining the approaches NHS bodies are taking in respect of achieving cost improvements, efficiencies, and financial sustainability.	Planning	To be confirmed
All-Wales thematic review of planned care	Chief Operating Officer	This work will follow on from our 2022 review. The specific focus of this work is to be confirmed.	Planning	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Examination of the Setting of Well-being Objectives (2023 Local Work)	Executive Director of Strategic Planning and Executive Director of Public Health	This work will assess the extent to which the Health Board has acted in accordance with the sustainable development principle when setting its well-being objectives as part of its arrangements for refreshing the organisation's long-term strategy. This work has been incorporated in, and will be reported, through our 2023 Structured Assessment.	Report drafting	February 2024
Follow-up of 2019 Clinical Coding follow-up review (2023 Local Work)	To be confirmed	This work will review the Health Board's progress in addressing the recommendations made in our 2019 clinical coding follow-up review.	Planning	To be confirmed

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
NHS Workforce data briefing	**September 2023**
NHS Wales Finances Data Tool - up to March 2023	**September 2023**
Approaches to achieving net zero across the UK	**September 2023**
'Cracks in the Foundations' – Building Safety in Wales	**August 2023**

Additional information

7 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Biodiversity and Resilience of Ecosystems Plan for Audit Wales 2023 – 2027	August 2023

8 There are no relevant Audit Wales consultations currently underway.

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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:	Internal Audit Recommendation Tracker Report				Agenda Item no.	2.7	
Meeting:	Audit and Assurance Committee	Public	x		Meeting Date:	7.11.2023	
		Private					
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Risk and Regulation Officer						

Main Report
Background and current situation:

The purpose of the report is to provide Members of the Audit and Assurance Committee ("the 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 Tracker").

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

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, 2020/21, 2021/22 and 2022/23.

Executive Director Opinion and 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 recorded within the Tracker totals 120.

112 recommendations, reported as either Partially Complete or as No Action having been taken were recorded in the Tracker at the July 2023 Committee meeting which have been carried forward to the November 2023 meeting. Thirty of these recommendations that had been completed were removed from the Tracker.

Subsequent to an Internal Audit Validation exercise, the detail of which is shared at Appendix B of agenda item 2.8 for this Committee meeting, three recommendations previously reported as complete have been re-added to the Tracker. These relate to the Audit Reports; Medical Equipment (Recommendations 5 and 6) and Welsh Language (Recommendation 6).

A further eight entries have also been added to the Tracker since the July 2023 Committee Meeting following completion of the following Internal Audit reports:

1) UHB Hybrid and Major Trauma Audit Report
2) Planned Care Transformation
3) Recommendation Tracking

Of the 120 recommendations listed within the Tracker, 22 are recorded as completed, 79 are listed as partially complete and 19 are listed as having no action taken or reported since the last Committee meeting.

Within the recommendations where 'no action' has been reported, two have a 'High Priority' rating for completion and relate to:

Audit Title	Recommendation Number:	Executive Lead:
Data Warehouse	R3/7	Director of Digital Health
New IT Service Desk System	R1/4	Director of Digital Health

The Data Warehouse Recommendation has an implementation date of the 31.07.2023. The New IT Service Desk System recommendation has implementation dates of the 31.03.2023 and 31.07.2023 for the two strands of the recommendation. An update on progress made against this recommendation will be shared at future Committee meetings.

The Committee are asked to consider whether additional assurance around completion of these High Priority Recommendations is required at the next Committee Meeting.

Reports Superseded

Three of the reports listed on the Tracker have now been superseded by new audits recently undertaken:

- The Infrastructure / Network Management recommendations have been superseded by the New IT Service Desk System issued January 2023 (lines 58 and 59).

- The Performance Reporting / Quality Data Report has also been superseded by Internal Audit's follow up review on the New Integrated Performance System which is being presented at the November 2023 Committee meeting.

- The Chemocare IT follow-up report has a limited rating and a new audit has been undertaken and will be issued with two actions to complete.

A full review of all outstanding recommendations has been undertaken since the July 2023 Committee Meeting. Each Executive Lead has been sent the recommendations made by Internal Audit which fall into their remits of work.

There are currently two outstanding recommendations for 2019/20 and 2020/21, four aged recommendations were reported at the July Committee Meeting. These recommendations will continue to be targeted and review in advance of the April 2024 Committee Meeting to ascertain whether or not the recommendations have been superseded or should be subject to a more up to date review.

It should be noted that the narrative within Column L (Executive Update) of the Tracker contains the updates provided for this meeting. Where no update has been shared for an individual entry this is confirmed within narrative and/or reflected in column J by an 'NA' entry.

The table below shows the number of internal audits which have been undertaken between 2019/20 - 2022/23 (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	7	12	8	3	30
Internal Audits 2022/23	6	18	3	2	29

Attached at Appendix 2 are summary tables which provide an update on the November 2023 position as of the 23 October 2023.

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

Recommendation:

The Committee are requested 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 2023.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration		Collaboration	x	Involvement	

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No

By maintaining an up to date Internal Audit Recommendation Tracker the Health Board mitigates the risk that it may be subject to legal or regulatory penalty.

Safety: Yes/No

N/A

Financial: Yes/No

N/A

Workforce: Yes/No

N/A

Legal: Yes/No
N/A
Reputational: Yes/No
N/A
Socio Economic: Yes/No
N/A
Equality and Health: Yes/No
N/A
Decarbonisation: Yes/No
N/A

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
N/A	

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Key: C – Complete PC – Partially Complete NA – No Action

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2019/20 (November 2023 Update)

Recommendation Status	High	C	PC	NA	Medium	C	PC	NA	Low	C	PC	NA
Overdue under 3 months												
Overdue by over 3 months under 6 months												
Overdue over 6 months under 12 months												
Overdue more than 12 months							2					
No date set												
Total					**2**		2					

Total number of recommendations outstanding as of 23 October 2023 for financial year 2019/20 is 2 which is the same position as in July 2023.

Key: C – Complete PC – Partially Complete NA – No Action

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2020/21 (November 2023 Update)

Recommendation Status	High	C	PC	NA	Medium	C	PC	NA	Low	C	PC	NA
Date not reached												
Overdue under 3 months												
Overdue by over 3 months under 6 months												
Overdue over 6 months under 12 months												
Overdue more than 12 months							3				1	
Total					**3**		3		**1**		1	

Total number of recommendations outstanding as of 23 October 2023 is which is the same position as in July 2023.

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Key: C – Complete PC – Partially Complete NA – No Action

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2021/22 (November 2023 Update)

Recommendation Status	High	C	PC	NA	Medium	C	PC	NA	Low	C	PC	NA
Date not reached												
No date agreed												
Overdue under 3 months												
Overdue by over 3 months under 6 months												
Overdue over 6 months under 12 months												
Overdue more than 12 months												
						2	4	3			2	1
Total					**9**	2	4	3	**3**		2	1

Total number of recommendations outstanding as of 23 October 2023 is 12 compared to the position in July 2023 when a total of 16 outstanding recommendations were noted.

Key: C – Complete PC – Partially Complete NA – No Action

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2022/23 (November 2023 Update)

Recommendation Status	High	C	PC	NA	Medium	C	PC	NA	Low	C	PC	NA
Date not reached						2	3			1	1	
No date agreed			1				7	1				
Overdue under 3 months							5	1				
Overdue by over 3 months under 6 months			3				28	5		2	4	5
Overdue over 6 months under 12 months		1	3			9	5			2	3	2
Overdue more than 12 months						3	4				1	1
Total	**8**	1	7		**73**	14	52	7	**21**	5	8	8

Total number of recommendations outstanding as of 22nd November 2023 is 102 (20 of which are listed as complete) compared to the position in July 2023 when a total of 119 outstanding recommendations were noted.

Saunders,Nathan
06/11/2023 11:21:06

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	M	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for November 2023: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2019-20	01/07/2020	Medical Staff Study Leave	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.	UHB Study Leave procedure document will be reviewed and strengthened in the areas outlined in the report. This will require agreement with the Local Negotiating Committee (LNC) of the UHB.	Executive Director of People and Culture	Executive Director of People and Culture & OD & Medical Director	PC	**Change to implementation date - moved to 1.02.2023** 1. The Study Leave Procedure has been amended to incorporate the audit recommendations and it has been shared with the LNC. The document includes a financial limit that can be claimed over a three year period which will bring consistency across all specialities. This change may have a negative financial impact for the UHB but will be positive in regards to engagement, attraction, rentention, etc. 2. Discussions with the LNC have paused due to the current financial position and the need to save £32m in 23/24. The decision to pause will be reviewed in April 2024.
2019-20	01/07/2020	Medical Staff Study Leave	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.	Capped annual or triannual budget allocations are to be introduced after discussion with the LNC. Honorary Academic Consultants are contractually entitled to 0.6 of this annual or triannual allocation as per contract terms and conditions. Once capped allocation agreed consistent budget line allocation will be anticipated against which spend can be measured.	Executive Director of People and Culture & Medical Director	Executive Director of People and Culture & Medical Director	PC	**Change to implementation date - moved to 1.02.2023** T1. The Study Leave Procedure has been amended to incorporate the audit recommendations and it has been shared with the LNC. The document includes a financial limit that can be claimed over a three year period which will bring consistency across all specialities. This change may have a negative financial impact for the UHB but will be positive in regards to engagement, attraction, rentention, etc. 2. Discussions with the LNC have paused due to the current financial position and the need to save £32m in 23/24. The decision to pause will be reviewed in April 2024.
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.	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.	Director of Digital & Health Intelligence	Director of Digital and Health Intelligence September 2021	PC	Oct '23 Data Quality policy and procedure being reviewed in light of the focus on the Data Improvement Group and other initiatives. The Data Quality policy is complete but not yet reviewed. It will be completed and taken through the relevant committee for approval.
2020-21	31.10.2021	Infrastructure / Network Management	R1/5	Medium	A formal patch and update policy and procedure should be developed which clearly articulates the decisions relating to patching and updates, and which sets out the process for applying patches and updates in a secure manner to reduce the risks associated with these. We note that this recommendation was also included in the IT Assessment Internal Audit Report.	Agreed The ability to implement this will be subject to directorate and service maintenance windows being agreed and application patch availability.	Director of Digital & Health Intelligence	Russell Kent, Head of Digital operations October 2021	PC	Oct '23 - Superceded as per new audit Jan 2023 Update - The networking audit was completed and a number of risks and priorities were highlighted. The network are working through a process of patching and updating devices as and where possible based on these recommendations. Upgrades to Cisco ISE and Fortinet firewall have improved the overall security standing of CAVUHB networking in H2 2022.
2020-21	30.11.2021	Infrastructure / Network Management	R2/5	Medium	A configuration management policy / procedure should be defined in order to enable efficient and effective control over IT assets and fully understand the configuration of each component that contributes to IT Services in order to: • account for all IT components associated with the Service; • provide accurate information and documentation to other Service Management processes; and • to provide a sound basis for Incident, Problem, Event, Change and Release Management (e.g. reduction of the amount of failed Changes). This should be underpinned by a configuration management record which records all items and their status.	Agreed. The Digital Health and Intelligence Department has procured and new helpdesk system and will be implementing configuration management and change management processes as part of this initiative.	Director of Digital & Health Intelligence	Russell Kent, Head of Digital Operations November 2021	PC	Oct '23 -Superceded as per new audit Jan 2023 Update - Ivanti Service Management includes, incident and problem management, as well as change management, asset management. Work continues to deply these systems with a completion date of Q4 2023.
2020-21	31.12.2021	Infrastructure / Network Management	R3/5	low	An overall statement or procedure should be developed that sets out the aims for network monitoring and management, and how this will be done. The procedure should note that the aim is to ensure that that relevant staff have alerts and reports so that imminent problems are detected and reported for prompt response and actions. Guidance should then be provided on the mechanism by which this is done	Agreed Departmental responsibilities will be clarified as part of the ITIL Support Framework Helpdesk implementation. Procedure documents will be focussed on key operations using a risk based priority approach.	Director of Digital & Health Intelligence	Russell Kent, Head of Digital Operations December 2021	PC	Oct '23 -Superceded as per new audit
2021-22	31.03.2022	Retention of Staff	R3/5	Medium	The available resources to deliver the Nurse Retention Action Plan and associated workstreams requires review, to determine if current capacity will facilitate effective delivery of the plan and improve nurse retention, if it is a Health Board priority.	The Nurse Retention Steering Group has struggled due to the operational pressures from COVID and Winter. We are optimistic that the pressures will stabilise by the end of March, which will allow the Workstream Leads to take forward the actions that have been agreed. Actions: • Steering Group to continue to meet monthly, these meetings need to have minutes and actions captured. • Workstream Leads will update the Retention Action Plan with key objectives, timescales, progress, etc. • Progress with the plan will be reported into the monthly meetings with the Executive Director of People & Culture in accordance with the theme 'Attract, Recruitment & Retain'.	Executive Director of People and Culture	Director of Nursing Strategic Nursing Workforce & Assistant Director of Workforce Resourcing	PC	Progress is being made in hot spot areas such as ED and ChfW with actions and intervencions supported by Education, Culture and Organisation Development (ECOD) and Nursing Hub.This in the main being undertaken by Senior Nurses in the Clinical Boards and wider organisation as well as their own full time roles. Publication of the HEIW retention Guidelines and Toolkits is expected to be launched July 23. HEIW will be funding an 8a post specifically for nurse retention for 24 months. HEIW retention guide and toolkit launched end Sept 2023. Nursing, P&C and I&I had 2 workshops to review whether actions apply just to nursing or all other staff groups. Will therefore have 1 UHB plan for all staff groups. Also incorporating the UHB plan written prior to HEIW which HoP&C and Directores of Nursing have beern utilising in key prority areas.First priority will be nursing. Requires structure of Project Bopard and workstreams, being identified as part of review. Review will be completed end Oct, working through the HEIW plan indicates that the UHB is already undertaking a lot of work in relation to retention band 8a post was pulled by HEIW, now reinstated for 24 months. UHB needs to advertise and appoint. The retention of R/Ns is improving across our Clinical Boards from 12.1% in Sept 22 to 10.1% in Sept 22.
2021-22	30.05.2022	Welsh Language Standards	R1/6	Medium	The Equality Strategy and Welsh Language Standards Group should reconsider the approach to the cascade of actions to Clinical Boards and Corporate Departments, to ensure implementation and compliance with the Welsh Language Standards.	Clinical Boards and Corporate Departments will be supported to develop individual action plans. These areas will then maintain responsibility to develop, own and report upon progress at the ESWLSG meetings.	Executive Director of People and Culture	Welsh Language Office & Assistant Director of OD	C	A document titled 'Welsh Langauge Standards: A Guide for Clinical Boards' is aviable on the Welsh Language SharePoint which supports Clinical and Service Boards in understanding the requirements of and implementing the Welsh Language Standards. The Welsh Language Officer regularly meets with Clinical Boards to support them with their compliance. The Head of E&I has met with the Executive Director of Corporate Governance with the initial proposal for the arrangements for a revised ESWLSG. Exec Director to speak to Chair for feedback. ESWLSG has been stood down with the current structure being reviewed. The recommendation has been met with the agreed action amended given the new proposed structure of ESWLSG.

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2021-22	30.05.2022	Welsh Language Standards	R3/6	Medium	As proposed by management, a Resource Needs Analysis to facilitate implementation, compliance and assurance with the Welsh Language Standards should be undertaken.	Create an agreed role description for the Welsh Language Champions. Support CB and Corporate Departments to introduce and embed, learning lessons from areas where this is already in place.	Executive Director of People and Culture	Welsh Language Office & Equality Manager	C	A role description for all Inclusion Ambassadors has been established, which includes Welsh Language Inclusion Ambassador (formally Champions). Welsh Language Ambassadors exist at Board level and in most of the Clinical Boards. People in these roles have recently met to discuss any challenges encountered as part of their role as an Ambassador and they will participate in organisation wide Inclusion Ambassador meetings facilitated by the Equity & Inclusion Team. These meetings will support learning lessons from other areas and embed learning throughout the UHB.
2021-22	30.05.2022	Welsh Language Standards	R6/6	Medium	To enhance the maturity of the risk management arrangements, the recording of the risks associated with the Welsh Language Standards should be strengthened to include risk mitigation and the nature of the risk score, to better inform the oversight and assurance forums.	Develop an enhanced dashboard to reflect recommendations. Present to ESWLSG for comment / agreement. Finalise for effective updating and reporting of risk.	Executive Director of People and Culture	Welsh Language Officer Equality Manager	PC	**Recommendation re-added following Internal Audit Recommendation.** Work is being undertaken with the Shaping Change team to improve the way that risks are managed. This work is scheduled to be completed in December 2023.
2021-22	30.09.2022	Performance Reporting (Data Quality)	R1/4	Low	To continue as planned to finalise and seek approval of the 'Procedure to compile the Cardiff and Vale Integrated Performance Report for Executive Management Team and Public Board Meeting'.	The content of the "Cardiff and Vale Integrated Performance Report for Executive Management Team and Public Board Meeting" has changed considerably recently and will continue to evolve as we test the effectiveness of the report with Board members. To support future content changes, we will refine our process to ensure this is clearly documented and shared with all executive director leads and their staff	Director of Digital & Health Intelligence	Director of Digital and Health Intelligence	PC	**Oct '23 -Superceded as per new audit**
2021-22	30.06.2022	Performance Reporting (Data Quality)	R2/4	Medium	The quality assurance arrangements of the Integrated Performance Report should be reviewed to ensure processes are in place to mitigate the risk of the anomalies highlighted within the audit sample.	Where no source information or data are available a standard message or indication (with an asterisk) of "No information or data available at source" will be used. With regards to decimal place accuracy, we will seek advice from the relevant leads for individual measure accuracy and introduce a new quality check.	Director of Digital & Health Intelligence	Information Manager	NA	**Oct '23 -Superceded as per new audit**
2021-22	30.06.2022	Performance Reporting (Data Quality)	R3/4	Low	Consideration should be given to risk assessing the defined indicators within the Balanced Scorecard, to identify those at greater risk of error. Appropriate quality assurance arrangements should be defined to mitigate the potential risk of error.	The compilation of the report is mainly a manual administrative task with limited automation. We have introduced additional quality assurance tasks to reduce administrative error.	Director of Digital & Health Intelligence	Information Manager	NA	**Oct '23 -Superceded as per new audit**
2021-22	30.06.2022	Performance Reporting (Data Quality)	R4/4	Medium	In keeping with managements intention to further develop the Balanced Scorecard and Integrated Performance Report, the audit observations should be addressed in future reporting periods to enhance the completeness and transparency of the report.	We have accepted your recommendations and have implemented steps to mitigate these risks. For example, we have expanded on the indicator labels to ensure those people with limited knowledge of these can understand these and we will indicate where a target is inappropriate or not required for an indicator. We have also introduced a new quality check.	Director of Digital & Health Intelligence	Information Manager	NA	**Oct '23 -Superceded as per new audit**
2021-22	Start Log July 2022 with first annual review July 2023	ChemoCare IT System - Final - **LIMITED**	R1/8	Medium	1.1 A formal supplier's performance monitoring mechanism should be established within both Adult Haematology and Paediatric services to ascertain that there are no frequent and significant breaches of SLA. 1.2 Outcome of the performance review should be periodically shared with the Shared Services Procurement team, as required by the procurement manual. 1.3 If possible, penalty clauses should be agreed with the supplier during the subsequent contract renewal process.	1.1 Create SLA breech log with annual review of this. 1.2 Annual review can be shared with Shared Services Procurement team. Will commence post-implementation of Version 6. 1.3 Penalty clauses will be discussed at next contract renewal (there is a national procurement process underway)	Director of Digital & Health Intelligence	Paeds System	PC	**Oct '23 -Superceded as per new audit**
2021-22	July 2022 (Allowing 2 months of user groups to discuss, agree and implement)	ChemoCare IT System - Final - **LIMITED**	R3/8	Low	Individual user training logs should be signed off and archived for record purpose	Electronic training log to be completed for all current users and updated training logs to be signed reflecting appropriate training for current users. Reporting module to be used to establish current list of active users. Discussions with system managers at both CTM and AB UHB's to ensure training logs completed locally and fed into central database of active users.	Director of Digital & Health Intelligence	David Trigg (Adult Haematology)	PC	**Oct '23 -Superceded as per new audit**
2021-22	31.07.2022	ChemoCare IT System - Final - **LIMITED**	R6/8	Medium	System owners should coordinate with both IT department and CIS to configure an auto alert system or an exception report to timely identify interface failures.	Will look at this as part of the V6 upgrade and ensure an auto alert system is in place.	Director of Digital & Health Intelligence	Kerry Crompton (for paediatric system) David Trigg (Adult Haematology)	PC	**Oct '23 -Superceded as per new audit**
2021-22	31.08.2022	ChemoCare IT System - Final - **LIMITED**	R8/8	Medium	The identified gaps should be taken into consideration at the time of the next BCP update once the version 6 goes live.	BCP Will be reviewed as recommended	Director of Digital & Health Intelligence	Kerry Crompton (for paediatric system) David Trigg (Adult Haematology)	NA	**Oct '23 -Superceded as per new audit**
2022-23	31.12.2022	Follow-up: Ultrasound Governance Final Internal Audit Report	R1/1	Medium	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).	The Ultrasound Clinical Governance Group has achieved good progress against the issuesraised from the Aug 2021 internal audit findings. The Ultrasound Clinical Governance Group (USCGG) has been re-established and clear reporting lines through to the responsible Executive Director of Therapies and Health Sciences (EDoTH) have been agreed and communicated via Exec QSE and the Audit and Assurance Committee via the USCGG ToRs. An engagement exercise has been conducted with Clinical Boards to identify key staff responsible for the delivery and training of Ultrasound in respective areas, the results of which will be made accessible to all once complete. This will complete the outstanding Clinical Board assurance recommendation. The USCGG have agreed an audit template and will arrange audit scheduling and recording at the next USCGG, where all key US staff will have been identified. Work to create an online Ultrasound Clinical Safety course is on-going and is on course to be made available later this year (2022). This is being aligned with similar information provided by the British Medical Ultrasound Society (BMUS) for a consistent UK approach.	Executive Director of Therapies and Health Science	Assistant Director of Therapies and Health Science	C	**20/10/2023 Update:** The audit tool is now available on AMaT. To improve compliance we are setting up an AMaT project to monitor uptake via the USCGG (using AMaT). Compliance across the UHB is reported as a standard agenda item on USCGG, which in turn reports into the Medical Equipment Group (MEG). The audit tool has been used by Medical Physics and uptake to other groups is being encouraged. Med Physics are presenting their experience of using the audit tool at the next USCGG meeting on 22nd Nov 2023. The online training resource is complete with a planned go-live Dec 2023.

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2022-23	1.11.2022	Stock Management - Neuromodulation Services (Specialist CB)	R4/5	Medium	The Neurosciences Directorate should instigate a process to proactively track orders placed, until goods are delivered to the neuroscience's office. Any issues which arise should be addressed.	The Service Manager will liaise with procurement colleagues at Lakeside stores to set up a process to ensure all stock is delivered to the Neurosciences Directorate Office and receipted by a nominated directorate colleague. The aim being that all receipting of goods being completed on delivery to the Neuroscience Directorate Office. Receipting goods in a timely manner will assist with order tracking to prevent loss, increase visibility of outstanding orders avoiding financial loss due to misplaced / undelivered goods. This will require support from procurement colleagues to ensure process is sound and is undertaken as required by the All Wales Policy or guidance. This practices adopted by the DMT has been incorporated into the current SOP. Further changes may be required once the process has been firmed up with Lakeside stores colleagues.	Chief Operating Officer	Directorate Manager - Neurosciences	C	Update 11/10/2023 - Outstanding actions have been completed and processes have been implemented to proactively track orders within the directorate. The high cost devices are now accurately tracked throughout the deliverly process which has resulted in all outstanding risk identified within the internal audit report being addressed.

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2022-23	31.08.2022	Waste Management	R2/8	Low	Budget processes should be defined, including cost allocation, query, and escalation mechanisms.	Agreed. Process map finance - budget allocation, issues, errors etc., to be detailed (ref MA2). Some areas have already been mapped out since the completion of the audit fieldwork.	Director of Finance	Interim Head of Estates Operations / Waste and Compliance Manager	PC	Working with Finance department to realign budgets against individaul waste streams.
2022-23	31.08.2022	Waste Management	R5/8	Medium	The UHB should conclude the formulation and operation of Key Performance indicators in respect of contracted parties to complement contractual arrangements.	Agreed, KPIs to be set for external contractors (ref MA5). A number of contracts are currently going through procurement, there is therefore an opportunity to now build these in.	Director of Finance	Waste and Compliance Manager	PC	Agreed, KPIs to be set for external contractors (ref MA5). A number of contracts have been processed via procurement, and agreed data/kpis are in place.
2022-23	31.08.2022 31.08.2022	Waste Management	R6/8	Medium	1. Waste signage at storage locations should be reviewed and improved to ensure clear, accurate instructions are provided for waste segregation and disposal. 2. Waste yards should be maintained to an appropriate standard and ensure that waste is correctly stored and segregated	1. Agreed, a review of all bin signage/labelling (ref MA6), will be undertaken. 2. Agreed	Director of Finance	Waste and Compliance Manager	PC	Many contract change over has taken place and has resulted in main stoarge and segregation areas being redesigned. Currently mapping new signage requirements to fit with changes and the increase in waste streams
2022-23	31.12.2022	Waste Management	R7/8	Low	A critical review of waste volumes and types across the UHB should be considered, to identify potential for waste minimisation in accordance with WHTM 07-01 (5.3 - 8).	Agreed. A critical review of waste volumes and types across the UHB will be considered to identify potential for waste minimisation. This is currently in progress.	Director of Finance	Waste and Compliance Manager	PC	A review of waste streams has been underway and linked with procurement tendering process for many waste streams 23/24 will be a year of collating data on all waste streams inclusive of increased recycling of UHB wastes
2022-23	31.10.2022	Medical and Dental Staff Bank	R1/3	Low	Management need to review the 'Recruitment of Locum Doctors and Dentists Operational Procedure' (UHB 131), which has been superseded by online resources and consider whether they update it in line with current processes.	The 'Recruitment of Locum Doctors and Dentists Operational Procedure' to be deleted off the online resources as the new Terms of Business for the Medical and Dental Staffbank now override.	Executive Medical Director	Head of Medical Workforce	PC	Old documentation deleted. All locum provision is actioned via the Medical Managed Bank. All current documention can be easily accessed via the Internet/sharepoint
2022-23	31.10.2022	Medical and Dental Staff Bank	R2/3	Medium	Rota-Coordinators need to ensure that shifts are made available in a timely manner on the Envoy system to ensure a greater chance of take up by Bank Staff. In instances where the Rota-Coordinator is unavailable, contingency and cover arrangements should be considered.	Short term absence will inevitably take place which will not always allow for a shift to be put on prospectively e.g. same day sickness etc. There will also be occasions whereby a locum will be required over a weekend/bank holiday that was not planned within the week and as the rota co-ordinator only work M-F/BH this will require action on their return. We can adopt a measure that all retrospective shifts are to be put on no later than 72 hours. The Medical and Dental Staffbank team will create a communication to go out to all service areas to update them of the above and will monitor over the next quarter to monitor adherence and report into MWAG.	Executive Medical Director	Head of Medical Workforce	PC	Communication was sent out. New Patchwork system introduced (in place of Envoy). Updates provided to MWAG
2022-23	31.10.2022	Medical and Dental Staff Bank	R3/3	Low	Management need to ensure that they meet regularly with Medacs, in accordance with the requirements of the Framework Agreement, so that the performance is regularly reviewed, and any issues can be discussed during the meeting.	These meetings are now scheduled monthly. Audience to include, Head of Medical Resourcing and Systems, Deputy Director of People & Culture, Deputy Medical Director and Medacs Healthcare.	Executive Medical Director	Head of Medical Workforce	NA	No update received
2022-23	30.11.2022 31.01.2023	Staff Wellbeing - Culture and Values	R1/10	Medium	A review of key documentation and sources should be undertaken to ensure the current 'Values and Behaviours Framework' is referenced appropriately. An update of the following is required: • The SharePoint intranet site 'Values and Behaviours' page; and • Medical job description templates.	As the staff intranet pages have been moved into the SharePoint site, this has brought with it some pages that are now out of date. The Assistant Director of OD, Culture and Wellbeing will work with the Head of Education, Culture and OD and the IT Directorate to ensure that the incorrect information is removed from the site. The Assistant Director of OD, Wellbeing and Culture will liaise with the Head of Medical Workforce to ensure that all templates are referencing the current values framework. Assurances have been provided that vacancies going out to advert are checked to ensure current values are communicated, and the incorrect templates will be removed and/or amended.	Executive Director of People and Culture	Assistant Director of OD, Wellbeing and Culture Head of Medical Workforce	C	The intranet pages have been taken down and all relevant information is being transferred to Sharepoint for staff to access - no 'out of date' content has been transferred to Sharepoint. To monitor this, the ECOD team will monitor the relevant pages on a quarterly basis. JD templates ongoing. All vacancies going out are checked to ensure current values and behaviours are communicated.
2022-23	31.01.2023	Staff Wellbeing - Culture and Values	R3/10	Medium	To enhance the People and Culture Plan's Priority Action Plan, consideration should be given to the following: • Clarity of the progress made against each objective; • RAG rating objectives; • The use of Microsoft Excel to capture the Plan and utilise the functionality; and • Targets and indicators to measure implementation.	Work is currently underway in strengthening identified KPIs for the plan, and identifying additional KPIs. The first year of the plan has been a learning experience and the development of effective measures and systems will be a focus for the one year review in January 2023. This review will include these recommendations. The current monthly reporting of Flash Reports, which inform a 6 monthly update to Strategy and Delivery Committee currently use a RAG rating, but it is recognised this needs enhancing as recommended. The review in January 2023 will strengthen the reporting and tracking of the People and Culture Plan, utilising the most effective platform, e.g. Excel. Work has already started on this, drawing upon the expertise of the Innovation Team. There is the possibility of a slight delay with the review due to the focus on retention within 'Winter Pressures' and focus of effort upon supporting the wellbeing of staff.	Executive Director of People and Culture	Executive Director of People and Culture Deputy Director of People and Culture Assistant Director of Resourcing Assistant Driector of OD, Wellbeing and Culture	PC	Conversations with Ceri Phillips (IM) around measurements and evaluation have taken place and will help inform progress in this area, although the development of the 'system' to record progress will require a significant investment in time.
2022-23	31.01.2023	Staff Wellbeing - Culture and Values	R4/10	Medium	A Terms of Reference for the Strategic Wellbeing Group should be completed to define the Group's purpose in the current climate. Membership, priorities and reporting lines (including that of the anticipated Operational Wellbeing Group) should be clarified.	Work has started on drafting the Terms of Reference for the Strategic Wellbeing Group which was previously focused on supporting staff through the emerging and continuing pandemic. The group continues to function effectively, supporting direction through Winter Pressures but will take a more long-term, strategic approach to staff wellbeing as we move into 2023. The Terms of Reference will be discussed in the December 2022 meeting and agreed by January 2023.	Executive Director of People and Culture	Executive Director of People and Culture Assistant Director of OD, Wellbeing and Culture	C	A newly formed 'Health and Wellbeing Steering Group' is in the early stages of development. Initial meetings have taken place and membership gathered from across the UHB. The draft TORs have been reviewed and a workshop session in October 2023 will finalise these, along with identification of initial priorities. The TORs include the relevant governance structure, including reporting mechanisms. Final draft to be agreed October 2023.
2022-23	28.02.2023 31.01.2023	Staff Wellbeing - Culture and Values	R5/10	Low	Wellbeing information contained on the Health Board's website and staff SharePoint site, require an update, specifically: • The 'Your Health and Wellbeing' section of the website should be updated to reflect the role of the Strategic Wellbeing Group, and information relating to the former Health and Wellbeing Advisory Group should be removed; and • Links within the SharePoint site require review to ensure effective signposting to dedicated wellbeing pages on the Health Board's website.	The Assistant Director of OD, Wellbeing and Culture will work with the Employee Wellbeing Services Team to ensure that all content is up-to-date, links corrected and out of date information removed. This will be a 'work in progress' as the team are currently responding to increased demand, however, we will work closely with the IT Department to rectify this. The new TORs for the Strategic Wellbeing Group will be agreed in January 2023 and uploaded upon sign-off.	Executive Director of People and Culture	Assistant Director of OD, Culture and Wellbeing	C	Please see above re Wellbeing Strategy Group. The Wellbeing Pages are up to date, and are continually reviewed. There are current challenges in the team due to existing vacancies and work is underway to redistribute areas of focus to ensure staff are appropriately supported with the most up-to-date support and information.
2022-23	28.02.2023	Staff Wellbeing - Culture and Values	R6/10	Medium	The monitoring arrangements for the Wellbeing Plan should be enhanced to ensure the timely delivery of agreed actions, within agreed funds available.	The UHB are currently developing the Wellbeing Strategy and Framework, which will include information on measures and monitoring. This will be put to Board for approval in February 2023. The Assistant Director of OD, Wellbeing and Culture is currently working with the Innovation and Improvement Team to develop the monitoring mechanism for the wellbeing projects, which will align with the measurements under the P&C Plan.	Executive Director of People and Culture	Assistant Director of OD, Culture and Wellbeing	PC	A delay in the formation of the Health and Wellbeing Steering Group has led to a pause on Framework developments. This has been identified as one of the priorities of the H&WB Steering Group and will be picked up in October. A task and finish group will be established to undertake the relevant engagement. The EWS had started to progress wellbeing reporting, however this has been impacted by existing vacancies and staff sickness. The team are exploring the use of CIVICA to support in providing data and a focus on measurements will commence in Quarter 3 and quarter 4. However, as demand may increase for EWS services over the Winter period, if the current admin support sickness continues progress may be slower than planned.
2022-23	31.01.2023 31.12.2022 31.01.2023	Staff Wellbeing - Culture and Values	R7/10	Medium	To evaluate the success of wellbeing initiatives, the Health Board should instigate a cultural assessment toolkit, or an alternative means of evaluation which will support the effective delivery of the People and Culture Plan.	Monitoring and Evaluation methodology will be developed alongside the Wellbeing Strategy and Framework. In terms of Cultural Assessment Toolkits, the UHB are currently piloting the 'Leadership and Compassion' Programme, designed by Prof Michael West and The King's Fund with NHSE/I, with support from HEIW. This trial will take place Oct-Dec 2022. The UHB is currently undertaking an options appraisal of Cultural Assessment Tools to identify the most appropriate.	Executive Director of People and Culture	Assistant Director of OD, Culture and Wellbeing	C	Please see above re measurements and evaluation. The Culture and Leadership Programme approach has been presented and agreed by Senior Leadership Board and is being presented at People and Culture Committee in November 2023. The Executive Team are identifying priority areas to focus resource, and ongoing work includes ALAS and Theatres. The P&C Team are working with Prof Michael West, The Kings Fund and HEIW to establish effective monitoring and evaluation of the CLP.

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2022-23	31.01.2023	Staff Wellbeing - Culture and Values	R10/10	Medium	The 'Board Assurance Framework Risk: Staff Wellbeing', should be reviewed to ensure key actions being taken to address the Occupational Health referral wait times are included. Where gaps in controls and assurances are identified these should be considered too.	Development is underway to ensure the KPIs of the People Health Services Team, which includes Occupational Health, Physiotherapy, and Employee Wellbeing Services are reported upon monthly as part of the wider reporting within People and Culture. This will be added onto the Board Assurance Framework. It is important to note that the issue is exacerbated by absence within the team due to sickness absence, and the relevant support is being provided to staff to enable timely return to work, including phased return etc.	Executive Director of People and Culture	Assistant Director of OD, Wellbeing and Culture Head of Occupational Health for CAV and CTM	PC	Following the launch of the Shaping Our Future Wellbeing Strategy, all BAF documents are being re-designed to ensure aligned to the new strategy. It is anticipated the revised BAF documents will be formed in November 2023. Sickness absence continues to cause significant challenges within Occupational Health, however, new collaborative working arrangements across CAV and CTM are providing additional resilience, and this will increase as we move into Phase 2 of the collaboration - this will support the wellbeing of the OH staff, and waiting times.
2022-23	31.12.2022	Implementation of National IT Systems (WNCR)	R1/4	Medium	Noting the improvements in communications with DHCW. The UHB should build on this by ensuring it is aware of the 3-5 year DHCW plan and the level of expected resource commitment from the Health Board for each item. This should feed into the C&V planning process.	Working with DHCW executive director colleagues, the national DHCW plan will be reviewed to ensure there is alignment with C&V's own strategic plans. Once the DHCW plan is available to C&V, we will incorporate into our strategic roadmap and planning process. The existing communication arrangements will continue: The process established includes: • Digital Directors Peer Group. At which DHCW provide an update of their plans and ongoing work; • Quarterly planning sessions with the Health Board and DHCW. These are two way and aim to ensure that plans are synchronised and allow the Health Board to influence and help inform the DHCW plans; • Informal executive to executive meetings planned for every 3 months	Director of Digital & Health Intelligence	Director of Digital & Health Intelligence	PC	Oct '23 - National/Local plan developed between DHCW and CAV showing the programmes and interdependencies which are shared at the regula Exec to Exec meetings (DHCW/CAV)
2022-23	31.10.2022	Implementation of National IT Systems (WNCR)	R2/4	Medium	All digital projects should be subject to a formal governance structure	A formal project governance structure has been put in place including risk monitoring for the whole of the programme including digital. Formal monitoring will be provided via the WNCR Board meetings and any digital risks arising will be reported upwards to exec director level and, if necessary, to the Senior Leadership Board (formerly HSMB). Regular updates will also be submitted to the Digital & Health Intelligence committee.	Director of Digital & Health Intelligence	Nurse Informatics Lead / IT Programme Manager	PC	Oct '23 WNCR implementation plans agreed, but fdependant on adequate WiFi & mobile device management solutions which is being implemented
2022-23	1. 31.12.2022 2. 31.12.2022	Implementation of National IT Systems (WNCR)	R3/4	Medium	A project plan should be developed that shows the scheduling of wards, and the processes required to implement within wards, along with the timescales and resource requirements.	There are two components to this recommendation: **1. Development of an implementation schedule** A provision roll-out schedule was devised in March 2022. This schedule indicated the data for implementation and equipment required on each ward. However, further WNCR implementation is unlikely to progress in the UHB until April 2023. This pause is necessitated to accommodate the launch of another digital platform Safecare. The UHB will also enter its ePMA implementation phase in April 2023. Actions: - Revise the WNCR roll out schedule in response to the Safecare and ePMA schedule (in to prevent wards having to adopt more than one digital platform at a time). Include within this schedule: • Number of colleagues to train • Quantity/type of equipment to deliver • Training times • Post 'go live' support times **2. Development of process required to implement** Following the pilot of WNCR to three wards, the project team is now able to develop a detailed process that includes: - Device configuration - User account and email set up - Active Directory maintenance - Business continuity configuration on designated PCs - Training guides - Trouble shooting guides - Out of hours support - Provision of supplementary booklets - Additional equipment requirements	Director of Digital & Health Intelligence	Nurse Informatics Lead	PC	September 23 - a solution to provide secure corprate wifi was purchased (ISE) however the digital team are still working on the Management of the devices to allow comencement of the implementation. The digital team for the WNCR are continuing to support the programme.
2022-23	03.08.2023	Implementation of National IT Systems (WNCR)	R4/4	Medium	The baseline assessment should be fed into a benefits register, and a benefits assessment and realisation process should be included within the project plan.	A benefits register will be developed to record: - Digital skills of nursing workforce - Comparison of documentation completion rates before/after WNCR implementation - Use of WNCR analytics to inform improvement work - Staff feedback - Patient feedback (undertaken by patient experience team) - Cost savings (based on removal of paper documents) - Time savings	Director of Digital & Health Intelligence	Nurse Informatics Lead	PC	Jan 23 - Development of benefits register - Dec 2022 Complete Assessment of benefits by Augst 2023 (or following completion of implementation). Partially complete for x4 live wards. Unable to complete until implementation concludes- awaiting an update from digital as to when work can recommence
2022-23	Q1 2023/24	Digital Strategy	R1/5	Medium	The roadmap should be further developed so that it defines a full plan towards digital transformation. Additional information should be built into the roadmap such as: • key activities; • resourcing; • milestones; and • links to recognised themes such as peoples, processes and technology.	The roadmap will continue to develop and evolve with those key elements around activities, required resources and milestones set out. We will align to the themes of People, Processes and Technology however, the resources and senior management capacity will dictate the speed and pace of delivery. This is a significant amount of work and corelates directly with 2.1.	Director of Digital & Health Intelligence	Director of Digital Transformation	PC	Update Oct 2023 - WG have yet to fund this resource to do this work. Accordingly, CAV is preparing an internal investment case with this detail which will go to the CAVUHB Investment Group in Q4 There is no ring fenced, additional or dedicated resource for this work
2022-23	Q1 2023/24	Digital Strategy	R2/5	Medium	The resources required to deliver each component within the roadmap should be defined to enable the Digital Directorate to map to available resources, identify gaps and enable planning.	A TOM will be produced following the Enterprise Architecture (EA) review (first stage) which is in progress. Further work and subsequent iteration of the EA will build on strategic documents business cases, the "Case for Investment" and Roadmap documentation. This will also include a high level cut of what is needed to support the SOFs programme as it iterates through its own blueprint and TOM development. These outputs will help populate a mid-term (5 to 10 year) view of the resource plan to support the TOM and subsequent updated roadmap. Delivery plans will be dependent upon investment decisions, Resources and senior management capacity will dictate the speed and pace of delivery.	Director of Digital & Health Intelligence	Director of Digital Transformation	PC	Update Oct 2023 - good progress has been made with EA work, an inital EA baseline has been achieved, all activities outlined completed bar the ToM which is still a work in progress given lack of resource; it is in draft format - see action R1/5 - the Investment Case speaks to capabilities (not all technical debt) in the next 3 to 5 years directly in support of SOFCS - D&HI and the SOFs programme leads work closely together and meet at least twice a month to ensure alignment. The 10 year plan including legacy debt would be part of the Digital SoC (as yet unresourced or funded). It should also be noted the EA post in the CAV D&HI structure is unfilled and these are skills we have had to buy in - there is no further funding pending investment case to continue this work but value is being extracted as it is informing roadmap detailed plans. There is no ring fenced, additional or dedicated resource for this work

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2022-23	Q1 2023/2024 Ongoing	Digital Strategy	R3/5	Medium	The Health Board should review the level of funding allocated to Digital to ensure that the organisational strategies and transformation can be realised.	The deliverables in 2.1 will enable the organisation to consider its options on how to achieve the necessary investment in Digital against a strategic investment plan. This investment will be for the transformation required to take the organisation to its New State. 3.1 refers to funding the day to day business of supporting the organisation with some limited capacity to support change. Discussions are taking place with the Director of Finance on an ongoing basis re: support to fund Digital for businessas usual however this requires additionality which is challenging in the current economic climate. Resourcing Digital is on the corporate risk register and will continue to be reviewed there and progress reported at DHIC.	Director of Digital & Health Intelligence	Director of Digital Transformation Director of Digital & Health Intelligence	PC	Update October 2023 - see R1/5 and R2/5 Regarding 3.1, the UHB is under financial pressure as is the public sector in Wales and there is no additional funding - dependency now is consideration of the Investment case . DHIC is appraised of the financial and resource position regularly. There is no ring fenced, additional or dedicated resource for this work
2022-23	Q1 2023/24	Digital Strategy	R4/5	Medium	The UHB should consider increased representation from Clinical Boards on DHIC	DHIC membership will be reviewed in light of the changes to the ME and CB governance model whereby a new Senior Leadership Board has been established. Wider representation from the SLB will be sought for DHIC committee membership (pending discussion with committee chair)	Director of Digital & Health Intelligence	Director of Digital & Health Intelligence	PC	Oct '23 - Clinical Board Directors invited to attend DHIC meetings routinely
2022-23	Q1 2023/24	Digital Strategy	R5/5	Medium	The operation of the Channel Programme Boards should be re-invigorated with regular meetings scheduled. The agenda for these should include an update position for the relevant strategy components. The purpose of the groups should be restated to enable clinicians and other stakeholders to have a greater say in the identification, prioritisation and scheduling of pertinent Digital items.	Governance arrangements were discussed at DSMB October 2022. Channel Boards were established when there was no space for digital conversations with the business providers of the UHB and have worked well to date. The DSMB Chair is leading the review with the CCIO and Directors in Digital to establish a revised governance model that can support digital with identification, prioritisation and scheduling of pertinent Digital items. Operational pressures in the UHB will though continue to potentially have an impact on attendance.	Director of Digital & Health Intelligence	Director of Digital & Health Intelligence Director of Digital Transformation	PC	October 2023 - following the discussions above and a presentation by DDHI in July 2023, 3 new Boards have been agreed, one is established with authority from SLB (the Digital Advisory Board) to support D&HI in the prioritisation/sequencing of works to ensure alignment with the organisations priorities. This group is developing its understanding, using data collated by the embryonic PMO in D&HI. It should be noted that PMO support is currently less than 0.4fte per week and so there are limits to what can be produced. That said, the DAB is engaged in achieving the aims for transparent and shared decision making on what happens and in what order where D&HI does not have capacity. Draft ToR are in circulation for the Clinical Design Authority Chair agreed a the CNIO) and Technical Design Authority (Chair is the CCIO) and once membership considered and agreed meetings will be set up. DSMB will follow however it should be noted that the Chair of DSMB is the SOFCS AMD with whom the DDT meets as part of the SOFs work group at least twice a month as well as other programme leads to ensure alignment. There is no ring fenced, additional or dedicated resource for this work
2022-23	7.12.2022	Medical Equipment	R1/7	Medium	The Medical Equipment Group should seek assurance from its members that they have raised the awareness of the revised policy and procedure within their areas of the Health Board, to ensure staff are aware of any changes to their responsibilities.	Add agenda item to next MEG and MDSO meeting, asking membership to disseminate Policy and Procedure to ensure their staff are aware of the new versions. Senior Leadership Board to discuss policy and disseminate the revised policy.	Executive Director of Therapies and Health Science	Head of Clinical Engineering Executive Director for Therapies and Health Science Director of Corporate Governance	PC	[EC aDoTH 10/23] This was updated with a request to be closed at July 23 meeting submission. The need to disseminate updates to the Med Equipment Policy and Procedure was disscussed at **December 2022** MEG and MDSO meetings. EDoTH to confirm if discussed at Senior Leadership Board.
2022-23	1.02.2023	Medical Equipment	R4/7	Medium	The Clinical Engineering Department should liaise with Directorate and Ward Management on a planned and scheduled basis to confirm the ongoing existence and location of medical equipment items, to ensure the accuracy of the Medusa medical equipment database.	Initially, Clinical Engineering will perform an audit of items not seen for over 10 years. Confirmation of accuracy will be sought from Directorates and Ward Management. Depending on the results of this initial audit follow up audits will be scheduled on a regular basis.	Executive Director of Therapies and Health Science	Head of Clinical Engineering	PC	**No, a further extension to the implementation date is required. Feb 2024.** [EC aDoTH 10/23] Please extend to May 2024 . The member of staff tasked with this (and other actions) has left since the July update and we are recuiting a replacement. Some preparatory work has begun on the audit, but operational pressures and lack of staff resource have delayed further progress. Implementation date changed to May 2023 to allow time to train staff and carry out work.
2022-23	1.04.2023	**Medical Equipment**	R5/7	Medium	A periodic review of the Medusa medical equipment database should be undertaken to ascertain the status and current use of loaned medical equipment items. At the next review, the Management of Medical Equipment Procedure should be revised to provide guidance relating to the recording, oversight and active management of externally loaned medical equipment items.	The commissioning process for long term loan equipment will be changed to record information regarding the basis of the loan where available. Users will be reminded via the MEG and MDSO groups to record or share this information. The action in recommendation 4 will serve to audit old, loaned equipment.	Executive Director of Therapies and Health Science	Head of Clinical Engineering	PC	**Recommendation re-added following Internal Audit Recommendation.** **[EC aDoTH 10/23] Please could we extend implementation date to May 24.** Discussed loaned equipment at December 2022 MEG, and requested that users inform CE of basis of loan agreements. Medical Equipment Procedure is currently being updated to include guidance to capture information as required in the recommendation.
2022-23	1.04.2023	**Medical Equipment**	R6/7	Medium	All medical equipment items that have undergone local decontamination prior to submission to the Clinical Engineering Department should be supported by a completed Contamination Status Clearance Certificate and the issuing book should be retained by the Emergency Unit. Additionally, the Management of Medical Equipment Procedure should be revised and updated to reflect the Ward/Unit based decontamination processes.	Clinical Engineering will work with the EU management to ensure decontamination certificates are available and completed. The Medical Equipment and Devices task and finish group will include the decontamination process in their revisions of the Policy and Procedure.	Executive Director of Therapies and Health Science	Head of Clinical Engineering	PC	**Recommendation re-added following Internal Audit Recommendation.** **[EC aDoTH 10/23] The revision of the policy is a significant piece of work, would a draft version containing this process would be sufficient evidence, otherwise and extension to December 2024 may be required.** EC (aDoTH Med Equip) met with EU manager Craig Davies to disucss decontamination and cleaning equipment in the EU. There is now a HCA with responsibility for medical equipment who will assist the department in meeting this recommendation. Explicit guidance on the need for decontamination certificates will be included in the revised Med Equip Procedure.
2022-23	1.04.2023	Medical Equipment	R7/7	Medium	The Medical Equipment Group should review the current arrangements in place for evidencing and verifying that appropriate training of medical equipment is taking place, particularly for equipment classified as high risk.	The recording of medical equipment training will be discussed at the next MEG to agree on the best way forward and gather evidence of best practice. The existing training on high-risk devices such as Defibrillators, Infusion Devices, POCT and US will be shared with the MEG and MDSO groups to increase awareness. ECOD have some training records on ESR which will be evidenced on as part of this action.	Executive Director of Therapies and Health Science	Head of Clinical Engineering	PC	**Implementation date moved to December 2023** **EC aDoTH 10/23] Practice education meeting has been re-instated, meeting was held 09/10/23, waiting to get ToR and attendance. SBAR for staff resource not proceeded with in current finanical climate, review in next FY. Inital discussions seem to indicate Allocate (Health Roster) already has the competncy module. Recommend moving implementation date forward 12 months to Dec 2025 or closing. We can provide evidence of training for high risk devices, ECOD do not have records themselves as far as we are aware.** Progress report 06/2023, EC (aDoTH, Med. Equip.) is working with colleagues in Clinical Engineering and senior nurses in CD+T to re-establish the practice development network, linking in with ECOD. An SBAR for staffing resource to support a training records system is going to be produced. Recommend making this action a longer term goal, December 2024.

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2022-23	30.04.2023	Development of Genomics Partnership Wales	R1/6	Low	As the GPW workstream arrangements are finalised and become operational, it should be ensured that for each workstream: • Key deliverables are clearly identified, including target dates for achievement. • The GPW senior teams receive routine highlight reports presenting progress against these milestones/dates; and • Any risks to the achievement of the same, which may impact the wider programme, should be reported to the Project Team and GPW Governance Board through the existing GPW reporting process.	Agreed. • Workstreams established under the Subject Matter Management (SMM) Group jurisdiction, each led by a Project Manager who reports progress to the SMM Group Chair. • Each Project Manager maintains the following (minimum) for each workstream: o Terms of Reference o Project Plan, identifying objectives and deliverables • SMM Group Chair (or deputy) compiles SMM Group Report which is shared with and reported to GPW Estates Senior Team (fortnightly) • Report identifies: o Overall progress report and RAG status o New risks and issues identified at a work stream, or overall level Workstream progress and planned work for next period, as well as any items for escalation to the GPW Estates Senior Team (e.g. for review, approvals, assurance, etc.) • SMM Group maintains a central Risk / Issues / Actions / Decisions log, contributed to by all workstream leads with operational output from workstream activities • All risks to be identified at the SMM Group level, escalated to the GPW Estates Senior Team and risk assessed as appropriate • GPW Estates Senior Team will then capture risks on meeting Risk Log as appropriate, for escalation to Project Team and/or GPW Governance Board through the risk registers as appropriate	Executive Director of Therapies and Health Science	GPW Programme Manager	C	Documentary evidence available from GPW programme team. All actions complete June 2023
2022-23	No date provided	Development of Genomics Partnership Wales	R4/6	Medium	4.1a A lessons learned review should be undertaken by Capital, Estates & Facilities, to ensure full understanding of the factors leading to the budget overspend in respect of management of the construction contract. 4.1b A lessons learned review should be undertaken by Digital to ensure full understanding of the factors leading to the budget overspend; and to ensure improved processes can be applied at future projects in respect of the determination of the IT budget requirements at the business case stage. 4.1c A report should be presented to an appropriate forum (e.g., Capital Management Group)setting out the findings of the above exercises.	a. Agreed b. Agreed c. Agreed	Executive Director of Therapies and Health Science	Projector Director Director of Digital & Health Intelligence Project Director	NA	No update received
2022-23	30.11.2022	Development of Genomics Partnership Wales	R5/6	Low	Payments should be made in accordance with contractual and/or legislative requirements.	Agreed. The DocuSign system has recently been implemented, which will expediate the process of payment approvals going forward.	Executive Director of Therapies and Health Science	Project Director	NA	No update received
2022-23	31.01.2023	Development of Genomics Partnership Wales	R6/6	Low	6a The UHB / PM should review the reasons for delays in the PIF issue/receipt process and ensure any avoidable delays are minimised going forward. 6b PIFs should be approved in a timely manner on receipt in Capital, Estates & Facilities.	6a Agreed. This will be completed and further reviewed in the lesson learned. 6b Agreed. The DocuSign system has recently been implemented, which will expediate the process of PIF approvals going forward.	Executive Director of Therapies and Health Science	Project Director	NA	No update received
2022-23	31.03.2023	Engineering Infrastructure	R1/6	Low	Further work is required to ensure the Project Bank Account is established and operating in line with Welsh Government policy.	Agreed. Further discussion ongoing with Contractor to enable project bank account to be put in place for the scheme.	Director of Planning	Project Manager	PC	The framework is currently undergoing re-tendering and included a requirement for contractors to implement project bank accounts where the value or timescale meets the relevant criteria.
2022-23	28.02.2023	Core Financial Systems (Treasury Management)	R1/4	Medium	The Treasury Management (Incorporating Cash Forecasting and Bank Account Controls) Financial Control Procedure should be strengthened as follows: - The requirements of the Standing Financial Instructions, section 7.3.1 (d) Banking Procedures should be addressed; - Consideration of developing, if not included within the FCP, a separate procedure to cover the access and control arrangements of the online banking system, Bankline; and - To enhance resilience, the inclusion of the process for developing the monthly cashflow forecast, which is a key document used to inform Welsh Government on a monthly basis of the Health Board's cash requirements.	•Agreed to revise FCP to include the requirements of 7.3.1 (d) also addressed in point 2 on management actions. •Agreed FCP to be updated to include control arrangements for access, inputting and authorisation of the online banking system. • Agreed to update the process document for develoing the monthly cashflow	Director of Finance	Rebecca Holliday, Head of Financial Services	PC	The FCP has been updated to address the points outlined in the internal report. The department has commenced a review of the cashflow process, it has become apparent that this review is quite extensive, taking into account the modernisation agenda and single points of failure in the current system. Therefore taking all these factors in account, it has been identified that cashflow modernisation/ review will be an ongoing process for the remainder of this financial year. In the interim a draft SOP is being produced which shall be subject to change once the new process is implemented.
2022-23	31.03.2023 31.07.2023	New IT Service Desk System	R1/4	High	1.1 A Standard Operating Procedure should be developed for the monitoring of open calls and calls set to 'Waiting for Customer' status. Customers with calls set to 'Waiting for Customer' status should receive two reminders, and these calls should be closed if the customer fails to respond after the second reminder. 1.2 Consideration should be given to making the target resolution date a mandatory field for all calls.	1.1 Service Desk Standard Operating Procedures have been created as part of the implementation. Standard reporting within the software has been configured to report Incidents and Service Requests which has passed baseline SLAs. Advanced reporting is currently being installed and configured using dynamic Microsoft Power Business Information reporting tools. 1.2 Target resolution date is already configured within the system, as this is linked to the SLA. Inclusion of a target resolution date is difficult to predict for non standard requests due to external factors, however, an indicative date will be included.	Director of Digital & Health Intelligence	IT Support Manager IT Support Manager	PC	Oct 23 Update - Standard Operating Procedures for the majority of processes have been created and shared within the teams. As the system is used further and more advanced features and functionality are added documentation is being added. This includes such things as Change Management, Asset Management, Problem Escalation.
2022-23	31.03.2023	New IT Service Desk System	R2/4	Medium	To enable Incidents to be effectively prioritised guidance should be developed for the use of Urgency and Impact levels when logging new Incidents. This should include clear definitions for each level and when they should be used, i.e. What does High, Medium and Low Impact and Urgency mean and when should these be used. The criteria used to automatically assign priority levels should also be reviewed to ensure calls are being effectively prioritised.	Further documentation will be created to ensure that Urgency and Impact of Incidents is clarified. Additionally, the automatic criteria for call priority will be detailed and documented.	Director of Digital & Health Intelligence	IT Support Manager	PC	Oct 23 Update - Priority categorisation for Incident Management has been agreed, documented and communicated within the Digital Teams. A new scoring and crititeria process has been implemented which prioritises calls based on impact and risk.
2022-23	31.03.2023	New IT Service Desk System	R3/4	Medium	A process should be developed to formally approve access to the system and to allocate appropriate access privileges, and to remove access from users that change post or leave the organisation.	Due to the Service Desk being owned and managed by the CAV IT support function, access is only provided to administrative staff on a need only basis. This is after appropriate training has been provided. As part of the improved Started, Movers and Leavers process within CAVUHB access rights are removed when staff members leave their role or organisation. The ISM platform is licenced using concurrent licences which are reviewed frequently, this provides additional controls around access.	Director of Digital & Health Intelligence	IT Support Manager	PC	Oct 23 Update - A formal process for requesting Service Desk access has been agreed and is in place. External teams within CAVUHB using the system are both cross charged the relevent licences cost, as well as limited in their view of the system by Role Based Access.

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2022-23	31.07.2023	New IT Service Desk System	R4/4	Medium	The service levels provided should be formally agreed with each user department. As part of this process an agreement setting out the responsibilities and expectations of all staff should be defined. Key Performance Indicators for the IT service desk should also be developed and regularly monitored and reported at an appropriate forum within the Digital & Health Intelligence Directorate.	A new Ivanti reporting server has been implemented within the last week. This server will be used to provide detailed, customised reports from Ivanti. KPI and SLA compliance reports will be created and reviewed within the next 3-6 months. These will also be fed formally into the Board via the digital and health intelligence sub-committee on a regular basis.	Director of Digital & Health Intelligence	IT Support Manager	PC	Oct 23 Update - Ivanti reporting has no been created including Power Business Information with interactive dashboards. These reports are shared with various Senior Digital Managers including the Director of IT. KPI and SLA compliance is being reported but not yet inforced due to adoption of the system and resourcing constraints within the Digital teams.
2022-23	28.02.2023	Access to In-Hours GMS Service Standards	R1/3	Medium	Management should revisit Welsh Government guidance to ensure Access Standards' performance and reporting requirements are met by the Health Board.	Access Standards guidance to be reviewed and appropriate corporate governance structure for reporting within the Health Board confirmed - Process for reporting established - TOR updated We reviewed the Terms of Reference and attendance of four Access Forums meetings, for the period 2021- 2022, and note the following: The Terms of Reference should undergo annual review according to its own review requirements, but we found no evidence of it being reviewed since it was finalised in January 2020. Whilst reviewing Access Forum attendance, we found one forum was not quorate. The Terms of Reference considers the Access Forum to be quorate with the following members in attendance, but we noted the absence of the Local Medical Committee representative at the December 2021 Access Forum: Director of Operations or delegate; Representative from the Primary Care Team; Locality Manager/Assistant Locality Manager;Community Health Council representative; Local Medical Committee Representative; and Practice Manager Representative. Further, we also note the absence of a member of PCIC management at three of the meetings reviewed, although their attendance does not impact on quoracy. As per the Terms of Reference, other membership at the Access Forum should include a Practice Manager representative from each cluster within the Health Board. There is an expectation that each Practice Manager representative shares examples of best practice, discussed at the forum, within their cluster. However, we found two of the Practice Manager representatives failed to attend one of the four forums reviewed, whilst one of the representatives failed to attend three of these four. Absence of these members is significant as GP practices rely on them to disseminate best practice examples to assist them in the implementation of the Access Standards. We note, Access Forum minutes are not shared with the	PCIC Director of Operations	Sarah Griffiths, Head of Primary Care	PC	**15/06/23-** Terms of reference in place/adopted. Discussions are continuing to review the appropriate reporting structure/forum to report access. Access data is provided as part of core Executive Review Data set (Monthly).
2022-23	31.03.2024	Endoscopy Insourcing	R6/6	Medium	It may be prudent to try and instigate an amendment to the contract (see section 6A of the SLA, Variation to Standard Specification) whereby the failure to achieve the agreed points each weekend would result in a proportional financial penalty, rather than the non-payment of invoices in full should the failure be caused by RHS not providing sufficient staff.	The directorate team will consider an amendment to the contract to include proportional financial penalty where RHS is unable to achieve the full weekly points / patient target.	Chief Operating Officer	General Manager	C	Update 17.10.23 1. Tender process complete, new contract in place whereby utilisation is maximised by overbooking of list and required point value reached. If provider is unable to staff list then no invoice presented resulting in proportional financial detriment. 2. No, Implementation Date of 31.03.2024 met. 3. N/A 4. Audit and Assurance Committee on 4th July 2023.
2022-23	31.03.2023	Medcial Records Tracking (Clinical Diagnostics & Therapeutics Clinical Board	R1/7	High	The Health Board's Records Management Policy (UHB 142 v3) and Procedure (UHB 326 v2) require review.	Review of The Health Board's Records Management Policy (UHB 142 v3) and Procedure (UHB 326 v2) will be undertaken to reflect subsequent changes in national and local legislation and guidance, as well as operational practice, with view to updated versions being approved and available to Health Board teams and employees.	Chief Operating Officer	To be determined following wider cross clinical board and corporate function discussions, led by the Director of Operations, Clinical Diagnostics & Therapeutics Clinical Board.	C	**Update 20.10.23** The Health Board's Records Management Policy has been updated and taken to the Digital & Health Intelligence Committee (15.08.23). The Records Management Policy was ratified and the supporting procedure approved.
2022-23	31.03.2023	Medcial Records Tracking (Clinical Diagnostics & Therapeutics Clinical Board	R2/7	High	In alignment with the review of the Records Management Policy and Procedure, the governance arrangements should be redesigned to provide effective oversight of the tracking of health records, to ensure there is a line of sight to the accountable executive of the policy and procedure.	The Health Board has a monthly Information Governance Sub-group chaired by the SIRO and attended by senior leaders including the Medical Director. Matters relating to the tracking of medical records can be escalated there. The group is linked to the Digital and Health Intelligence Committee (formerly the Information Governance Sub-Committee), and as such relevant points and actions will be raised accordingly at organisational governance fora. It is acknowledged that the mechanism for receiving points of escalation is often responsive in nature. Review of current governance arrangements related to medical records management will be undertaken with recommendations made, and subsequently enacted, to ensure a clearer line of sight to the accountable executive of related policy and procedures and related Heath Board.	Chief Operating Officer		PC	**Update 20.10.23** The redesign of governance arrangements for effective oversight of the tracking of medical records, led through the Information Governance Sub-group, will see an adapted version of the Medical Records management Group (MRMG) reinstated and chaired by the Medical Director. This is now anticipated to recommence in quarter 4 of 2023/24.
2022-23	3.03.2023	Medcial Records Tracking (Clinical Diagnostics & Therapeutics Clinical Board	R4/7	Medium	Management should formally track progress of taking forward lessons learnt to mitigate the risk of known issues recurring and to assist in identifying barriers that can be escalated for resolution.	A Health Board 'Tracking of Medical Record Learning and Improvement Proposal' will be developed. This will incorporate the points outlined in the Ombudsman response November 2021. Learning and progress on improvement will be assessed through Clinical Board's Quality, Safety & Patient Experience meetings, with further oversight	Chief Operating Officer	Directors of Nursing, and to be determined following wider discussion	PC	**Update 20.10.23** Formally tracking lessons learnt and the metrics related to them will align within QSE agendas, with specific oversight via the proposed MRMG. Implementation of the scanning of medical records related to concerns and the full restriction of access to Health Records filing library staff only (05.6.23), outlines demonstrable actions taken to address issues identified through learning exercises
2022-23	31.03.2023 28.02.2023	Medcial Records Tracking (Clinical Diagnostics & Therapeutics Clinical Board	R5/7	High	Management should ensure staff are reminded of their responsibilities to return health records once used and the importance of updating PMS or PARIS following a change in location.	This will be taken forward as part of Agreed Management Action 4, specifically in relation to point 4 of Matters Arising 4. Departmental (Health Records), reinforcement of correct processes and good practice related to storage of medical records, will be undertaken prior to this.	Chief Operating Officer	As recommendation 4 Head of Health records	PC	**Update 20.10.23** As part of an impact assessment of delivering fully restricted filing libraries - which will include an accompanying customer survey - the importance of tracking records at all points of delivery and transfer will be highlighted. The impact assessment will also include internal and external tracking audits; on a sample basis. The results will be shared with Clinical Boards and for onward discussion at QSE meetings.
2022-23	28.02.2023	Medcial Records Tracking (Clinical Diagnostics & Therapeutics Clinical Board	R6/7	Medium	Management should consider enhancing the operational efficiency and effectiveness to track medical records, based on our findings associated with the alternative filing systems in use, the indexing of records, the inconsistencies between UHL and UHW, and random spot checks on locations.	The department will revise its related local Standard Operating Procedures to ensure consistency of practice across sites, particularly in relation to the points outlined. Emphasis will be placed on regular sample location and tracking checks and hierarchy of actions depending on findings. A specific plan to complete the progress made towards a universal filing system (location-based tracking), will be developed. This will link to the Security and Storage action plan aligned to Recommendation 3.	Chief Operating Officer	Directorate Manager Patient Administration and Outpatients	PC	**Update 20.10.23** Operational efficiency and effectiveness has been improved via the sharing of tracking techniques, with standard operating procedures being revised accordingly. With the full restriction of Health Records filing libraries achieved, work has begun to switch the remaining areas to Location Based Filing; Filing Library 4 UHW and the adjacent overflow room. As a part of this transition, filing library staff have access to more hardware to track records in-situ, significantly reducing filing time and reducing the risk of tracking errors. Sample tracking audits (spot checks), will form part of the impact assessment related to fully restricted filing libraries and be part of audit cycles.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	M	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for November 2023: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2022-23	31.07.2023	Medcial Records Tracking (Clinical Diagnostics & Therapeutics Clinical Board	R7/7	Low	Following the implementation of recommendations 1 and 2 within this report, consideration should be given by management and the relevant governance forums of how the known barriers to digitisation can be addressed, if the Health Board aspires to digitise Health Records.	An assessment and proposal document will be created outlining known and potential barriers to digitisation and how they can be addressed, linking to current Health Board strategies and programmes, and specifically to national and organisational Digital work plans and schemes.	Chief Operating Officer	Director of Digital & Health Intelligence	PC	**Update 20.10.23** In recent months, the Board have been provided, by the Director of Digital & Health Intelligence, with an overview of Digital & Health Intelligence plans; this following various updates to Management Executive and Senior Leadership Board meetings. An Internal investment case is to be submitted in quarter 4 of 2023/24. This is a 3 to 5 year investment case of which digitsation forms a key element as a benefit driver for electronic clinical notes, specifically a digital integrated care record. In the interim, review of internal and Welsh Health Board mechanisms will continue to incrementally improve the current breadth and depth of the digital record platforms available. This will enable a surer foundation should the investment and resource needed be secured.
2022-23	31.04.2023	Management of Locum Junior Doctors (Children & Women's Clinical Board)	R1/4	Medium	Management within the Acute Child Health Directorate need to ensure that they grant approval for a Locum Junior Doctor working within their respective Directorate prior to them carrying out any shifts.	CHFW: There are some occasions when there is short term sickness, that the vacant shift is put on Envoy retrospectively. This can be during weekends or out of hours when the medical staffing coordinator is not present. Approval is granted prior to the start of the shift by the clinical lead for junior medical workforce, however is not recorded on envoy until the next working day. The directorate management team will work closely with the lead for junior medical workforce to identify a process that will ensure all vacant shifts are recorded prior to any shift being worked when the rota coordinator is not in place (out of hours and at weekends). The efficacy of this process will be regularly audited by the Directorate Management team and amended until it is sustainably embedded as business as usual.	Chief Operating Officer	Dr Genevieve Thueux, Assistant Clinical Director for Workforce (Lead for Junior Medical Workforce) Victoria Taylor, Medical Staffing Coordinator Directorate Management Team	C	**24.10.23** Checking of envoy and patchwork on a Monday morning now normal practice to identify if any locums booked over the weekend or out of hour period (following approval from Clinical Lead).
2022-23	31.03.2023 31.03.2023	Management of Locum Junior Doctors (Children & Women's Clinical Board)	R2/4	Medium	Management should ensure that the rates paid are in line with the Directorate approved rates, in instances where the rates paid do deviate from the recommended rates evidence should be retained to support these decisions. We acknowledge that there will be a rate card introduced for the M4 corridor in 2023.	1. Obstetrics and Gynaecology: Prior to locum shifts being offered to colleagues, the rate of pay will be confirmed with the Directorate Manager / Service Manager / Clinical Director by the rota-coordinator for assurances that those working shifts are told of the correct rates. If at any time rates of pay need to change, Clinical Board approval will be sought in writing. 2. CHFW: Prior to a rate card being introduced, the directorate are working to agreed rates. In some instances where there have been difficulties covering the service a higher rate of pay has been authorised. This is to ensure safe staffing levels across the clinical areas. The team will ensure evidence is retained to support the agreed higher rate of pay and Clinical Board authorisation will be sought in writing.	Chief Operating Officer	Rhodri John, Directorate Manager Clinical Lead / Directorate Management Team	C	**24.10.23** Pay rate card has now been introduced. Any locums are encouraged to join the internal bank as external agency locums are being reduced. This has happened with two of our locum consultants.
2022-23	31.03.2023	Management of Locum Junior Doctors (Children & Women's Clinical Board)	R3/4	Medium	In instances where management are approving the payment of shifts in excess of the hours requested, management should ensure that appropriate reasons are provided for the additional time, and that staff are encouraged to take appropriate rest-breaks.	CHFW: During high pressures on the wards there are occasions where staff are unable to take their rest breaks. Assistant Clinical Director for Workforce will remind all doctors of the importance to take their allocated break and record these as part of their worked shift.	Chief Operating Officer	Dr Genevieve Thueux, Assistant Clinical Director for Workforce (Lead for Junior Medical Workforce)	C	**24.10.23** All junior doctors are reminded of the need to take their breaks at handover. Clinical leads will also remind juniors need to take breaks and ensure they are allocated.
2022-23	31.03.2023 28.02.2023	Management of Locum Junior Doctors (Children & Women's Clinical Board)	R4/4	Medium	Rota-Coordinators need to ensure that all bank shifts for Locum Junior Doctors are entered onto the Envoy system prior to the shift being worked to facilitate accurate financial planning and reporting.	Obstetrics and Gynaecology: Rota coordinator will remind all clinical leads to notify of any vacant shifts each month. This will ensure Envoy is up to date with any outstanding shifts prior to being filled. This will be regularly audited by the Directorate Management Team. CHFW: Rota coordinator will remind all clinical leads to notify of any vacant shifts each month. This will ensure Envoy is up to date with any outstanding shifts prior to being filled. This will be regularly audited by the Directorate Management Team	Chief Operating Officer	Rhodri John, Directorate Manager Clinical Leads Victoria Taylor, Medical Staffing Coordinator	C	**24.10.23** Checking of envoy and patchwork on a Monday morning now normal practice to identify if any locums booked over the weekend or out of hour period (following approval from Clinical Lead). This is also checked everyday by Medical Staffing coordinator.
2022-23	No Agreed Deadline	Decarbonisation	R2/11	Medium	DAPs should be fully costed to fully determine the total funding required.	This point is noted. C&V are producing their new DAP before end March 2023. Feasibility studies will need to be commissioned as part of that plan.	Director of Planning		PC	The action plan was written with prudence in mind. In light of the current financial situation, a review of the plan has taken place and where money needed to be allocated a replan has taken place to consider how the same outcomes can be achieved by spending no money. These will be taken to the Decabonisation Delivery Group in December 2023.
2022-23	No Agreed Deadline	Decarbonisation	R3/11	Medium	DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	This point is noted. C&V are producing their new DAP before end March 2023.For this year, funding has been received from WG Decarb fund, and Re:Fit. Bids have gone in to EFAB.To quantify.	Director of Planning		PC	**In our 23/24 DAP, Estates work is being funded by EFAB and Re:Fit. The plan was conscious of the likely financial predicament when it was written with the DAP recognising a small amount of local revenue funding being required to deliver the plan. As the financial position worsened alternative zero cost means of delivery are being sought.**
2022-23	No Agreed Deadline	Decarbonisation	R4/11	Medium	NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	C&V do not have confidence in this data given that the means of calculation was different to the reporting WG requested in 2022. Using data input into EFPMS, C&V have established a carbon footprint for 18/19 through to 21/22. Stripping out supply chain it shows a 1% reduction in emissions over that period. WG have provided an interim response to these and other data concerns and they will determine what action to be taken to baselines and targets after the next set of data is complied in summer 2023 (foir f/y 22/23)	Director of Planning		PC	**It is still the case that the baseline for 2018/19 bears no relation to the way carbon emissions are calculated in 2023. There have been differences in calculation between 21/22 and 22/23 with respect to what needs to be specifically reported (asks from WG) and how procurement colleagues are calculating emissions. WG have also previously been informed by C&V that emissions calculations do not take into account the effects of inflation. C&V are able to track the emissions that are in our control consistently between 2018/19 and 2022/23. There has been an aggregate drop of 6% in our emissions relating to emissions we control (building, fleet and waste). The challenge therefore is being able to track a consistent carbon emission figure across all categories and years. Emissions for 22/23 was shared with the Finance & Performance Cttee in 9/23.**
2022-23	No Agreed Deadline	Decarbonisation	R6/11	Medium	Proposed management/accountability structures should be fully implemented as intended within the DAPs.	Governance in place, though is still new with first gathering of Delivery and Working Group members formally in November.	Director of Planning		PC	**Governance in place. September Decarbonisation Delivery Group did not take place as it was not quorate. Next meeting scheduled for December 2023.**
2022-23	No Agreed Deadline	Decarbonisation	R7/11	Medium	Where decarbonisation falls within the existing environmental remit of committees/ meetings, it is important that an appropriate profile is set. Terms of Reference and agendas should be reviewed to ensure that sufficient focus is provided.	Decarbonisation governance has been established as an independent entity. Requirements to review Terms of Reference has been noted and feature in C&V's draft DAP for 23/24.	Director of Planning		PC	**Quarterly, an update is provided to the Finance and Performance Cttee.**
2022-23	No Agreed Deadline	Decarbonisation	R9/11	Medium	In accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/ collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training.	Noted. Cardiff and Vale UHB would support the development and role out of Decarbonisation training.	Director of Planning	Programme Diector - Redevelopment	PC	**C&V have not commissioned any training, though have been pointing colleagues to training provided by CTMUHB and HEIW.**
2022-23	No Agreed Deadline	Decarbonisation	R11/11	Medium	The same rigour and monitoring should be applied to internally commissioned/ funded initiatives to ensure the outcomes are adequately recorded/reported.	Noted, we will scope the additional opportunities across the organisation	Director of Planning		PC	**No funding is being managed at this time.**
2022-23	31.07.2023	Financial Reports and Savings Targets	R1/3	Low	To enhance resilience management should consider creating a desktop procedure, which outlines those responsible for collating data to inform each of the tables within the Monthly Monitoring Return to Welsh Government and the source of the data within the tables.	Produce a Desktop Procedure outlining data sources and process for collation and completion of the Monthly Monitoring Return to Welsh Government.	Director of Finance	Principal Fiannce Manager (PE)	NA	The existing procedure is being reviewed with a view to updating to refelect current process and data souces by the end of October 2023
2022-23	31.07.2023	Financial Reports and Savings Targets	R2/3	Low	To support the robustness of the financial reporting process, the sources of data which inform the monthly 'Finance Report' should be evident and retraceable.	Produce a Desktop Procedure outlining data sources and process for collation and completion of the Monthly "Finance Report".	Director of Finance	Principal Fiannce Manager (PE)	NA	The existing procedure is being reviewed with a view to updating to refelect current process and data souces by the end of October 2023

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	M	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for November 2023: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2022-23	31.03.2023 31.05.2023	Nurse Staffing Levels Act	R1/3	Medium	The 'Nurse Staffing Levels Operating Framework' should be updated and made available on the intranet so that staff can access it. There should also be information on the nurse staffing levels act on the intranet	A) Work has started to create a Nurse Staffing Levels Act information page on C&VUHB SharePoint (intranet). The page will contain the Nurse Staffing Levels Operating Framework as well as other resources such as the Frequently Asked Questions and the All Wales Informing Patients poster for adults and paediatrics. B) The Operating Framework will be reviewed and updated to incorporate changes as a result of the introduction of SafeCare across C&VUHB. Specific additions to the framework will include: o Disaggregated SafeCare responsibilities for wards, senior nurse, temporary staffing department and agencies; o Management of red flags and routes of escalation; o Expectations of daily staffing meetings; and o Responsibilities for evidencing mitigating actions The Operating Framework will be signed off by the designated person. The updated version will be uploaded onto the Nurse Staffing Levels information page.	Executive Nurse Director	Emma Davies, Nurse Staffing Levels Lead Jason Roberts, Executive Nurse Director Emma Davies, Nurse Staffing Levels Lead	NA	
2022-23	30.04.2023 30.04.2023 30.06.2023 31.05.2023 31.05.2023 Ongoing 30.06.2023	Nurse Staffing Levels Act	R2/3	Medium	2.1 - Approval of the agreed nurse staffing levels by the Designated Person should be evidenced on the Nurse Staffing Level - Workforce Planning templates. 2.2 - The Finance budget reports for the WTE staff should be amended to align with the correct Nurse staffing levels.	2.1 - A) The establishment review process is well established in C&VUHB. Establishment reviews take place with the Designated Person and dates have been confirmed for the upcoming reviews in preparation for presentation to board in May 2023. B) The Designated Person to sign the workforce planning template. Nurse Staffing Levels Lead to confirm this prior to inclusion in the board report. C) Review the establishment review process as part of the Operating Framework setting out a clear timeline for future establishment review. 2.2 - A) As per the Operating Framework, Finance Partners in each Clinical Board to be present during establishment reviews. Ensure the signed off establishment templates are signed by finance partners and that these templates are used to inform the budget reports. B) Ensure agreed establishments are updated in Health Roster and this is reviewed bi-annually following presentation to board (May and November). C) Periodically undertake audits to confirm alignment of ESR, HealthRoster, Finance Ledger and NSA sign off establishments D) Review the workforce planning template prior to the next establishment review, consider increasing the details around Headcount per shift with the introduction of additional roles.	Executive Nurse Director		NA	
2022-23	31.03.2023 31.03.2023 31.05.2023 Ongoing	Nurse Staffing Levels Act	R3/3	Medium	Management should ensure that all wards display the ward staffing levels to inform the patients of Nurse staffing levels for each ward. Management should ensure that the Nurse staffing levels being displayed are correct and up to date. Management should ensure that 'frequently asked questions' on the nurse staffing levels (Wales) Act 2016 are available on the wards for patients to be able to access.	A) The correct All Wales Informing Patients Poster for adults and paediatrics and Frequently Asked Questions to be sent out to all Senior and Lead Nurses and Ward Sisters and Charge Nurses. B) The All Wales Informing Patient's Poster and FAQs will also be available on the newly created Nurse Staffing Levels Act SharePoint page. C) Following the current establishment reviews, a review of all 25B wards and a selection of 25A areas will be completed to ensure current establishments on the correct posters are displayed bilingually. The availability of the Frequency Asked Questions will also be reviewed. This process will be documented and shared with the designated person. D) As part of the UHB's Ward Accreditation programme, confirmation that the correct NSA information is displayed will be obtained before a ward is accredited	Executive Nurse Director	Emma Davies, Nurse Staffing Levels Lead Emma Davies, Nurse Staffing Levels Lead Emma Davies, Nurse Staffing Levels Lead Aron White, Nurse Informatics Lead / Helen Bonello	NA	
2022-23	30.04.2023 30.06.2023 30.09.2023 30.04.2023 30.06.2023	Individual Patient Funding Requests	R2/2	Medium	2.1 Management should remind clinicians to complete all sections within the IPFR application. 2.2 Standard templates including the decision record should be used as required. Where there are exceptions to this practise, this should be updated within the SOP. 2.3 Management should strive towards timely processing of all documents (as stated in the IPFR Policy) to avoid delay in the IPFR application process. 2.4 Management should ensure that IPFR applications full amount approved, period covered, and timeline required for completion of an outcome questionnaire (where already determined) is clearly stated within the decision record.	2.1 The IPFR Team will remind clinicians to complete all the relevant sections within the IPFR form as detailed in the SOP. 2.2 The SOP will be updated to reflect that standard documents may be tailored to reflect the individual circumstances of the specific applications and associated decisions. The IPFR Team will work with the IPFR Chair to develop a Chair's Action Decision Record which aligns with the IPFR Panel Decision Record. 2.3 As per the All Wales IPFR Policy, the initial decision letter will continue to be sent within 5 working days. The IPFR Team will aim to also send the letter containing the decision rationale within 5 working days, once the clinical detail has been ratified by the IPFR Chair. 2.4 We will ensure that duration of the funding is explicit in the decision letter (cycles, annual, excessive toxicity, progression, death or trial period). We will specify how often an outcome data questionnaire is required to be completed by the clinician in the decision letter. We will update the SOP to specify that an Outcome Data Questionnaire is expected every 6 months unless the IPFR Panel specify an alternative period.	Director of Planning	IPFR Commissioning Officer IPFR Commissioning Officer IPFR Commissioning Officer IPFR Commissioning Officer	C	2.1 Complete. SOP updated to reflect action. SOP currently being taken through internal governance processes for adoption of amendments. 2.2 Complete. SOP updated to reflect action. SOP currently being taken through internal governance processes for adoption of amendments. 2.3 Complete. Where the Chair ratifies the clinical rationale within 5 working days, the second notification letter is sent within this timescale. 2.4 Complete. Template letter has been amended to reflect this action.
2022-23	31.07.2023	Clinical Audit - Follow-up	R1/1	Low	Management need to ensure that the Clinical Audit Policy is formally approved by the Quality, Safety and Experience Committee. Following approval, the policy should be made available on the Clinical Audit Sharepoint page.	The Clinical Audit Policy has been developed and circulated for comment to the Clinical Effectiveness Committee and the Clinical Board Directors. It will be circulated wider through the UHB policy ratification process by Corporate Governance, followed by discussion at the Senior Leadership Board, and finally approval in the Quality Safety and Experience Committee. It will be made available to staff via the Clinical Audit Share point page.	Executive Medical Director	Head of Patient Safety and Quality Assurance	NA	
2022-23	19.05.2023	Nurse Bank (Temporary Staffing Department) Follow up	R2/3	Low	Management need to ensure that more staff are trained on the agency invoice report so cover can be provided in the event that an employee is absent.	Two members of the team have now been identified to be trained and assist with the processing of invoices.	Executive Director of People and Culture	Senior Nurse, Temporary Staffing & Strategic Nursing Workforce	C	Two members of the team have been identified and training has commenced.
2022-23	30.04.2023 30.04.2023	Charitable Funds	R3/5	Medium	To ensure charitable funds expenditure is appropriate and accounted for correctly the following action should be undertaken: • Fundholders should be reminded regarding the eligibility guidance on items that can be purchased from charitable funds; • All expenditure should be approved prior to it being incurred; • A record should be maintained by the Fundraising Department on decisions made to approve expenditure from funds that they manage. Information should include fund expenditure to be charged to, reason for expenditure, names of approver and date; and • With regards to purchase order 725863146 due to the time that has elapsed regarding the accrual management should consider removing the system accrual.	• The Head of Financial Services shall circulate the eligibility guidance to all fund holders and requistioners, on items that can be purchased from Charitable Funds. • Also Fund holders and requistioners shall be reminded that prior approval is required for all expenditure. • Of the 5 samples selected above, 3 of the sample's expenditure had been approved prior to being incurred. • Order 725863146 – has been cancelled and an annual review shall be completed of all aged system accruals pre-yearend close down. • Funds managed within the fundraising dept., a formal recording process will be implemented to account for decisions made to approve from those funds. Information will include fund expenditure to be charged to, reason for expenditure and names of approvers	Director of Finance	Head of Financial Services - RH Director of Communications and Engagement	PC	An email has been circualted to all fund holders with guidance on 1: Charitable Funds core and non core expenditure 2: procurement limits & authoristaion routes 3: confirming all expedniture needs to be approved before being committed. 3: Fundraising Department have revised expenditure schedules to included approvers name/ dates / company name & reason for expenditure.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	M	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for November 2023: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2022-23	No date provided	Charitable Funds	R5/5	High	An annual operating plan for the fundraising department should be submitted to the Charitable Funds Committee at the beginning of each financial year. The plan should provide specific details regarding the structure of the department, individual staff costs and also non staff costs. Details should also be provided of an estimate of staff costs that can be recharged to specific appeals and funds that the fundraising staff support noting the net costs that can be expected to be recharged to the 'general fund'. An update on the plan should be reported at each meeting of the Charitable Funds Committee noting any changes to the structure that will impact on the 'recharge' to the general fund.	The Health Charity is currently reviewing its strategy and in line with good practice has been engaging with CFC members and others to review and redevelop it collaboratively. Part of the strategy review entailed a recognition to include an Annual Operational Plan. This will be developed in Quarter 1 of 2023 and will be reviewed agreed via the Charitable Funds Committee and be embedded as part of its annual governance reporting mechanisms. This will include staff structure, costings and projections on any identified changes to the core staff establishment that require additional funding. Operational changes to staffing, responding and reacting to workforce or project requirements that do not require additional funding from general reserves, specific funds or have external funding will continue to follow the current reporting mechanisms and sign off via the Day to day operational responsibilities of the Director of Communications and sign off by the lead Executive as identified under section 2.27 above.	Director of Finance	Director of Communications & Engagement	PC	The Health Charity has developed a draft Operational Plan for 2023/24 which has been submitted to the quarterly Charitable Funds Committe meeting scheduled for 20.06.23*. The plan includes projected income/expenditure and current/projected staff costs for this period. The Health Charity and Charitable Funds Finance team are working collaboaratively to ensure that the projected financial plan is regularly revised and updated to reflect actual income/expenditure, which will be reported back to the CFC meetings via a newly developed Events reporting template . This template will also be used to report operationlal staff changes. *Subsequent annual reports will be submitted to the CFC meeting in the first quarter of each year, i.e. Jan - March, outlining the plan for the following financial year.
2022-23	30.06.2023	Community Patient Appliances (SS CB)	R1/5	Medium	The review of the 'Request for Repair' procedure should be completed and finalised, to provide clarity to staff and service users.	Finalisation of the Request for Repair is pending completion of the actions from the recent RCA, described in section 2.21. These actions have been communicated with the ALAS QSE and will be presented to SpS Clinical Board QSE at next scheduled opportunity.	Chief Operating Officer	Interim Assistant of Therapies & Health Science & Directorate Manager, ALAS	C	Review and updated process for 'Request of Repair' now complete and part of ALAS QMS (ISO9001 certified).
2022-23	30.06.2023	Community Patient Appliances (SS CB)	R2/5	Medium	Following our review of Repair Worksheet documentation, the following should be adhered to for completeness of records: - Field Service Engineers (FSEs) must ensure that Repair Worksheets for completed repairs are signed and dated by the service user where possible, or a note documented to explain the absence of a signature; and - Repair Worksheets are returned to the Senior Technical Officer in a timely manner and the documentation scanned onto the BEST system.	An additional 'Safety Check' checklist has been added to all FSE paper work. This should be completed at each repair to ensure opportunities are not missed to identify unsafe equipment. Completion of the check list will be reported on at fortnightly Operational meetings and form part of the regular ISO 9001 audit cycle. - Team to review and agree the process which will ensure that the completed forms are always scanned on the system and any non-completed forms are raised with the PMC Technical Manager for investigation. - The MTO team are responsible for the receipt, triage, recording and action of any returned actions from the Field Service Team. - Reports on number of FSE jobs completed, number of those with further work to reported at fortnightly PMS Ops meeting.	Chief Operating Officer	Russel Bailey, Technical Officer	C	Process around correct management of FSE paper work complete. Signing of repair paperwork is active, being monitored and reported at fortnightly PMS operational meetings. Responsibility clearly aligned to MTO lead. The new repair worksheet process, along with the reporting and monitoring, are now in place and actively being monitored.
2022-23	30.06.2023 30.06.2023 31.07.2023	Community Patient Appliances (SS CB)	R4/5	Low	Consideration should be given to the arrangements in place to undertake annual inspections of all powered wheelchairs to inform the Service's planned repairs programme, given the current limitations on existing resources.	Service to review approach to Planned Preventative Maintenance (PPMs). The additional Field Service Engineers check lists now contain a safety check that can be used as a PPM. Service to review how these can be incorporated into PPM cycle to reduce duplication of effort. Recruitment to full establishment of FSE staff in order to meet demand.	Chief Operating Officer	Russel, Bailey, Technical Officer	C	The addition of the safety check list has helped with addressing PPMs. The Field Service Engineering (FSE) team have been low on staff (due to long term sick). 2 additional staff have recently been recruited. The Power Replacement Program (to replace all obsolete powered wheelchairs) is complete. Future work is to conduct an annual validation of the fleet of powered wheelchairs across South Wales to better anticipate future obsolescence and help mange both safety and financial risk.
2022-23	31.07.2023	Data Warehouse	R1/7	Low	A map of feeds should be produced	Documentation of all feeds willb e put in place with outine procedure to maintain and keep up to date.	Director of Digital & Health Intelligence	Head of Business Intelligence	PC	Oct '23 Not completed due to long term vacancy in the team which has only just been approved for recrutitment.
2022-23	31.07.2023	Data Warehouse	R2/7	Medium	As the LDR is developed, the department should prioritise the development of replacement feeds from the LDR for those feeds that are currently a manual process.	An assessment of manual data feeds will be undertaken to identify and document which would be suitable for and benefit from migrating to the LDR. Note actual redevelopment of feeds would be subject to resource and prioritisation in the longer term.	Director of Digital & Health Intelligence	Head of Business Intelligence	PC	Oct '23 Some work has been done to identify manual feeds that can be decommissioned. LDR resource constraints mean redevelopment cannot be progressed at this time.
2022-23	31.07.2023	Data Warehouse	R3/7	High	The database should be upgraded. A patch strategy should be defined and implemented	The PMS database is planned for upgrade in September/October 2023. Following the upgrade of PMS, the Data Warehouse database will also be migrated to the latest Oracle database and be included within our new Oracle Goldengate infrastructure. A patching strategy will be implemented for both the PMS and Data Warehouse databases.	Director of Digital & Health Intelligence	Senior Developer	PC	Oct '23 Due to circumstances outside of our control a delay of 3 months was introduced. This has now been resolved and the upgrade is moving forward with the 3 month adjustment of timescales.
2022-23	31.10.2023	Data Warehouse	R4/7	Medium	Leads for data use should be identified within Clinical Boards in order to facilitate better links with Digital. Lead contacts for each Clinical Board should be defined within Digital, within the constraints of the staff resource available.	List of current digital coordinators in clinical boards will be reviewed and gaps identified. D&HI will work with Clinical Boards who haven't nominated a coordinator to demonstrate the benefits of the approach.	Director of Digital & Health Intelligence	Head of Digital Services Management	PC	
2022-23	31.03.2024	Data Warehouse	R5/7	Medium	A report / information catalogue should be devised in order to make clear what information is available to staff.	It is planned to build catalogues as part of the implementaton of Power BI and the LDR	Director of Digital & Health Intelligence	Head of Business Intelligence (Power BI) Head of Architecture and Analytics (LDR)	PC	Oct '23 A meta data catalogue will be installed in the LDR architecture for all users to contribute and consume. This will happen following the final configuration of the LDR architecture which is being hindered by resource constraints in the Network Team to finish the job
2022-23	31.03.2024	Data Warehouse	R6/7	Medium	A skills framework should be developed that identifies the required skills within the department that are needed to deliver a modern information and analytics service. This should be underpinned by a development plan setting out how skills will be brought in, either by development of staff, recruitment, or by partnering with other organisations eg Cardiff University.	Training plan for existing Informatics and BI staff is in place which will become the departments standard training pack for new starters going forward. Training will be delivered on-line via UDEMY training platform and will run for at least 12 months.	Director of Digital & Health Intelligence	Head of Business Intelligence	PC	Sept '23 new starters have undergone the core training programme but existing staff have not due to resource constraints and vacancies.
2022-23	31.03.2024	Data Warehouse	R7/7	Medium	A data strategy should be fully defined, along with a supporting roadmap. This should consider the appropriateness of the warehouse for the future. We note that there is a large amount of valuable information and reporting being provided from the data warehouse. To start anew would be a resource intensive undertaking, however the warehouse may not be able to fully provide a modern analytics function. As such the capability of Jupyter workbooks should be fully assessed to ensure it is capable of meeting the demands of the organisation.	We are committed to and are working to develop a data strategy which will address the warehouse issue raised but also the wider issue of providing data to those that need it.	Director of Digital & Health Intelligence	Director of Digital & Health Intelligence	PC	Oct '23 Due to resource constraints some progress has been made in this area.
2022-23	31.07.2023	Inclusion and Equality	R1/3	Medium	A review of the Terms of Reference along with the membership and remit of the ESWLSG is required by management, along with the formation of subgroups to facilitate decision-making and implementation.	The Terms of Reference, including membership and governance requirements of the ESWLSG are currently under review. This review will be informed by the governance surrounding the UHB's Equality, Equity and Experience Framework (currently at consultation), the requirements of the People and Culture Committee and the outcome of this audit. This review will include the identification of any required sub groups / steering groups / working groups and subsequent membership requirements and TORs.	Executive Director of People and Culture	Assistant Director of OD, Wellbeing & Culture	PC	The People and Culture Committee commenced in May 2023, and as part of developing effective governance and reporting arrangements to ensure the UHB meets it's legislative and ethical requirements, ESWLSG has been stood down while a more effective model is developed. The challenge with the group previously had been around ensuring ownership of the E&I and WL agenda, and there was inconsistency with reporting and representation from CBs and SBs. The main focus of the new group(s) will be ensuring understanding, ownership, measuring and reporting upon legislative requirements. The Head of E&I has met with the Executive Director of Corporate Governance with the initial proposal for the arrangements for a revised ESWLSG. Exec Director to speak to Chair for feedback.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	M	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for November 2023: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2022-23	30.09.2023	Inclusion and Equality	R2/3	High	To ensure compliance with the organisation's objectives and legislative requirements, management should undertake a review of the responsibilities of the team members and the structures in place within the Health Board to support the team.	The People and Culture Directorate will commence a benchmarking exercise to assess the effectiveness of current capacity compared to other NHS organisations. This is not restricted to the Equity and Inclusion Team, but also looking at Welsh Language, and Education, Culture and OD. This is being looked at alongside the UHBs commitment to delivering the SEP, meeting its Socio Economic Duties, and responding to WG direction, including the Anti-Racist Wales Action Plan; WRES etc. This will be completed, and the UHB will be presented with a paper, outlining the findings, team capacity findingshighlighting any areas of risk / any short-falls. This will go to the People and Culture Committee in the first instance.	Executive Director of People and Culture	Assistant Director of OD, Wellbeing and Culture	PC	The benchmarking exercise has been completed and a paper has been drafted to go to the Executive Director of P&C in the first instance. The department recognises a limited resource within Equity & Inclusion; however, the current financial climate impacts on the ability to move forward with this. This will continue to be logged as a risk. with a view to revist in 2024.
2022-23	31.05.2023	Inclusion and Equality	R3/3	Medium	Management should ensure that a robust process is in place to enable the required action plans to be effectively developed and delivered. This should include effective structures to support the Inclusion and Equality Team, including development of the Inclusion Ambassadors and Equality sub-groups.	The review and refresh of the TORs of the ESWLSG (Action 1), will reinforce the reporting and local accountability against equality actions, while enabling a forum that shapes strategic direction against EDI (and Welsh Language). The reviewed TORs will include reporting accountability for Clinical and Service Boards, along with reporting to the People and Culture Committee, and Board.	Executive Director of People and Culture	Assistant Director of OD, Wellbeing and Culture	PC	Please see above re changes to ESWLSG. (Line 99). This will ensure effective monitoring, understanding and ownership across the UHB.
2022-23	30.09.2023 30.05.2023	Risk Management	R1/4	Medium	1.1 - Further risk management education/training be delivered at directorates/departments level to ensure that risk owners understand their responsibilities in relation to maintaining accurate risk information within risk registers. 1.2 - Risk Registers in place for the Surgery Clinical Board and the directorates be reviewed, updated and high-profile risk information be shared on an on-going basis with the Risk and Regulation Team ("Check and Challenge" process).	1.1 - Action agreed – The risk and regulation team will provide further educational support to clinical board and directorate leads to ensure that risk owners understand their responsibilities in relation to maintaining accurate risk information within risk register and have access to relevant supporting documentation and literature. 1.2 Action Agreed – The Head of Risk and Regulation will remind the Surgery Clinical Board of their obligations in this regard.	Director of Corporate Governance	Head of Risk and Regulation	PC	1.1 The Risk and Regulation team have corresponded with all Clinical Board Triumvirates and Corporate Directorate risk leads to offer training to risk leads within these areas and their directorates. Regular check and challenge feedback will also continue to be provided as well as ad hoc guidance and support to all colleagues. 1.2 The Head of Risk and Regulation has met with the Surgery Clinical Board Director of Nursing and received re-assurance that directorate and clinical board risk registers are in place and that regular reviews of these registers are undertaken locally and at monthly Executive Clinical Board review meetings.
2022-23	30.06.2023	Risk Management	R2/4	Medium	Risk owners must ensure that all newly identified risks are properly documented within the Risk Assessment form and for this to be reviewed/approved by the Risk Owners and Clinical Board Directors in line with the Risk Management Procedures.	Action Agreed – The Head of Risk and Regulation will make clinical colleagues and risk leads aware of this recommendation and their obligations as part of the additional education to be provided, as detailed in response to Recommendation 1	Director of Corporate Governance	Head of Risk and Regulation	PC	The Risk and Regulation team have corresponded with all Clinical Board Triumvirates and Corporate Directorate risk leads to remind them of the need to document newly identified risks within Risk Assessment documents.
2022-23	30.06.2023	Risk Management	R3/4	Medium	Staff within Clinical Boards and Directorates be reminded of their responsibility to actively engage with the escalation/de-escalation process to ensure that risk registers contain risk information that is relevant and up to date.	Action Agreed – The Corporate Governance Team will regularly remind Clinical Boards and Directorates of their responsibility to actively engage with the escalation/de-escalation process to ensure that risk registers contain risk information that is relevant and up to date. These reminders will take place at monthly Executive Clinical Board Reviews.	Director of Corporate Governance	Director of Corporate Governance / Head of Risk and Regulation	PC	The Risk and Regulation team have corresponded with all Clinical Board Triumvirates and Corporate Directorate risk leads to remind them of the need to periodically review their risks and to escalate/de-escalate them following the implementation of controls/mitigations so that recorded risks remain up to date.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	M	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for November 2023: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2022-23	30.06.2023	Risk Management	R4/4	Medium	Risk owners must ensure that action sto address control gaps / weaknesses are frequently monitored and that progress of achieving these is documented and updated within the risk registers in a timely manner.	Action agreed - The Corporate Governance Team will regularly rmind Clinical Boards and Directorates of their responsibilities in this regard. These reminders will take place at monthly Executive Clinical Board Reviews.	Director of Corporate Governance	Head of Risk and Regulation	PC	The Risk and Regulation team have corresponded with all Clinical Board Triumvirates and Corporate Directorate risk leads to remind them of the need to periodically review their risks and open actions to address control gaps and weaknesses so that risk mitigations remain fully up to date and effective.
2022-23	31.07.2023	Management of Health Board Policies	R2/9	High	The out of date policies and procedures should be reviewed, updated and published as soon as possible.	Whilst a detailed plan to address to the previous recommendations made by Internal Audit in 2019/20 was drawn up and presented to the Audit and Assurance Committee in November last year, unfortunately it has been very challenging adhering to the timescales set out in the plan. This has been due to a number of reasons, including limited resource with the Corporate Governance team to undertake this large piece of work. The plan will be updated to reflect the recommendations made (see agreed management action 7 below), but in the meantime the following actions will be undertaken as soon as possible:- a) Head of Corporate Governance to review the current Policies Tracker and ensure that each Policy/other controlled document referenced on the Tracker has an Executive Lead sponsor; b) Produce an updated list of out of date Policies/other controlled documents per Executive Lead and issue to the same for comment with regards to likely timescales to review each policy. c) Executive Leads to work with the Head of Corporate Governance to provide a completed list of all of those out of date policies/other written controlled documents by the end of July 2023.	Director of Corporate Governance	Head of Corporate Governance	PC	This work remains ongoing within the Corporate Governance Team
2022-23	31.07.2023	Management of Health Board Policies	R3/9	Medium	• Further work is required to resolve the 44 blank rows with Date to Review to 2022 where no Executive Lead is identified; • Comments on the tracker should include sufficient information so that the status of policies and procedures can be clearly understood including what further action is required; • The large number of gaps in the tracker spreadsheet should be reviewed and cleared; and • The multiple variants of Executive Lead titles should be reviewed and amended so that there is a consistent approach.	The Head of Corporate Governance will undertake a comprehensive review of the policies tracker to address the recommendations made. The Corporate Governance team developed the "tracker" last year as a starting point for this large piece or work in order to record the policies/procedures which were registered on the Corporate Governance team's system and the review dates of the same etc. It is also used by the Corporate Governance team to record the work which the team is and has been undertaking since August last year with regards to putting the Corporate Policies register on a much better footing. For example, it provides the team with a status position of policies/procedures as we work through the tracker list). It is a tool to record the work being undertaken by the Corporate Governance team to produce a fully functioning policy management system.	Director of Corporate Governance	Head of Corporate Governance	PC	This work remains ongoing within the Corporate Governance Team
2022-23	31.05.2023	Management of Health Board Policies	R4/9	Medium	• Staff should be notified when draft policies and procedures are added to the consultation page on Sharepoint; and • The cover emails accompanying draft policies and procedures provided to South Glamorgan Community Health Council, the Stakeholder Reference Group and the Local Partnership Forum for comment should make it clear that the documents are being provided for consultation and the deadline by which any responses must be received.	The Corporate Governance team notify the relevant contact/policy author as soon as the policy/procedure document has been published for consultation and a link to the relevant SharePoint link is provided. The relevant policy author should notify relevant members of staff once the document has been published on Sharepoint. Cover emails accompanying draft policies and procedures provided to Llais (formerly the Community Health Council), the Stakeholder Reference Group and the Local Partnership Forum for comment now clearly state that the documents are being provided for consulation and the deadline by which any responses must be received.	Director of Corporate Governance	Head of Corporate Governance	PC	This work remains ongoing within the Corporate Governance Team
2022-23	31.07.2023 31.05.2023	Management of Health Board Policies	R5/9	Low	The links to UHB 001 Management of Policies, Procedures and Other Written Control Documents Policy and UHB 242 Written Control Documents - Development and Approval Procedure should be amended so that they work correctly.	Noted. The Policy (UHB 001) and accompanying Procedure (UHB 242) are to be reviewed and all links will be updated to ensure that they operate properly. There is a template section on the Policies page of Sharepoint where staff can access the Health Board's templates for a Policy and (ii) a Procedure. This section will be updated to include the other template documents referred to in Policy UHB 001 and Procedure UHB 242.	Director of Corporate Governance	Head of Corporate Governance	PC	This work remains ongoing within the Corporate Governance Team
2022-23	30.09.2023	Management of Health Board Policies	R6/9	Medium	The Standing Operating Procedure which covers the Corporate Governance Team's management of the Corporate Policies should be reviewed and updated once all work on getting the policy management system fully up to date has been successfully completed.	Noted. There are various strands to the Corporate Governance Team's work in relation to putting the management of Corporate policies on a much better footing. This involves working with the Health Board's archivist and IT colleagues to put in place a more efficient policy management system. The SOP will be updated to reflect that work, in addition to any other improvements identified when the policy management system has been fully updated.	Director of Corporate Governance	Head of Corporate Governance	PC	
2022-23	30.06.2023	Management of Health Board Policies	R7/9	Medium	If all actions in the Corporate Policies Management System Plan 2022/23 have not been completed and scheduled targets have not all been met by the May 2023 deadline, then a progress update and revised target completion dates should be presented at the next available Audit Committee.	The timescales set out in the Policies Management System Plan were ambitious and very challenging. Given the current resource within the Corporate Governance team, it has been very difficult adhering to the timescales set out in the original Plan. The Head of Corporate Governance will review the Corporate Policies Management System Plan 2022/23 with the Director of Corporate Governance. The updated Plan will be presented to the Audit Committee on 4 July 2023.	Director of Corporate Governance	Head of Corporate Governance	PC	The updated Plan will be presented to the Audit Committee on 4 July 2023.
2022-23	30.09.2023 31.07.2023	Management of Health Board Policies	R8/9	Medium	• The most appropriate structure for managing policies and procedures should be developed and applied consistently on the Health Board's website and Sharepoint. • The policies and procedures published on the Health Board's website and Sharepoint should be checked for accuracy and corrected where necessary.	As highlighted above, the Head of Corporate Governance is working with the Health Board's archivist in order to develop a more appropriate structure (including better categorisation) for the published policies and procedures. It is anticipated that once developed, this structure will be common to both the Health Board's website and SharePoint. Noted. A thorough review of the policies and procedures published on the Health Board's website and SharePoint will be undertaken to ensure accuracy as recommended.	Director of Corporate Governance	Head of Corporate Governance	PC	This work remains ongoing within the Corporate Governance Team
2022-23	30.06.2023 31.05.2023	Management of Health Board Policies	R9/9	Medium	For each new or amended policy or procedure, the Executive Lead should provide Corporate Governance with a statement indicating how staff and stakeholders have been notified and this information should be included in the Corporate Governance policies and procedures tracker.	The Corporate Governance team will strengthen its SOP so that the team routinely notify the Stakeholder Reference Group, the Local Partnership Forum and Llais (formerly the Community Health Council) once a policy/procedure has been approved and/or published. The Corporate Governance team now request a statement from the Executive Lead and/or policy author once the document has been approved and is ready for publication. The Policy Tracker has been updated to include a comment box to capture these statements, and it is already being populated.	Director of Corporate Governance	Head of Corporate Governance	PC	This work remains ongoing within the Corporate Governance Team
2022-23	31.07.2023	UHW-Hybrid and Major Trauma Theatres	R1/4	Low	The Project Execution Plan should be updated to reflect current governance arrangements.	Agreed – The Project Execution Plan will be updated. The project is currently on hold, subject to Welsh Government approval of the required funding. Therefore, whilst a July date is included as update they will not be ratified by the Group until the project re-commences	Director of Planning	Project Director	NA	The scheme is currently in delay as a result of the preferred supplier withdrawing the proposed equipment for the new facility and a new tendering exercise will be undertaken to confirm a new provider. It is anticipated that any revisions to the costs will be provided to WG in Q4.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	M	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for November 2023: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2022-23	31.08.2023	UHW-Hybrid and Major Trauma Theatres	R2/4	Medium	The UHB should consider putting in place a dedicated Project Board for this scheme ahead of the Construction phase commencing to ensure appropriate oversight.	Agreed – Director of Capital, Estates & Facilities to initiate discussions with an aim to take forward within the UHB. This will not be finalised until Welsh Government approval of funding has been approved, therefore target date will need to be	Director of Planning	Director of Capital, Estates & Facilities	NA	A dedicated Project Board will be established following approval of the scheme by WG
2022-23	31.08.2023	UHW-Hybrid and Major Trauma Theatres	R3/4	Low	Terms of Reference for the Project Team should be developed and ratified.	Agreed- the Terms of Reference will be developed and ratified. The project is currently on hold, subject to Welsh Government approval of the required funding. Therefore, whilst an August date is included as un update, the ToR's will not be ratified by the Group until the project re-commences.	Director of Planning	Project Director	NA	A new Terms of Reference will be developed in advance of the project team meeting and new project board when the project restarts
2022-23	31.07.2023 31.07.2023 Future action for other projects Future action for other projects	UHW-Hybrid and Major Trauma Theatres	R4/4	Medium	1. The SCP Call off Contract will be resubmitted for signature by the UHB Chair. 2. The UHB should confirm that appropriate insurances are in place in respect of the SCP. 3. **At future projects** Contracts should be executed prior to the commencement of works / duties. 4. **At future projects** All contracts should be dated.	1. Agreed - the SCP Call off Contract will be resubmitted for signature by the UHB Chair. 2. Agreed the UHB will confirm at the earliest opportunity that appropriate insurances are in place in respect of the SCP. 3. Agreed -Future Projects Contracts will be signed prior to the commencement of works. 4. Agreed - Future Projects - Contracts will be dated.	Director of Planning	Project Director	NA	Items 1 & 2 will be addressed when the scheme re-commences. Items 3 & 4 being addressed at all future projects
2022-23	Complete 28.06.2023 30.06.2023 30.06.2023	Planned Care Transformation Delivery	R1/1	Medium	The terms of reference and work programmes for committees and the workstream groups need to be reviewed and updated to reflect the current governance arrangements	1.1 The Terms of Reference for the Planned Care Improvement Board were approved on the 28th April 2023. 1.2 T he Terms of Reference for the Outpatients Delivery Group (formerly Outpatient Transformation Programme Board) have been re-drafted in June 2023 and will be approved at the first meeting of the refreshed Outpatient Delivery Group on 28 June 2023 1.3 The Terms of Reference for the Diagnostics Delivery Group and Theatres Delivery Group (formerly Theatres Improvement Group) require updating to reflect the changes in governance structure as above. 1.4 The Risks and Issues Log for the Diagnostics Delivery Group requires completion as above.	Chief Operating Officer	Joanna North, Senior Programme Manager – Planned Care	NA	
2022-23	30.11.2023	Recommendation Tracking	R1/3	Medium	1. The Risk and Regulation team should ensure that the narrative provides effective confirmation for all recommendations deemed completed by the Executive or operational lead. 2. Where there has been prior agreement with Internal or External Audit that the recommendation can be closed, this should be noted within the recommendation tracker to provide an appropriate audit trail.	1. Recommendation agreed – The narrative included within updates is the detail provided by executive and operational leads. The Risk and Regulation team will continue to remind colleagues of the need to provide more detailed feedback and will request additional detail when this is not forthcoming. 2. Recommendation agreed – This detail will be included in future instances.	Director of Corporate Governance	Risk and Regulation Team	C	All emails sent out remind colleagues of the need to provide additional detailed feedback where needed. Trackers are also returned to ask for additional support or evidence to close of any outstanding recommendations.
2022-23	30.11.2023	Recommendation Tracking	R2/3	Low	The Risk and Regulation team should ensure consistent reporting of review bodies recommendations from one meeting to the next.	Recommendation Agreed – A review of reporting mechanisms will be undertaken.	Director of Corporate Governance	Risk and Regulation Team	C	Where inconsistencies have been noted these have been isolated incidents and consistent reporting of recommendations is undertaken.
2022-23	30.11.2023	Recommendation Tracking	R3/3	Low	The reports and tracker should be scrutinised in more depth at the Committee meetings to ensure that outstanding recommendations from previous years that have not yet been implemented are challenged and scrutinised.	Recommendation Agreed – Work will be undertaken to ensure that items for scrutiny are highlighted to the Committee within reports. Conversations have been had and will continue to be had with the Audit and Assurance Committee Chair to support this process.	Director of Corporate Governance	Risk and Regulation Team	PC	Discussions have been had with the Committee chair to encourage robust review of recommendations. It is anticipated that this receommendation will be completed following the November Committee meeting.

Report Title:	Audit Wales Recommendation Tracking Report				Agenda Item no.	2.8	
Meeting:	Audit and Assurance Committee		Public	x	Meeting Date:	04.07.2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Risk and Regulation Officer						

Main Report
Background and current situation:

The purpose of the report is to provide Members of the Audit and Assurance Committee ("the Committee) with assurance on the implementation of recommendations which have been made by Audit Wales by means of an External Audit Recommendation tracking report ("the Tracker").

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

There have been no new recommendations added to the Tracker since the July 2023 Committee meeting. Out of the 29 recommendations carried forward from July 2023, 10 are reported as complete, 15 have been partially completed, and 4 are reported as having no action taken.

- Six recommendations are 1+ year's overdue with one showing no date specified
- Fourteen are 6+ months overdue
- Two are greater than 3+ months but less than 6 months.
- One is less than three months
- Five of the recommendations remain on target to be completed on the agreed implementation date although a number of these have not been updated for this meeting.

Since July 2023, a review of all outstanding recommendations has been conducted with executive and operational leads for each recommendation. This work will be reported to the Audit and Assurance Committee on a quarterly basis to provide updates on the status of recommendations. Between each instance of reporting to Committee the Risk and Regulation team will also continue meeting with Audit Wales Colleagues to verify progress made against recommendations included within the Tracker.

The table at Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken in 19/20, 20/21 and 21/22 as at 20 October 2023.

Recommendation:

The Audit and Assurance 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.

To note the continuing development of the Audit Wales Recommendation Tracker.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
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*									
Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
By maintaining an up to date Audit Wales Recommendation Tracker, the Health Board mitigates the risk that it may be subject scrutiny and supports the ongoing achievement of best practice recommendations.
Safety: N/A
Financial: N/A
Workforce: N/A
Legal: N/A
Reputational: N/A
Socio Economic: N/A
)
Equality and Health: N/A
Decarbonisation: N/A

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
06/11/2023 11:21:06

Audit Wales Recommendations 2019/20 – 2022/23 (November 2023)

External Audit	Complete	No action	Partially complete	No Date Specified	0 mths	< 3 mths	> 3 mths	+6 mths	+ 1 year	Grand Total
Assessment of Progress Against Previous ICT Recommendations			1						1	1
Audit of Accounts Report Addendum – Recommendations 2022-23			6					6		6
Audit of Accounts Report Addendum – Recommendations 2021-22			4					2	2	4
Clinical Coding Follow-up from 2014			1	1						1
Estates Follow-up Review	2		1					3		3
Review of Quality Governance Arrangements	**2**	**2**	1		1			1	3	5
Structured Assessment 2022		**2**	1			1		2		3
Taking Care of Carers	**6**				4		2			6
Total	**10**	**4**	**15**	**1**	**5**	**1**	**2**	**14**	**6**	**29**

According to the table above, No recommendations have been added to the Tracker since last reported at the Committee in July 2023. The total number of recommendations is currently 29, with 10 actions reported as complete. Fifteen actions are partially completed and 4 have no recorded update since the last Committee meeting. Six outstanding actions were more than a year behind schedule. Fourteen recommendations are more than six months overdue, with one indicating no date specified. Two actions have exceeded their agreed-upon deadlines by over three months, but less than six.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Management Response	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update November 2023 Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2019-20	No date specified	Clinical Coding Follow-up From 2014 not yet completed	R2	**Medical Records:** 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.	b) To facilitate the achievement of the Welsh Government target that 95% of coding activity should be completed within one month of the end of the hospital episode, it is important that clinical coders get timely access to the patient's medical records. From our last review we found that tracking of records was an issue. If records are not tracked effectively this means it can take longer for coders to access them. Coders are reporting that they are tracking records, however practices across the Health Board are not consistent and still cause issues.	Director of Digital and Health Intelligence	Head of Information Governance	PC	**May 2023 -** From the 5th June 2023 all filing libraries are being restricted so that only medical records personnel retain access which should improve compliance with the WG target for coding activity. **March 2023 Update-** • The mobile tracking technology being assessed by Medical Records is being rethought due to technical challenges. • An internal audit into the tracking of patient records concluded in January 2023 and will inform future implementation. • Medical Records are instead currently trialling a single device within the filing libraries. b)The UHB is developing mobile tracking technology which would support an audit programme designed to determine levels of tracking compliance across departments Head of IG working with Medical Record's Directorate Manager to implement regular auditing function.
2020-21	Jun-21	Assessment of Progress Against Previous ICT Recommendations	R4/5	Rollout appropriate and regular offline information governance training to employees without PC access.	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.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	**September 2023 update: Need to advise on whether all staff have access to ESR?** **May 2023 -** By sepetember 2023 all staff should have access to ESR training materials electronically via their own desk top of LED run sessions. A programme for digitally enabling the entire workforce is being developed, focussing initially on nursing staff, provide NADEX and email accounts to them, starting in September 2022 to support the implementation of the Welsh Nursing Care Record. the aim is to extend to all staff during 2022/23. Roll out of additional devices to nursing staff on track to commence September 2022.
2021-22	Windows 7 replacement - February 22 Servers - March 2023	Audit of Accounts Report Addendum - Recommendations	R2/6	The Health Board should replace its unsupported servers and devices. Where replacment is not currently feasible, the Health Board should ensure that robust mitigating arrangments 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.	There are ongoing programmes in place to replace or upgrade all affected devices. Jan 2022 Update: The majority of the CAVUHB workstation estate has now been upgraded with less than 8% left to complete. In Nov 2021 the server team in CAVUHB began decommissioning legacy server operating systems and upgrading where possible, this work is planned to continue throughout 2022/23. DHCW Nessus and SIEMs solutions have also been implemented in Dec 2021, along side a dedicated Ivanti patch management solution. A new Anti-Virus solution has been implemented for the CAVUHB server estate in Dec 2021.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	**Oct 2023 -** All Windows 7 devices have been replaced where possible, any specialist devices left have controls in place and restrictions applied to mitigate any security risks. The relevant departments have been contacted to liaise with suppliers or vendors to replace and upgrade ASAP. All CAVUHB servers directly under the management of CAV Digital now have fully monitored and updated AV. CAV Digital continue to work with suppliers and vendors to address any others.
2021-22	Feb-22	Audit of Accounts Report Addendum - Recommendations	R3/6	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 test the revised DR plan to ensure that it works as intended.	The IT DR Plan is being reviewed and updated as part of a programme to refresh IT Security documentation. Jan 2022 Update: HPE StoreOnce backup and archiving solution with a capacity of 1PB has been purchased and due to be implemented in Feb 2022. This will form part of a new Backup and DR approach for CAVUHB. This will be achieved by retiring tape media and consolidated with Veeam software throughout, to be carried out during early 2022.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	**Oct 2023 -** Implementation of the new HPE StoreOnce backup repositories has been completed. They currently reside in the SAC building Pods 1 & 2. They will be moving to UHL and Woodland House in 2024 when the required networking has been completed. **September 2023:** Completion of work to be undertaken during Q4 2023/4
2021-22	Feb-22	Audit of Accounts Report Addendum - Recommendations	R4/6	The Health Board should update its IT change control policy and procedure	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. Jan 2022 Update: Ivanti Helpdesk and Change Management Module is scheduled to be implemented W/C 10th Jan 2022.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	**Oct 2023 -** Change Management is now in use by Digital Operations and will be used in the new CD1 Genomics site at Coryton in November 23. The wider Digital teams within CAV will adopt change control througout 2024
2021-22	Nov-22	Audit of Accounts Report Addendum - Recommendations	R5/6	The Health Board should evaluate and consider upgrading its IT1 and IT2 data centre controls, or, decommissioning and replacing them with a better, fit for purpose, data centre.	Future reliance on these rooms is being reviewed and potential part decommissioning will be considered. Jan 2022 Update: Additional funding has been allocated for these improvements. Further consolidation of the two datacentres has progressed and a remote DR/Backup location in UHL has been identified. This new DR site will be developed over the next 12 months, subject to appropriate funds being available.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	**Oct 2023 -** Electrical work has been completed in CRI, UHL and Woodland House. Migration of DR and secondary systems will start in early 2024 with Server Team Management and Backup servers going first. This process will take 6-12 months. The majority of services and servers have been moved from IT1 and IT2 with a view to consolidate in the SAC building and then to UHL and Woodland House as appropriate.
2021-22	Feb-25	Taking Care of the Carers	R1/6	**Retaining a strong focus on staff wellbeing** NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as eing at higher risk from COVID-19.	Cardiff and Vale University Health Board (CAV UHB) continues to maintain a strong focus on wellbeing through a variety of initiatives which include UHB-wide interventions (e.g. supporting the capacity of the Employee Wellbeing Services; wellbeing conversations promoted as part of VBAs and regular 1-2-1s; effective inductions) and targeted pieces of work (e.g. Shwartz Rounds; Med TRiM, hydration stations and staff rooms and Wellbeing Retreats). The overarching framework for this is the People and Culture plan which has been informed by colleague feedback, data and the Health Intervention Report (specifically in relation to staff wellbeing).	Executive Director of People and Culture	Assistant Director of Organisational Development	C	The UHB People and Culture Plan 2022-25 sets out the priorities we will focus upon over the next three years, with a clear aim of improving the wellbeing, inclusion, capability and engagement of our workforce. The recent refresh of the UHB Shaping Our Future Wellbeing Strategy, highlights the key objective of 'Putting people first', which includes our patients, our communities and our colleagues. In terms of retaining a strong focus on staff wellbeing, the UHB has improved both its intent and governance around this. This includes: •Culture and Wellbeing identified as a potential risk and reported upon quarterly via the Board Assurance Framework. •Recently updated terms of reference and membership of the Colleague Health and Wellbeing Steering Group (previously Wellbeing Strategy Group), which includes governance and reporting arrangements to the People and Culture Committee and, where necessary, Board. •Development of a UHB Health and Wellbeing Framework led by People and Culture, supported by Health and Wellbeing Steering Group. •Review of the People and Culture priority objectives for 2024/25 in line with the Clinical Board objectives, with themes including: oPeople feel valued, developed, supported and engaged •A focus on wellbeing and culture in the Clinical Board Executive Reviews. •Continuous monitoring of COVID-19 in the community with appropriate response and communications to all staff. •A fully resourced Employee Wellbeing Service following UHB support to make the temporary counselling positions substantive

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2021-22	Mar-25	Taking Care of the Carers	R2/6	**Considering workforce issues in recovery plans** NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.	The impact of COVID-19 on the health and care system continues to take its toll on both the delivery of services and the wellbeing of our staff. With many COVID restrictions lifted, the challenges of increasing service demand, waiting lists and financial strain continue. The People and Culture Plan sets out the themes we will focus on over the next three years, with a clear focus on improving the wellbeing, inclusion, capability and engagement of our workforce. This Plan is aligned with the Operational plan; thereby ensuring a whole-system approach. The specific developments under the People and Culture Plan are reported upon monthly and progress is documented in a flash report. Ongoing review of actions and priorities continue, informed by direction provided by WG, feedback from colleagues and workforce data. Recent engagement exercises with staff have included a Wellbeing Survey for the Medical Workforce (closed 31st July 2022), and the launch of a three month engagement platform (Winning Temp) aimed at our Nursing and Midwifery Staff and ODPs. Feedback from these exercises will inform response and priorities to ensure safe, effective and high quality healthcare.	Executive Director of People and Culture	Executive Director of People and Culture Assistant Director of Organisational Development Assistant Director of Resourcing	C	The UHB People and Culture Plan 2022-25 sets out the priorities we will focus upon over the next three years and is reviewed on an annual basis in light of emerging trends, horizon scanning and partnership working with Clinical and Service Boards. This has a clear aim of improving the wellbeing, inclusion, capability and engagement of our workforce. The recent refresh of the UHB Shaping Our Future Wellbeing Strategy, highlights the key objective of 'Putting people first', which includes our patients, our communities and our colleagues. In terms of considering workforce issues in recovery plans, the UHB has worked with Clinical and Service Boards to ensure that annual plans reflect the workforce implications, including resourcing, retention, culture, inclusivity and wellbeing. Areas that also support this and provides assurance that workforce issues are considered include: •Wellbeing and Culture identified as potential risks and reported upon quarterly via the Board Assurance Framework. •Recently updated terms of reference and membership of the Colleague Health and Wellbeing Steering Group (previously Wellbeing Strategy Group), which includes governance and reporting arrangements to the People and Culture Committee and, where necessary, Board. •Review of the People and Culture priority objectives for 2024/25 in line with the Clinical Board objectives, with themes including: People feel valued, developed, supported and engaged •A focus on wellbeing and culture in the Clinical Board Executive Reviews and annual plans. •UHB prioritised roll-out of an evidence based 'Culture and Leadership Programme' to support analysis of, and improvement in team cultures and working practices, from diagnosis through to delivery and evalutation.
2021-22	Mar-23	Taking Care of the Carers	R3/6	**Evaluating the effectiveness and impact of the staff wellbeing offer** NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully	The People Health and Wellbeing Services Team, which includes Occupational Health, Employee Wellbeing Services, Health Intervention and Physiotherapy Services, are developing effective means of measuring both delivery of services (e.g. Counselling appointments; Pre-Employment Health Checks); and impact of those services. This information is being developed to be incorporated into a quarterly report which will also feed the progress reports on the People and Culture Plan. Base-line information is collated in all areas where targeted interventions are being developed, to ensure an effective means of measuring impact and outcomes. The development of the Wellbeing Framework will also incorporate tools and templates to ensure that interventions, projects etc are effectively measured. The People and Culture Team are working with Innovation and Improvement to shape monitoring and evaluation.	Executive Director of People and Culture	Assistant Director of Organisational Development	C	The People and Culture Plan, and subsequent annual priorities are reported upon quarterly and are underpinned by key performance indicators and outcome measures. These are reported to the People and Culture Committee and the Executive Board. The reporting covers more than what could be viewed as the 'traditional' wellbeing offer and work undertaken to positively impact upon the employee experience, including wellbeing, often sits under cultural work, learning and development, ways of working and systems, leadership and management development, equity and inclusion etc. As mentioned in previous points, this work is identified, planned, measured and evaluated as part of the People and Culture Plan. Other mechanisms, such as workforce data, Staff Surveys and engagement, staff networks, raising concerns, KPIs etc will also be used. The Health and Wellbeing Framework will also contain further detail on effectively measuring and evaluating the staff wellbeing offer. In addition, monitoring and evaluating our People Health and Wellbeing Services (Occupational Health and
2021-22	Nov-23	Taking Care of the Carers	R4/6	**Enhancing collaborative approaches to supporting staff wellbeing** NHS bodies should, through the National Health and Wellbeing Network and/or other relevant national groups and fora, continue to collaborate to ensure there is adequate capacity and expertise to support specific staff wellbeing requirements in specialist areas, such as psychotherapy, as well as to maximise opportunities to share learning and resources in respect of more general approaches to staff wellbeing.	Recent developments in this area include Cardiff and Vale's participation and involvement in the All Wales Staff Welfare Group, looking at ways to support and improve the wellbeing of NHS colleagues across Wales. Part of this involvement is the sharing of the work CAV are doing around Wellbeing Retreats; hydration and physical environment work. Work continues to progress, and the UHB now has representation on the working groups that have stemmed from the over-arching steering group.	Executive Director of People and Culture	Assistant Director of Organisational Development	C	The UHB continues to be an active member of the All Wales Health and Wellbeing Network in terms of contribution, co-production and disseminating information back to the UHB to enable good practice and shape and inform approaches, intervention and opportunities to enhance staff wellbeing. The Executive Director of People and Culture also sits on the All Wales Staff Welfare Group, supporting the strategic development of the staff welfare offer for Wales. The review and refresh of the Colleague Health and Wellbeing Steering Group brings together colleagues from across the UHB, representing professions, Clinical and Service Boards, staff groups and varying areas of expertise. As part of the TORs, the group will engage with and co-design / co-produce agreed pieces of work with staff representatives and TU members – this will start initially with the development of the Health and Wellbeing Framework. The Steering Group works closely with the Health Charity to identify areas for collaborative working, along with external partners such as HEI / FEI and other NHS Wales bodies. The UHB is embedding a range of methods to engage Clinical Boards, Teams and Senior Leaders in improving culture, and therefore the experience and wellbeing of colleagues. The Culture and Leadership Programme is one such evidenced and measurable approach in the organisational development toolkit that ensures that colleague involvement, participation and feedback is gathered to enable improvement to culture, experience, wellbeing and patient experiences and outcomes. As part of the Strategic Equality Plan engagement, feedback from colleagues, external stakeholders, communities and patients will shape our Strategic Objectives for the next 4 years (2024-2028). The UHB will continue to collaboate with staff networks, wellbeing champions, the Camerados initiative, as well as through Safety walk arounds, Ask the CEO, and through the relationships with our TU colleagues.
2021-22	Feb-25	Taking Care of the Carers	R5/6	**Providing continued assurance to boards and committees** NHS bodies should continue to provide regular and ongoing assurance to their Boards and relevant committees on all applicable matters relating to staff wellbeing. In doing so, NHS bodies should avoid only providing a general description of the programmes, services, initiatives, and approaches they have in place to support staff wellbeing. They should also provide assurance that these programmes, services, initiatives, and approaches are having the desired effect on staff wellbeing and deliver value for money. Furthermore, all NHS bodies should ensure their Boards maintain effective oversight of key workforce performance indicators – this does not happen in all organisations at present.	Quarterly updates to the Board / more regular reports for management executive team meetings Updates and discussions at Local Partnership Forums and LNCs. Update, discussion and feedback at Clinical Boards Bi-monthly Wellbeing Strategy Group meetings - latest update 03/08/2022 Ongoing evaluation of staff wellbeing offer, including access, impact and value awaiting OH Services evaluation. Feedback and discussion at staff networks to inform priorities / direction of travel Attendance of AD of OD at key strategy meetings / COVID recovery meetings to ensure staff wellbeing at forefront of decisions ; EHIA completion to support policy / process and decision making - EHIA Process currently being reviewed in partnership with Innovation and Improvement Team to embed in organisational programmes of work. Staff feedback regarding wellbeing also obtained via NHS Wales Staff Survey, MES, localised surveys and trial of engagement tool with nursing staff (March-May 2022). MES Workshops took place in March and April 2022, follow up focus groups scheduled for June and July 2022 led by the Medical Director and AD of Organisational Development. Wellbeing Survey for Medical Workforce going live in June 2022. Winning Temp engagement platform being trialled with all Nursing and Midwifery staff opened w/c18th July 2022, open until mid October 2022, enabling weekly 'check ins' and temperature checks. Communication plan in development to be shared with staff to manage expectations and provide regular updates. Wellbeing retreats have started, two held to date - informal feedback very positive with further engagement to obtain more meaningful feedback scheduled for September 2022 working with The Fathom Trust. Analysis of the Medical Workforce Wellbeing Survey to be carried out in August 2022. This information to be triangulated with other engagement outputs (MES; other surveys) to inform wellbeing priorities via the Executive Medical Director. Work also commencing on Anti-Racist Wales Action Plan.	Executive Director of People and Culture	Assistant Director of Organisational Development	C	The UHB has strengthened the assurance around reporting upon all matters relating to staff wellbeing. As detailed in a range of responses, this is through a variety of means, and work has been undertaken to ensure the quality and content of the reporting is sufficient to provide assurance that these programmes, services, initiatives, and approaches are having the desired effect on staff wellbeing and deliver value for money. Board Assurance Framework – reporting upon Wellbeing and Culture (including Equity, Inclusion and Welsh Language) Progress on the People and Culture Plan reported to People and Culture Committee, SDDG and Executive Board. 6 monthly reporting from the Colleague Health and Wellbeing Steering Group on progress around wellbeing priorities and the Health and Wellbeing Framework. People and Culture Dashboard has been developed to provide analysis of workforce data, and in 2024/25 it will include the KPIs and insights from the People Health and Wellbeing Service. The UHB will continue to engage colleagues leading on change in the completion of EHIAs. Progress against action plans are reported to Senior Leadership Board, People and Culture Committee and Board where necessary (e.g. Anti-Racist Wales Action Plan).
2021-22	Mar-23	Taking Care of the Carers	R6/6	**Building on local and national staff engagement arrangements** NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	xisting staff engagement mechanisms include: •NHS Wales Staff Survey - planned for October 2022 (as per information from HEIW) •Medical Engagement Scale - follow up online engagement sessions in March/April 2022; focus groups and visits to targeted areas planned in June/July 2022 and a follow-up wellbeing survey to all Medical Workforce June-August 2022 •Freedom to Speak Up - CAV part of all Wales working group •HR Processes and Procedures •Respect and Resolution Policies and Procedures •Trade Union Representatives •Existing Staff Networks – LGBTQ+; One Voice (Black, Asian, Minority Ethnic); Long Covid; Access Ability Network launched April 2022 •14,000 voices campaign (on-site visits / staff groups / teams etc)	Executive Director of People and Culture	Assistant Director of Organisational Development	C	The UHB has a range of staff engagement mechanisms which will be reviewed annually to ensure delivering accessible and effective engagement for staff: •Current work on improving accessibility and awareness around 'Freedom to Speak Up', this includes aligning and simplifying the ways in which all colleagues can raise concerns. •Tendable system – wards based auditing tool that enables live capture of data to support quality of delivery •2024/25 will see priority action taken to enhance existing staff networks and develop new staff networks – in line with the actions within the Anti-Racist Action Plan •NHS Wales Staff Survey 2023 – communication and engagement plan in place to cascade results from February 2024 and support CBs in interpreting and taking action •Continued partnership working with Trade Union Partners via LNC, LPF and National Forums •Continuation and enhancement of live, online 'Ask the CEO / Exec etc' sessions held bi-monthly •Localised engagement aligned to specific strategic projects, e.g. Shaping our future clinical services

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2022/23	Sep-22	Review of Quality Governance Arrangements	R1/7	The Surgery Clinical Board and Surgical Services Directorate revised their quality priorities in response to the COVID-19 pandemic. However, there appears to be poor alignment between these operational priorities and the Health Board's key delivery actions for quality and safety as outlined in its Annual Plan for 2021-22. The Health Board, therefore, should ensure there is better alignment between operational and strategic quality and safety priorities as articulated in the Health Board's 10-year strategy and new Quality, Safety, and Patient Experience Framework.	To work with all Clinical Boards to agree the QSE priorities aligning to the framework and Annual Plan and to the IMTP. Develop generic and specific Quality indicators aligned to the QSE Priorities in the QSE framework for Clinical Boards which are reported through QSE structure. and QSE Committee. These will be reported by exception as required and in totality at their scheduled presentation to the Committee.	Executive Nurse Director	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality	C	A Quality Indicators report is shared at QSE committee bi monthly with a deep dive into a specific indicator in the other month. The indicators align with the Duty of Quality. Th clinical board provide their assurance reports to QSE in the new templated format and can include reference to the development against the QSE Framework, Annual Plan and IMTP. The Integrated Board report recognises the interrelationship between the operation delivery and the QSE measurements.
2022/23	Oct-22	Review of Quality Governance Arrangements	R3/7	Clinical Audit The Health Board is developing a Clinical Audit Strategy and Policy, but there has been a delay in progress due to capacity and IT system challenges within the Clinical Audit Team. Internal Audit completed a review of the Health Board's clinical audit arrangements during 2021 and gave a limited assurance rating, identifying several key matters that need to be addressed. Whilst the Health Board is making some progress in this area, it should: a) complete the work on its clinical audit strategy, policy, and plan. The plan should cover mandated national audits, corporate-wide, and local audits informed by areas of risk. This plan should be approved by the corporate Quality, Safety and Experience Committee and progress of its delivery monitored routinely; and b) ensure that recommendations arising from the Internal Audit review of clinical audit are implemented as a priority.	The Clinical Audit Plan is to be shared at the Audit and Assurance Committee and discussed at the October QSE Committee meeting. The plan will reference all of the actions from this report. Compliance with internal audit findings will continue to be monitored via the Audit and Assurance Committee. Some investment has been provided to Clinical Audit from in year one form the internal Business case (monies to be provided over a 3 year period). Posts are being recruited into - investment was provided for a Clinical Effectiveness lead Band 8a and an Audit co-ordinator band 5. Additional resource was provided for a band 5 post to support the AMAT programme. AMAT - Audit management and tracking system has been purchased and is being rolled out through a phased implementation	Executive Nurse Director	Head of Quality Assurance & Clinical Effectiveness	C	• The Clinical Audit policy and strategy have now been ratified • AMaT has been implemented across the UHB • Substantial assurance has been awarded by internal audit
2022/23	QSE Framework to 2026 May 2023 Project plan completion October 2022	Review of Quality Governance Arrangements	R4/7	Values and Behaviours The Health Board's Values and Behaviours Framework sets out its vision for a quality and patient-safety-focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses, incidents, and raising and listening to staff concerns. The Health Board, therefore, should undertake work to understand why some staff feel: a) that their mistakes are held against them or kept in their personal file; b) that the Health Board does not provide feedback about changes put into place following incident reports or inform staff about errors that happen in their team or department; and c) they don't feel free to question the decision or actions of those with more authority and are afraid to ask questions when something does not seem right .	A safety culture with a focus upon psychological safety is an enabler of the QSE Framework. Members of the team are undertaking an IHI (Institute for Healthcare Improvement) Leadership course, and their focussed piece of work will address these issues. A project plan is being developed and will be part of the QSE implementation of the framework Culture surveys and feedback will be part of the evaluation with our quality metrics and will be undertaken annually in quarter 4 to assess whether values and behaviours have improved. Work will be aligned with organisational development colleagues supported through the people and culture plan.	Executive Nurse Director	Head of Patient Safety and Quality reporting to Executive Nurse Director as Executive sponsor for the programme	NA	No update received for February April, July and November 2023 meeting
2022/23	Mar-24	Review of Quality Governance Arrangements	R5/7	**Personal Appraisal Development Reviews (PADRs)** The Health Board compliance rate for appraisals is consistently below the national target of 85%. The Health Board reports that operational pressures are adversely affecting compliance and enabling work has not delivered the level of improvement anticipated over the COVID-19 pandemic period. The Health Board, therefore, should take appropriate action to improve performance in relation to PADRs at both corporate and operational levels.	The UHB has recognised the issue regarding VBA compliance and an improvement plan has been put in place focusing on communication and engagement, training and support and the impact on staff wellbeing and performance outcomes. This improvement plan has been developed with Trade Union Partners and will be delivered in collaboration with TU Partners. Recognising ongoing service pressures across the UHB as we manage the pandemic recovery phase and ever increasing service demands, the UHB target is to increase compliance to 50% in 2022/23, followed by a target of 85% in 2023/24.	Executive Director of People and Culture	Assistant Director of OD, Wellbeing and Culture	PC	VBA compliance continues to be a focus of Clinical Board Executive Reviews and progress against the target of 85% is monitored. An update paper was presented to People and Culture Committee in June 2023, this included a breakdown of compliance against the target and trajectories. Although overall compliance is currently below 85%, ranging from 84.8% to 55.69%, with an organisational compliance of 67.81%, work is being undertaken to support completion through a streamlined VBA document, simplified instructions enabing the staff member to upload into ESR, and a video with step-by-step instructions now available as part of the VBA toolkit. HoPC are also working with ECOD to support CBs in achieving the target of 85%.
2022/23	Aug-22	Review of Quality Governance Arrangements	R7/7	**Monitoring and Reporting** There is no evidence to indicate that the four harms associated with COVID-19 have routinely been reported to the Board either through the integrated performance report or systems resilience update. Furthermore, there was limited evidence that Clinical Boards consider the four harms associated with COVID-19 as part of the reporting to the corporate Quality, Safety, and Experience Committee. The Health Board, therefore, should ensure that the four harms associated with COVID-19 are routinely considered by Clinical Boards and reported to the corporate Quality, Safety, and	The revised template for the Clinical Boards QSE meetings will incorporate the 4 harms associated with COVID-19 reporting The notes and action logs of the clinical Boards will be shared at the QSE Committee meetings.	Director of Corporate Governance	The	NA	No update received for July 2023 meeting
2022/23	Year end 2022/2023	Audit of Accounts Report Addendum	R3/9	**Delays in receiving working papers and supporting evidence:** For 2022-23 the Health Board should provide us with all the relevant records, per the agreed Audit Deliverables document in place for that year. Also, the Health Board should ensure that all supporting records are provided in a timely manner, particularly during the first couple of weeks of the 2022-23 audit.	The main working papers were delivered as per the deliverables document however some additional supporting papers were provided in week 2 (following the additional WG reporting deadlines which fall in week 1 of the annual audit). A review of all working papers and deliverable dates will be carried out to help ensure audit have all the information they require in the first week of audit to prevent delays going forwards. A review of working paper formats for debtors and creditors will also be carried out to identify improvements to minimise the need for multiple files/supporting papers.	Director of Finance	Director of Finance	PC	The UHB is working with Audit Wales to implement the use of Inflo Collaborate software with Audit Wales to manage Audit queries during the 2022/23 Annual Accounts Audit Part of 2022-23 Annual Accounts Processes. A Review process has been undertaken to improve 2022-23 Accounts functionality and improve input to WAO during the Audit period. Work is ongoing in line with Accounts preparation and submission deadlines.
2022/23	Year end 2022/2023	Audit of Accounts Report Addendum	R4/9	**Lack of detailed instructions to the valuers:** Prior to a valuation being undertaken, the Health Board should issue and agree a formal instruction to its valuers.	A full specification has been issues in relation to the quinquennial view by Welsh Government. In relation to our ad hoc valuations throughout the year, we will agree formal instructions to the District Valuer by valuation type going forward.	Director of Finance	Director of Finance	PC	Part of 2022-23 Annual Accounts Processes. A Review process has been undertaken to improve 2022-23 Accounts functionality and improve input to WAO during the Audit period. Work is ongoing in line with Accounts preparation and submission deadlines.
2022/23	Year end 2022/2023	Audit of Accounts Report Addendum	R5/9	**Assets not being depreciated when brought into use:** The Health Board should accurately apply its accounting policy and depreciate all assets when they are brought into use.	Additional controls have been added to the year-end procedures to ensure assets are depreciated correctly.	Director of Finance	Director of Finance	PC	Part of 2022-23 Annual Accounts Processes. A Review process has been undertaken to improve 2022-23 Accounts functionality and improve input to WAO during the Audit period. Work is ongoing in line with Accounts preparation and submission deadlines.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Management Response	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update November 2023 Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2022/23	Year end 2022/2023	Audit of Accounts Report Addendum	R6/9	**Some working papers were not referenced to the agreed Audit Deliverables Document:** For 2022-23 the Health Board should reference all its information to the agreed Audit Deliverables Document.	To ensure satisfactory naming and sharing of documents in 22/23 a premeeting would be advisable to get agreement on titles and distribution list. Working paper titles where amended in 21/22 to aid understanding of contents but this was based on accounts notes not deliverables – will update further in 22/23 based on Audit Wales guidance.	Director of Finance	Director of Finance	PC	The UHB is working with Audit Wales to implement the use of Inflo Collaborate software with Audit Wales to manage the Audit Deliverables. Part of 2022-23 Annual Accounts Processes. A Review process has been undertaken to improve 2022-23 Accounts functionality and improve input to WAO during the Audit period. Work is ongoing in line with Accounts preparation and submission deadlines.
2022/23	Year end 2022/2023	Audit of Accounts Report Addendum	R7/9	**Weaknesses in network security vulnerability assessments:** The Health Board should strengthen its assessment of network security vulnerability by: • completing regular external penetration testing on the network perimeter, including at least annually by an accredited third party; and • actively monitoring the internal network penetration testing to promptly identify and address any weakness.	The UHB is currently in the process of appointing a dedicated cyber team. Two positions have been filled and we are recruiting a further two posts. An externally performed penetration test is being scheduled for Q4 of 2022/23. Once the cyber posts are in place, we will be in a position to proactively use a number of cyber tools at our disposal. This includes: SIEM, which is currently operational and staff are in the process of being trained. Defender for Endpoint, currently in the process of being onboarded and, Nessus, operated by the server team but will be supported by the cyber department. We anticipate that all roles will be appointed to by Q3 of 2022/23	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	**September 2023:** Band 5 appointed, releasing capacity for the 2 x cyber analysts to utilise existing proactive monitoring tools Penetration tests being conducted on an adhoc basis
2022/23	31/03/2023	Audit of Accounts Report Addendum	R9/9	**Progress against previous years' recommendations:** The quality of some of the Health Board's underlying working papers requires further improvement **1. 2019-20:** 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. **2. 2020-21:** The Health Board should replace its unsupported Windows 2008 servers and W7 devices. **3. 2020-21:** The Health Board should update and test its IT Disaster Recovery Plan (DRP) to gain assurance that IT systems can be restored if needed. **4. 2020-21:** The Health Board should update its IT change-control policy and procedure. **5. 2020-21:** The Health Board should evaluate and consider upgrading its IT1 and IT2 data centre controls	1. The Health Board improved some of its processes and records for 2021-22 and we understand that it plans more improvements for 2022-23. We will continue to liaise with the finance team on the improvements. 2. The Health Board has an ongoing programme in place to replace or upgrade all affected devices. 3. The Health Board is reviewing and updating its IT DRP as part of a programme to refresh its IT security documentation. 4. The Health Board is updating its change control policy as part of its new helpdesk system. 5. The Health Board is currently reviewing its data centre rooms and is considering whether to decommission some of them	Director of Finance	Director of Finance	PC	1. Ref : Financial Accounts Issues :-Part of 2022-23 Annual Accounts Processes. A Review process has been undertaken to improve 2022-23 Accounts functionality and improve input to WAO during the Audit period. Work is ongoing in line with Accounts preparation and submission deadlines. 2. Work to replace Win7 devices is complete. work to replace 2008 server estate is on-going due to clinical service dependencies (additional controls have been put in place in the interim, pending migration and replacement). 3. The DR plan has been updated and is scheduled to be tested (Qtr4 22/23) 4. IT change control policy and procedure has been produced in draft, which will be published by end Qtr4 22/23). 5. The IT1 DC is being consolidated into IT2 with a second site identified and being set up as additional resilience (in by Qtr4 22/23 and fully operational by Q1 23/24).
2022/23	31/03/2023	Estates Follow Up Review	R1/3	**Develop a fully-costed Estates Management Strategy:** The Health Board could not provide a copy of its estate management strategy, which it reported was agreed in 2017. However, the Health Board is currently in the early stages of developing a new estates strategy. The new strategy should clearly set out: - a baseline assessment of the condition of the current estate and the total resources (including workforce) needed to maintain it against available resources; - how the estate will be maintained and resourced to the required standard in the short- and medium term; and - plans for maintaining and investing in the current estate whilst implementing its estates investment programme.	A copy of the estate's strategy based on the operational team requirements was provided, but this strategy dealt with service delivery and did not review, in depth, the outlined areas contained within this audit recommendation. The Estates Strategy going forward will provide the following as outlined within the recommendation. In the interim and immediate; it will state how the estate will be maintained, based on current workforce and funding, until the baseline assessment has been completed. The strategy will outline, where necessary, the prioritisation of work in relation to patient safety, health and safety, structural integrity and statutory compliance against the backdrop of available budgets and workforce. It will indicate that a baseline assessment will be completed and programme of completion provided. The baseline assessment will include a condition survey review in accordance with Estate code, six facet survey or similar. This survey information will then be used to assess, prioritise and re-align the workforce, required to maintain the site, dependent on the highlighted risks within the survey, and the available budget within the Health Board, in the short- and medium-term. It is anticipated that the survey information will take approximately 18 months to procure and complete. A further period of	Director of Capital Estates and Facilities	Director of Capital Estates and Facilities	PC	A condition survey has been procured and tenders are awaiting return on the 27/10/2023.
2022/23	28/02/2023	Estates Follow Up Review	R2/3	**Introduce a system to inspect a percentage of repairs each month:** We found that the Health Board is yet to develop a system to inspect a percentage of repairs each month. This is an essential element for any estate maintenance service, providing vital assurance that work is being carried out in compliance with the relevant safety and quality standards. The Health Board should introduce a monthly inspection regime by March 2023.	Agreed Mica interrogation and monthly reports set up (Complete) Initial agreement of content of inspections and form they will take (October 2022) Initial KPI's developed and monitoring commencement (November 2022). Review of forms and KPI's (February 2023).	Director of Capital Estates and Facilities	Director of Capital Estates and Facilities	C	A quality assessment report of jobs completed within the last month period is provided at performance meetings with the Director of Capital, Estates and Facilities present.
2022/23	31/01/2023	Estates Follow Up Review	R3/3	**Strengthen performance management:** We found that the Health Board is continuing to develop KPIs for its estates and facilities services but is yet to establish a suitable format to report the information internally and up to the Board for assurance. By March 2023, the Health Board should ensure that: - relevant estates and facilities KPIs are included in the integrated performance report which is received by the Board; and - the KPIs are linked to the new estates strategy.	Agreed. Current KPI formats are being assessed along with content (December 2023). Once KPI content is agreed and data capture refined, information will be presented to the Board with bi-monthly performance feedback at the Service Board meetings (January 2023). The KPI's will help inform and be linked into the Estates Strategy when completed.	Director of Capital Estates and Facilities	Director of Capital Estates and Facilities	C	The KPI formats have been reviewed and updated and monthly performance reviews are scheduled with Estates and Facilities departments, charied by the Director of Capital, Estates and Facilities. The KPIs are being reported to the bi-monthly Service Board meeting and have recently been shared with the Executive Director of Finance for information.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Management Response	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update November 2023 Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2022/23	31.03.2023 30.09.2023 30.09.2023 30.09.2023	Structured Assessment 2022	R1/3	**Strategic alignment of processes, structures and resources:** R1 The Health Board plans to refresh its 10-year strategy by 2023. It should seek to use this opportunity to review and reshape its wider processes, structures, resources, and arrangements to ensure they are fully aligned to the organisation's refreshed strategic objectives and associated risks, with a particular focus on its: • Board Assurance Framework; • Performance Management Framework; • Committee structures, terms of reference, and workplans; and • Long-term financial plan.	Agree the work in relation to the **Committee Structures** is in hand and the new Committees and other changes to the Committee Structures will be established for the new financial year after approval at the Board at the end of March 2023 The **Board Assurance Framework** currently reflects the risks to the achievement of the Strategic Objectives of the organisation and once the Strategy refresh is complete the BAF will be reviewed to ensure alignment to the Strategic Objectives. **Performance Management Framework** – This was presented to S&D Committee in 2020 and there is a need to update this document in line with the refreshed Strategy and revised Committee Structure. **Long Term Financial Plan** – The strategy refresh will be supported by the development of a long-term financial model which will build from the current resource position and show how financially the health board will deliver the strategy within its financial allocation. This will show the strategic investments and how they will be afforded over the strategic timeframe for example, public health, estates and digital strategy.	Director of Corporate Governance Director of Corporate Governance Director of Digital Health Intelligence Director of Finance		NA	Work remains ongoing to achieve recommendation which will feed into the development of the Health Board's Strategy Refresh for 2023/24. November 2023 Committee - No update shared from Digital & Health Intelligence First draft Long Term Financial Model will be boing to Board Development on 26th October 2023 for debate and discussion.
2022/23	Draft to be shared by 31.03.2023	Structured Assessment 2022	R2/3	**Enhancing the Integrated Performance Report** The Integrated Performance Report provides a good overview of the Health Board's performance. However, details of the actions being taken to sustain or improve performance that falls below target appears in some sections of the report but not others. The Health Board, therefore, should ensure this information is provided consistently throughout the report to strengthen the assurances provided to the Board that appropriate action is being taken to sustain or improve performance.	Accepted. The Integrated Performance Report is being reviewed and will be refreshed to provide a clear overview of performance with the ability to drill down into more detail where appropriate. The format is likely to change to reflect the recommendation and to provide the Board with a more comprehensive report.	Director of Digital and Health Intelligence		NA	No Update shared for April, July and November Committee meeting
2022/23	28.02.2023 31.01.2023 31.01.2023 31.03.2023 31.01.2023 31.01.2023 31.01.2023	Structured Assessment 2022	R3/3	**Enhancing administrative governance arrangements further** Whilst the Health Board has good arrangements in place for conducting Board and committee business effectively and transparently, opportunities exist to enhance these arrangements further. The Health Board, therefore, should: **a)** Post more frequent reminders about Board and committee meetings on social media and provide links to papers; **b)** Ensure the papers for all Advisory Group meetings are published on the Health Board's website in a timely manner; **c)** Make abridged minutes of private Board and committee meetings available publicly as soon as possible after each meeting; **d)** Ensure the dates Terms of Reference were last reviewed and approved are clearly displayed on the documents; **e)** Circulate presentations in advance of meetings or, where this is not possible, make copies available to members and the public (via the website) as soon as possible afterwards; and **f)** Ensure public papers include an explanation as to why some matters are being discussed in private rather than in public	**a)** We worked with our Communications department last year to issue tweets and reminders to the public via the Health Board's social media platforms. At the moment, our Communications team issues a monthly post/tweet at the beginning of the month which sets out the details of the Board and Committee meetings due to take place that month. The concern raised by our Communications team was that the public may not interact if we issue frequent posts during the month with regards to its Board / Committee meetings, and if that happens it could harm the Health Board's accounts / social media "overall reach". We will have a further conversation with our Communications team to see if it is feasible to issue more frequent reminders via our social media platforms. **b)** Noted. The Corporate Governance team will work with our colleagues to ensure that the papers for the advisory groups are published on the Health Board's website in a timely manner and to ensure that the website page is up to date with regards to the Advisory Group's meeting dates. **c)** Noted. We will attend to this straightway. **d)** Noted. We will ensure that the dates on which the Committees' Terms of Reference were reviewed and approved are clearly shown on the cover sheet of the document. **e)** As far as possible, we publish copies of presentations in advance of the meetings. Where the presentation slides have not been made available before the meeting, we endeavour to publish copies of the same as soon as possible after the meeting. We will strengthen our processes in relation to this to ensure appropriate publication of the presentations. **f)** Noted. Going forward, we will insert some appropriate wording in the Public agenda to explain why certain items are being referred to our Private Board/Committees.	Director of Corporate Governance	Head of Corporate Governance	PC	a) Work remains ongoing to achieve this recommendation. Discussions are underway with the Health Board Communications team and plans are being developed to achieve the remaining procedural and logistical recommendations as soon as possible. b) The meeting dates for this year's SRG meetings have been published on the website, along with some of the meeting papers. The meeting papers for the LPF are publicly available up to February 2023. We are working with our colleagues who administer the SRG and the LPF to complete this action and aim to have all meeting dates and meeting papers published on the website by the end of June 2023. c) This has not yet been actioned, although we will commence this action from now. d) This action has been completed. e) We ask for copies of presentations and, as far as possible, publish them in advance of the meetings. Where that is not possible, we publish the presentations as soon as possible following the meeting . f) This action has been completed.

Report Title:	Regulatory Compliance Tracking Report				Agenda Item no.	2.9	
Meeting:	Audit and Assurance Committee		Public	x	Meeting Date:	7.11.2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Risk and Regulation Officer						

Main Report
Background and current situation:

The purpose of this report is to provide Members of the Audit and Assurance Committee ('the Committee') with assurance on the implementation of recommendations which have been made by external regulatory and legislative bodies, of which the Health Board is obliged to comply with. Assurance in this regard if provided by means of a Legislative and Regulatory Compliance Tracking report.

This report also continues to include commentary on the Health Boards management of Welsh Health Circulars.

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

The tracker provides the following details:

- All Regulatory Bodies that have active recommendations with the Health Board. Also contained within the tracker are the details of Regulatory Bodies that have previously inspected the Health Board despite there being no live recommendations. This is to ensure that the tracker remains a comprehensive list of all potential regulatory bodies.
- The Regulatory Standard which is being inspected is listed where this information is available.
- The Lead Executive in each case is detailed as is the accountable operational lead so that it is clear who is responsible for completion of the recommendation at an executive and operational level.
- The Assurance Committee where any inspection reports will be presented along with any action plans as a result of inspection. This column, coupled with the comments section, provides assurance to the Committee that progress against and compliance with recommendations is being routinely monitored and scrutinised.
- A Red, Amber, Green (RAG) rating that highlights where the recommendation sits against the agreed implementation date. Entries are rag rates as follows:

  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.

Welsh Health Circulars

In addition, the updates below are also shared in relation to the Health Board's Management of Welsh Health Circulars (WHCs) A separate Tracker document is held for the monitoring of WHC's and is managed by the Team.

An extract from the WHC tracker is copied below as an example of the information recorded:

Welsh Health Circular (WHC) No	Name of WHC	Date Issued	Status	Action Needed By	Category	Overarching Actions Required	Lead Executive	Work in Progress	Work Completed	Status RAG Rated: Blue Complete, Green On track to Meet Deadline, Red	Comments
2021/006	Elections to Senedd Cymru May 2021 Guidance for NHS Wales	11.03.21	Action	24.03.21	Governance	The principles set out in the guidance apply to the NHS at all times, but particular note should be taken in the period between the start of the formal campaign on 25 March and up to and including polling day 6 May.Chief Executives of NHS organisations should ensure that the principles in this guidance are followed.	CEO		Yes		Guidance shared with CEO and Chair and Board Secretary and referred to in various meetings where discussions or decisions could be election relevant.

Since the July 2023 Committee meeting the following Circulars have been added to the tracker and triaged to executive colleagues for action:

2023/023 The National Influenza Immunisation Programme 2023 - 24
2023/024 Changes to Shingles vaccinations (from September 2023)
2023/025 Suspected cancer pathway: guidelines
2023/026 NHS framework for research and development
2023/029 Winter respiratory vaccination programme 2023 - 2024
2023/030 New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2)
2023/031 Healthcare associated infections and antimicrobial resistance improvement goals 2023 - 24
2023/033 COVID-19 vaccine products
2023/034 NHS Welsh Sustainability Conference and Awards
2023/036 NHS Wales speaking up safety framework
2023/037 Patient testing framework for autumn / winter 2023

As of the 17 October 2023 the Health Board's WHC tracker was fully up to date and each WHC detailed on the Welsh Government website had been allocated to an Executive Lead to monitor and action.

Regulatory Tracker

The Regulatory Tracker attached to this report is up to date as of the 17 October 2023 and will continue to be updated throughout the organisation and reported to the Committee on a bi-meeting basis.

Following the July 2023 Committee Meeting a total of 4 completed entries have been removed from the register. 7 further entries have been reported as complete since the July 2023 Committee Meeting and are reported in the attached Tracker.

The ongoing review of progress against regulatory body inspections and recommendations should reduce the risk that key regulatory requirements are missed and the procedure for tracking such progress will also enable the Committee and Board to have oversight of the Health Board's compliance with regulatory requirements so that appropriate action can be taken to address emerging trends.

- **Assurance** can be taken from the ongoing monitoring and management of External Regulatory Reports and Recommendations.

Recommendation:

The Committee are requested to:

(a) To review the updates shared and to take assurance from the continuing development and review of the Legislative and Regulatory Compliance Tracker.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
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	
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	
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*									
Prevention		Long term		Integration	x	Collaboration	x	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
By maintaining an up to date Regulatory Recommendation Tracker the Health Board mitigates the risk that it may be subject to legal or regulatory penalty.
Safety: No
Financial: No
Workforce: No
Legal: Yes
Whilst no specific Legal Impact assessment has been undertaken the monitoring and tracking of compliance with regulatory recommendations contribute to the Health Board's compliance with it's legal requirements.
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

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 THERAPEUTICS AND TOXICOLOGY CENTRE														
AUTHORISING ENGINEER - NWSSP														
Capital Estates and Facilities	**Capital Estates and Facilities**	NWSSP	Ventilation AE	May-22	Authorising Engineer (Ventilation) Annual Report - Ventilation AE	Executive Director of Finance	Strategy and Delivery Committee/Ventilation Safety Group	Director of Capital Estates and Facilities	May-23	4 recommendations	May-23	A review of recommendations made has been undertaken. 1 of the 4 Recommendations has complete - 3 remain Partially Complete		PC
Capital Estates and Facilities	**Capital Estates and Facilities**	NWSSP	Low Voltage Systems	Feb-22	Authorising Engineer (Low Voltage) Annual Report	Executive Director of Finance	Strategy and Delivery Committee	Director of Capital Estates and Facilities	Feb-23	9 recommendations	Feb-23	A review of recommendations made has been undertaken. 4 of the 9 Recommendations have been completed - 5 remain Partially Complete		**PC**
Capital Estates and Facilities	**Capital Estates and Facilities**	NWSSP	(Medical Gas Pipe Line Systems	May-22	Authorising Engineer (Medical Gas Pipe Line Systems) Annual Report	Executive Director of Finance	Strategy and Delivery Committee	Director of Capital Estates and Facilities	May-23	13 recommendations	May-23	A review of recommendations made has been undertaken. 4 of the 13 Recommendations have been completed - 9 remain Partially Complete		**PC**
ALL WALES QUALITY ASSURANCE PHARMACY														
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy SMPU	27.01.2020 - Re - Inspected 04.05.2022	Quality Assurance of Aseptic Preparation Services	Executive Medical Director	QSE Committee/ Management of medicines group	Clinical Director of Pharmacy and Medicines Management	05.05.2023	105 Actions Highlighted	05.05.2023	Update: 18/10/2023 - 14 outstanding actions, 1 over target. Audit carried out 03&04/10/2023 awaiting new report. Outstanding actions to be carried forward onto new report.		**PC**
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy UHL	06.08.2020 - Re Inspected - 22.11.21	Quality Assurance of Aseptic Preparation Services	Executive Medical Director	QSE Committee/ Management of medicines group	Clinical Director of Pharmacy and Medicines Management	01.11.2023	50 deficiencies highlighted	01.11.2023	16/01/23 16 Deficiencies addressed and completed. Decision as to the funding for the 4 glove isolator and the required works on the facilities required to progress several of the deficiencies. Repy to the audit with actions submitted 17/2/23. Awaiting if ations accepted by Auditor.		**PC**
BRITISH STANDARDS INSTITUTE														
CARDIFF AND VALE OF GLAMORGAN FOOD HYGIENE RATINGS														
Capital Estates and Facilities	Catering and Hospitality	Cardiff and Vale of Glamorgan Food Hygeine Ratings	Health Board Wide	6.07.2021 - 14.09.2023	Unnanounced inspection	Executive Director of Finance	Health and Safety Committee	**Head of Catering Services**	N/A	25 Food Hygiene Ratings of 4 and 5 was achieved with no major contraventions	31.07.2021 - 14.10.2023	An update will be shared at the October Health and Safety Committee meeting providing assurance to the Health Board.		**C**
Capital Estates and Facilities	Catering and Hospitality	Cardiff and Vale of Glamorgan Food Hygeine Ratings	Aroma Unit, Woodland House	17.08.2023	Unnanounced inspection	Executive Director of Finance	Health and Safety Committee	**Head of Catering Services**	N/A	A Food Hygiene Rating of 4 was achieved with no major contraventions	30.09.2023	An update will be shared at the October Health and Safety Committee meeting providing assurance to the Health Board.		**PC**
Capital Estates and Facilities	Catering and Hospitality	Cardiff and Vale of Glamorgan Food Hygeine Ratings	Aroma Units, UHW	12.05.2022	Unnanounced inspection	Executive Director of Finance	Health and Safety Committee	**Head of Catering Services**	N/A	A Food Hygiene Rating of 4 and 5 was achieved with no major contraventions	23.06.2023	An update will be shared at the October Health and Safety Committee meeting providing assurance to the Health Board.		**PC**
CAPITAL EXPENDITURE INTERNAL REVIEW														
Clinical Coding														
Digital Health	Clinical Coding	DHCW	Clinical Coding	24.06.2022	Clinical Coding Audit	Director of Digital Health Intelligence	Digital Heath Intelligence Committee	**Director of Digital Health Intelligence**	N/A	A total of 5 recommendations were made regarding clinical coding practice within the Health Board.	N/A	Of the 5 recommendations, 4 are recorded as complete. Work remains ongoing within endoscopy to compete/close out the final recommendation.		**PC**
COMMUNITY HEALTH COUNCIL														
Specialist Services - Ward B1	Ward B1	CHC	Ward B1	TBC	CHC Recommendations	Executive Director of Strategic Planning	QSE Committee	Specialist Services CB Director of Nursing	N/A	A total of 7 recommendations were made regarding ward B1's facilities.	ASAP	4 of the 7 Recommendations are reported as complete. The remaining recommendations remain in progress.		**PC**
Medicine	Stroke Rehab Ward	CHC	Medicine CB - Stroke Rehab Ward	31.08.2022	CHC Recommendations	Executive Director of Strategic Planning	QSE Committee	Medicine CB Director of Nursing	31.08.2022	A total of 4 recommendations were made regarding the Stroke Rehab Ward's facilities. The other two recommendations are going through the capital planning process to repair to floor.	ASAP	2 of the 4 recommendations are reported as completed.		**PC**
Children and Women	Childrens Hospital for Wales	CHC	Island Ward	08.08.2022	CHC Recommendations	Executive Director of Strategic Planning	QSE Committee	Children and Women CB Director of Nursing	N/A	A total of 4 recommendations were made regarding the Patient and Parent Experience and facilities within Island Ward	ASAP	1 of the 4 recommendations is reported as complete.		**PC**

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)
Medicine	Medicine	CHC	Ward East 4	06.07.2022	CHC Recommendations	Executive Director of Strategic Planning	QSE Committee	Medicine CB Director of Nursing	N/A	A total of 7 recommendations were made regarding ward East 4's facilities.	ASAP	5 of 7 Recommendations are reported as complete. The remaining recommendations remain in progress and require estates input and purchase of equipment.		**PC**
Children and Women	Maternity Led Unit	CHC	Maternity Led Unit	18.07.2022	CHC Recommendations	Executive Director of Strategic Planning	QSE Committee	Children and Women CB Director of Nursing	N/A	A total of 4 recommendations were made regarding Patient and Staff experience, Staffing Levels and Estates infrastructure, most notably lift services.	ASAP	All 4 recommendations require are partially complete but rely on wider UHB support to finalise.		**PC**
ECT Accreditation														
Mental Health	Adult Mental Health		ECT Suite	30.06.2022			QSE Committee	Kara Hannigan	N/A	100% all standards, excellent commendations in all four domains		Standards Met. No further actions		**C**
FIRE AND RESCUE SERVICES														
Mental Health	Capital and Asset Management	Fire and Rescue Services	Mental Health HYC and Vale MH Services, Barry Hospital	14.04.2021	Regluatory Reform (Fire Safety) Order 2005	Executive Director of People and Culture	Health and Safety	**Head of Health and Safety**	N/A	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."	Ongoing	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 still rests with the Fire Authority's Compliance team for deliberation as to whether they might proceed with prosecution. N.B. An Article 27 letter dated 15th September 2021 was served on the CEO requiring pertinent information to be forwarded to the Fire Authority within 14 days of the date of the letter. This information was duly forwarded to the Fire Authority. A letter under caution was issued against the executive director for public health on 01/12/2021. This has been responded to and a subsequent meeting held with the chief fire officer for SWFRS, the UHB CEO, new responsible exec for fire and new fire safety manager. The notice remains open but close collaboration exists between the two parties. On 1st November 2021 significant organisational changes were made resulting in the fire team moving to sit under H&S. 11/01/2023: SWFRS have taken the decision to prosecute the UHB for alleged contraventions. A plea hearing was conducted by Cardiff magistrate court where the UHB entered 'No plea'. Hearing was held at Cardiff Crown court on 13th January 2023 where the UHB entered 'Not guilty' pleas to all 4 offences. Legal proceedings remain ongoing.		**PC**
Medicine	Capital and Asset Management /UHW - Ward A4	Fire and Rescue Services	UHW Ward A4	29.09.2021	Regluatory Reform (Fire Safety) Order 2005	Executive Director of People and Culture	Health and Safety	**Head of Health and Safety**	31.03.2023	Duty of Works: EN59/21 - Article 8: Duty to take general fire precautions Article 13: Fire fighting and fire detection Article 15: Procedures for Serious and Imminent Danger and for Danger Areas Arcile 21: Training	31.03.2023	Measures have been agreed with and implemented by senior managers of the UHB's Estates Service Board. Consequenlty the enforcing authority inspector has agreed to extend the date of this notice for 12 months to enable all works to be completed. The reasonably practicable work has been completed within the timesacale, work is currently being undertaken to complete the outstanding scope of work. Compliance date is 31/03/2023. The work has now been completed by the CEF team with the exception of a fire door set which has yet to be delivered. The head of health and safety is to obtain assurance that all aspects of the enforcement notice have been satisfied before inviting SWFRS back for a reinspection. This is likey to take place in early February.		**PC**
HEALTH EDUCATION AND IMPROVEMENT WALES														
CD&T	Radiology		Radiology	31.07.2023		Medical Director	QSE Committee	Somashekara Shivashanka	N/A	9 recommendations were made across the directorate in regard to trainees. This included evaluation into the induction programme; improving communication lines and working relationships across other departments; developing the trainee forum; ensuring feedback sent to the Academy is returned to HB in timely manner; balance workforce with service pressures; consider geographical distribution of ultrasound machines closer to ICU; improve IT infrastructure; improve physical environment in department.		All of the recommendations are complete as per report.		**C**
Children and Women	Obs & Gynae		Obs & Gynae	30.06.2023		Medical Director	QSE Committee	Martin Edwards	N/A	6 recommendations were made across the directorate. Review how curriculum is delivered; Health Board to provide HEIW with audit data around gynaecology data and study leave exception reporting system; for training and education purposes, to provide update on consultation recruitment and ensure adequate levels of senior cover; non training grade doctors support with progression to registrar; quality unit at HEIW recommendation to review; faculty team have met with foundation and GP trainees		All of the recommendations are complete with full response in report.		**C**
Medicine	Department of Gastroenterology			24.07.2023	27.09.2023	Medical Director	QSE Committee			6 Recommendations were made across the directorate.				
Mental Health	Dept of Psychiatry		Dept of Psychiatry			Medical Director	QSE Committee	Somashekara Shivashanka	N/A	8 recommendations were made across the directorate		All of the recommendatons are complete with full response in report		**C**

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)
Specialist Services	Cardiothoracic		Cardiothoracic Surgery	21.04.2023	1.10.2023	Medical Director	QSE Committee		N/A	8 recommendations were made across the directorate				
HEALTH INSPECTORATE WALES														
PCIC	HMP Cardiff	HIW	HMP Cardiff	N/A - Desktop review	HIW	Executive Nurse Director	QSE Committee	Executive Director of Nursing - Head of HMP Cardiff Healthcare	**N/A**	A total of 11 recommendations made.	**Various**	2 of the 11 recommendations have completed with a number of the remaining entries recroded as partially complete.		**PC**
Medicine	Welsh Ambulance Services NHS Trust	HIW	A&E	Oct-21	HIW	Executive Nurse Director	QSE Committee	Executive Nurse Director/Chief Operating Officer	**N/A**	A total of 13 recommendations were made.	**N/A**	9 of the 13 recommendations have completed. The remaining 4 recommendations are parially complete.		**PC**
Medicine	Emergency / Assessment Units	HIW	A&E	20.06.2022	HIW	Executive Nurse Director	QSE Committee	Executive Nurse Director	**TBC**	A total of 16 recommendatons were made	**N/A**	15 of the 16 recommendations are reported as complete . An educataion plan is being developed to respond to the final recommendation.		**PC**
Specialist Services	Cardiothoracic Services	HIW	Surgery Ward 6	Mar-22	HIW	Executive Nurse Director	QSE Committee	Specialist Services Clinical Board Triumvirate	**TBC**	A total of 21 recommendations were made in relation to a number of issues, including Patient Safety, Patient Experience, Quality and Estates.	**N/A**	9 recommendations are reported as complete. The remaining 12 recommendations are reported as partially complete with progress being made against sub-recommendations which are reported as complete.		**PC**
CD&T	Diagnostic Imaging Department	HIW	Diagnostic Imaging Department	Aug-22	HIW	Executive Director of Therapies and Health Science	QSE Committee	CD&T Clinical Board Triumvirate	**TBC**	A total of 9 recommendationswere made relating to improvement of Staffing and operational procedures and guidelines.	**N/A**	7 of the 9 recommendations are reported as complete. The remaining two recommendations are reported as Partially Complete with detailed progress updates provided		**PC**
CD&T	Nuclear Medicine Department	HIW	Nuclear Medicine Department	Oct-22	HIW	Executive Director of Therapies and Health Science	QSE Committee	CD&T Clinical Board Triumvirate	**TBC**	A total of 7 recommendationswere made relating to improvement of Staffing and operational procedures and guidelines, including Welsh Language Standards.	**N/A**	7 of the 8 recommendations are reported as complete.		**PC**
HEALTH AND SAFETY EXECUTIVE														
Capital Estates	CEF- Led by Health and Safety	HSE	Laboratory Testing Services - UHW	27/01/2022	HSE Statutory Inspection	Executive Director of People and Culture	Health and Safety Committee	Head of Health & Safety	01.02.2023	Request for information in relation to local exhaust an extract ventilation systems. Details of maintenance and agreements in place between UHB and Cardiff University forwarded to HSE.	**PC**	Information provided to HSE. 05/01/2023 - Meeting held at the request of HSE with the intention of taking a voluntary statement from the Head of Estates and Facilities. Agreement on the day that CAVUHB would formally provide answers to HSE questions by the end of January 2023 and the Head of Estates and Facilities would then sign a voluntary statement to this. During the meeting on 05/01/2023, the Head of H&S signed a voluntary statemtent in relation to information previously sent to them in February 2022. Further meeting with HSE 01/02/2023 and Head of Estates and Facilities provided a voluntary statement relating to an information request from the HSE. No further update		**PC**
	Executive	CEO/H&S	Operaional Areas	29/09/2023	musculoskeletal injuries and Violence and Aggression against staff	Executive Director of People and Culture	Health and Safety Committee	Head of Health & Safety	14 and 15.11.2023	The HSE have recommenced a UK wide NHS intervention programme started in 2018 which focused on the control of musculoskeletal injuries and Violence and Aggression against staff. They met with the CEO, Executive Director of People and Culture and the Head of H&S on 29/09/2023 in order to obtain an understanding of the UHB's approach at a corporate level and this will be followed up with interventions to operational areas on 14th and 15th November 2023	**C**	An audit programme commneced on the back of the impending intervention, actions produced and being worked through with the clinical/service boards. Several documents forwarded to HSE post the corporate intervention. Ongoing.		
Surgery	Public Health Wales	HSE have written to P'HW. It is record here for information	PHW Microbiology Laboratory	19/08/2022	RIDDOR at PHW Microbiology Laboratory	Executive Director of People and Culture	Health and Safety Committee	Head of Health & Safety	1.04.2023	HSE investigated a dangerous occurrence notified under RIDDOR at PHW microbiology laboratory. They conducted an inspection 17/01/2023 and PHW are required to provide a response by 01/04/2023	**PC**	H&S and CEF have been kept informed of progress. Visist took place 17th January 2023 Complete - No further concerns for CAVUHB.		**C**
HUMAN TISSUE AUTHORITY														
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	Head of Information Governance	TBC	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	9 of the 25 recommendations made by the ICO remain outstanding. The ICO undertook a follow up investigation in November 2021 and concluded that there was still a risk of non-compliance with data protection legislation and recommended urgent action tto complete outstanding recommendations. Updates are shared at the Digital Health Intelligence Committee. **No progress reported since the April 2023 Committee meeting.**		**NA**
JOINT ACCREDIATION COMMITTEE														

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)
Specialist Services	Haematology	JACIE	South Wales BMT Programme	TBC	6th edition of JACIE standards	Executive Director of Medicine	QSE Committee	Executive Director of Medicine	01.09.2024	Minor deficiencies noted	01.09.2024	Programme received formal re-accrediation notice - There are ongong discussions with the executive board regarding a new facility for BMT / Haematology as the service will not achieve re-accreditation post he next inspection cycle. A capital planning project team has been established to develop the business case to support the development of a refurbhsied facility for the service. **No progress reported since the April 2023 committeemeeting.**		**PC**
MEDICAL GENETICS														
MHRA														
CD&T	Pharmacy SMPU and UHL	MHRA	Pharmacy SMPU	12.10.2021 9.05.2023	Good manufacturing practice (GMP) and good distribution practice (GDP)	Executive Medical Director	QSE Committee	Clinical Director of Pharmacy and Medicines Management	TBC and 2 years	8 Recommendations 3 majors and 5 others	16/12/2021 and 31.03.2024	1 action outstanding but partially completed Type 1 letter Significant issues: Unresolved Air Handling Unit and facility issues to meet requirements of the regulator		**PC**
CD&T	RadioPharmacy / Medical Physics	MHRA	Radiopharmacy / Medical Physics	3.10.2023		Executive Medical Director	QSE Committee	Clinical Director of Pharmacy and Medicines Management	TBC	1 Critical deficiency comprised off 44 actions required	31.12.2023	Type 4 letter and referral to IAG due to Senior and Executive management had not exercised adequate oversight to ensure that the facility, equipment and processes were appropriately designed, qualified and validated in support of Aseptic product manufacturing		**PC**
NATURAL RESOURCES WALES														
OFFICE FOR NUCLEAR REGULATION														
QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES														
RESEARCH AND DEVELOPMENT														
UKAS														
WELSH WATER														
Capital Estates and Facilities	UHW	Welsh Water	UHW	13.05.2022	Site Inspection	Executive Director of Finance	Health and Safety Committee	Director of Capital Estates and Facilities	tbc	Contraventions of sections 73-75 Water Industry Act 1991 and Water Supply (water fittings) Regulations 1999 (The Regulations) relating to contamination, waste, misuse, erroneous meassurement and undue consumption of water at the premises.112	20.06.2022	**All actions that were identified have been completed and closed out on MICAD. Action tracker updated and completed. Follow up site visit by Welsh Water was satisfactory.**		**C**
WSAC														
Surgery	Audiology	WSAC	Audiology - paediatrics	04.11.2021	Audiology / Paediatric QS	Executive Director of Therapies and Health Science	QSE Committee	Paediatric Cochlear Implant Lead - Razun Miah/Rhian Hughes/Ellen Thomas	01.11.2024	85% target met in individual standards and 90% overall target met - 95.22% overall compliance score achieved	01.11.2024	5 recommendations made relating to Standards, 1a.3, 2a.8, 3a.5 &3a.6, 6a.1 and 7b.1. 3 of the 5 recommendations are reported as complete, Two recommendations remain partially complete with action plans in place. **There are no updates to report to the November meeting**		**PC**
Surgery	Audiology	WSAC	Audiology - Adult Rehabilitation	22.11.2022	Audiology - Adult Rehabilitation	Executive Director of Therapies and Health Science	QSE Committee	Lorraine Lewis	22.11.2025	85% target met in individual standards except for one and 90% overall target met - ~ 94% overall compliance score achieved	22.11.2025	4 r ecommendations made relating to standardss 1.a.5, 1.c.6, 5.d.3 and 6.b.1, one of which is reported as completed. **There are no updates to report to the November meeting**		**PC**
WEST MIDLANDS QRS														

Report Title:	Procurement Compliance Report – Chair's Action Review			Agenda Item no.	2.10
Meeting:	Audit Committee	Public	X	Meeting Date:	5th November 2023
		Private			
Status *(please tick one only)*:	Assurance X	Approval		Information	
Lead Executive:	Executive Director of Finance				
Report Author (Title):	Assistant Director of Procurement Services and Executive Procurement Lead – C&V				

Main Report
Background and current situation:

The UHB's Standing Orders & Standing Financial Instructions require that Board approval is obtained for the purchase of all goods and services for contracts over the value of £500k.

There are some situations where approval must be sought outside Board approval and therefore, a Chair's Action request is submitted. The reasons can be as follows; -

- Urgent Operational Requirement
- Unforeseen/unplanned circumstances
- Emergencies
- Exemptions

A review of the number of Board and Chair's Actions reports was requested by the Director of Finance and this report provides a follow up review to the March 2023 report.

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

In March 2023, a review of Board approvals was undertaken for financial year 2021/22 and up to December 2022 for 2022/23 financial year.

In 2021/22 the majority of approvals (72) were issued via the Chair's Action route with 2 through the formal Board meeting. During the financial year 2022/23 up to December 2022 (at the time of the first report), Procurement Services issued 36 requests. This was highlighted to Procurement Services and therefore, planning for approval was advised to be in line with Board meeting dates.

In order to confirm the number of genuine Chair's Action requests, Procurement commenced tracking the Board/Chair's Action requests from September 2022 with the below categories. In addition to these categories, two further types (categories 6 and 7) have been included since January 2023.

1. Board Agenda does not have capacity for request
2. Emergency/Unforeseen circumstances
3. Exemption - contract value above estimated contract value
4. Procurement have not provided sufficient time within Board dates for approval
5. Urgent Operational Requirement
6. Delays to process causing Procurement to miss the project planned Board date
7. AW Contracts Ratification which are being challenged and/or not in line with Board dates

The table below provides the numbers and categories for the Chair's Actions from the initial report, the remaining 2022/23 financial year and this financial year to date. In the period, from March 2023 to the end of September 2023, there have been 15 Chair's Action requests.

Cat Number	Category	March 2022 to December 2022	January 2023 to March 2023	April 2023 to September 2023
1	Board Agenda does not have capacity for request	7	0	0
2	Emergency/Unforeseen circumstances	3	0	1
3	Exemption - contract value above estimated contract value	0	0	0
4	Procurement have not provided sufficient time within Board dates for approval	0	2	1
5	Urgent Operational Requirement	24	2	4
6	Delays to process causing Procurement to miss the project planned Board date	New category	6	5
7	AW Contracts Ratification which are being challenged and/or not in line with Board dates	New category	1	4
	Total	**34**	**11**	**15**

In order to understand the background to these requests, Procurement have provided examples of categories 5, 6 and 7 below as these are the highest contributing factors to Chair's Actions in this current financial year.

Category	Contract Title	Reason
5	Repairs of Lifts at Cardiff & Vale University Health Board	Given the poor condition of the lift inventory, the Health Board required an urgent repairs to mitigate any health and safety risks or concerns.
5	Supply and Support/Maintenance of Adastra Software and Odyssey SaaS Services	AW contract has been let, however, this has not been rolled out as the testing phase has not been undertaken. C&V Health Board had to put in a 3-year contract with the current supplier to ensure continuity of 111/CAV24 OOH service. Timescales of local Frontline team being made aware of the requirement meant the approval sign off had to go for Chair's Action.
6	Uplift for Genomics Construction Stage 4, 5 & 6 - SCP	The lack of the completed design, landlord negotiations and subsequent substantial changes to the IT specification within the scheme has resulted in additional cost pressures and prolongation within the contract cost and time envelope of £946,869.61 ex VAT. The uplift approval was urgently required to ensure the construction was completed on time.
6	Provision of Two Mobile Theatres and Recovery Area	Due to clarifications on the decommissioning costs, funding of this exit price and the IRFS16 implications, the Health Board was not in a position to issue paperwork for consideration at the Board meeting as planned. The Board did not meet again until November and the contract was required to be renewed prior to this date.
6	POLARIS Trial	Procurement Report approval delayed by Service causing Procurement to miss the planned Board date.
7	Ophthalmology Consumables	AW Contract, however, Local Frontline team were not made aware in time and needed to review and validate

		the ratification documents. The local Frontline team challenge the cost pressure forecast for the Health Board which resulted in a reduction in cost pressure for C&V.

Procurement will continue to work with both AW Procurement Services and the Health Board to channel all over £500k requests via the appropriate formal Board approval process in a timely manner.

Recommendation:

The Board / Committee are requested to:

- **NOTE** the contents of the Report

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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

Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk:
As outlined in the above section
Safety:
As outlined in the above section
Financial:
As outlined in the above section
Workforce:
As outlined in the above section
Legal:
As outlined in the above section
Reputational:

As outlined in the above section
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
06/11/2023 11:21:06

Report Title:	Procurement Compliance Report / Single Tender Actions				Agenda Item no.	2.11	
Meeting:	Audit Committee		Public	X	Meeting Date:	7th November 2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Executive Director of Finance						
Report Author (Title):	Assistant Director of Procurement Services and Executive Procurement Lead – C&V						

Main Report
Background and current situation:

The UHB's Standing Orders & Standing Financial Instructions require that the purchase of all goods and services be subject to competition in accordance with good procurement practice, making reference to minimum thresholds for quotes and competitive tendering arrangements.

There are some situations where this is not always practical and requests for Single Quotation Actions (SQA) or Single Tender Actions (STA) are made in accordance with the Procedure for the Approval of Single Tender Action. There are sound reasons why STA/SQA's are permitted within the Health Board, these are as follows but not limited to:-

- Sole Supplier of Goods or Services
- Proprietary items, i.e. Trademarked, patented
- Capability with existing equipment or service
- Regulatory, i.e. Human Tissue Act (HTA)
- Urgent Operational Requirement
- Covid-19
- Unforeseen/unplanned circumstances
- Emergencies
- Exemptions

To support the management of STA/SQA requests, an online quotation system was implemented in April 2019, to test the market and promote competition, this should reduce the number of STA/SQA's.

There are also some situations where contracts are extended outside of the original contract scope to ensure patient safety and operational delivery of the Health Board's core services.

Unfortunately, there are times where individuals act outside Procurement Regulations and Standing Financials Instructions which need to be reported as a non-compliant process, which is a direct breach, and could compromise competition and value for money. There are some exemptions within these breaches in relation to unforeseen/unplanned circumstances, emergencies and more recently, Covid-19.

Should Non-Compliant Activity occur a letter from the Director of Finance will be sent to the Clinical Director/Department Head and copied to the relevant Executive Director to seek assurance that measures will be put in place to ensure that a breach does not occur again. If repeated breaches continue this will be escalated to the CEO.

Saunders.Nathan
06/11/2023 11:21:06

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

ASSESSMENT AND ASSURANCE

Non-Compliant Activity (16)

This is activity where departments have engaged suppliers without Procurement involvement and therefore, have incurred a direct breach of SFI's.

Description Title	Value at Risk Excl VAT	Contract Expiry	Length at Risk/ Breach	Clinical Board	Reason	Action/Status
Platinum Service Contract for Nexion 2000 Model	£15,317.00	N/A	12 months	Clinical Diagnostics and Therapies	Service did not engage with Procurement	Closed - Procurement have included in contracts work programme to ensure any renewal is undertaken compliantly
Storage Management and Retention	£5,091.84	N/A	12 months	Surgery Services and Dental	Service did not engage with Procurement	In Progress – Procurement engaging with department to determine if there is a requirement going forward and to complete a new Procurement.
Pectus Bar consumables	£5,410.00	N/A	One off service	Specialist	Service did not engage with Procurement	In Progress – Procurement engaging with department to determine if there is a requirement going forward and to complete a new Procurement.
Peter Hilary Services for Climb	£15,500.00	N/A	One off service	Executives	Service did not engage with Procurement	Closed – One off requirement.
DXR Secure Access	£6,272.00	N/A	One off service	Executives	Service did not engage with Procurement	Closed – One off requirement.
Pelvic Floor Services	£14,586.00	N/A	1 Month	Surgery Services and Dental	Service did not engage with Procurement	Closed - One off requirement and Procurement have met with R&D to explain the governance requirements
Medical Genetics Testing	£10,810.00	N/A	One off service	AWMGS	Service did not engage with Procurement	Closed – One off requirement.

Provision of Cardiac Agency Staff	£42,099.35	31st July 2023	1 month	Surgery Services and Dental	Service continued to engage agency post contract expiry.	In Progress – Replacement contract was not approved by Finance. Procurement advised department to cease agency upon contract expiry.
DigiSafe Consulting	£19,996.00	N/A	9 months	Executives	Service did not engage with Procurement	Closed – one off service
Cloud Cyber Security Awareness solution	£18,150.00	N/A	12 months	Executives	Service did not engage with Procurement	Closed – Agreement on the contracts work programme with a note to provide official termination three months prior to expiry in line with t&cs of the call off.
Insourcing for Ophthalmology Procedures	£41,300.00	N/A	2 months	Surgery Services and Dental	Contract had expired, however, Service continued to utilise the provider	In Progress – Procurement engaging with Service for a new STA moving forward
Health Hack 2022 Renal Project	£12,833.33	N/A	12 months	Surgery Services and Dental	Service did not engage with Procurement	Closed - Project now completed, no other further requirement
Purchase of Impella CP Smart Assist Sets	£26,500.00	N/A	2 purchases	Specialist	Service did not engage with Procurement	In progress – Procurement working with service to put in a long term contract
Rental of 3T heater cooler	£6,000.00	N/A	8 months	Specialist	Service did not engage with Procurement	Closed - Procurement have included in contracts work programme to ensure any renewal is undertaken compliantly
OSCE Testing	£6,352.00	N/A	One off purchase	Executives	Purchasing was under £5k SFI thresholds, however, following review of expenditure agreed to proceed to long term solution.	In progress - Procurement arranging for compliant long term contract, exercise undertaken and currently within approval stage
Software Maintenance for Medical Records Scanner	£39,946.00	N/A	12 months	Clinical Diagnostics and Therapies	Contract was auto renewed without completion of appropriate STA	Closed - Procurement to work with service to put in place a 2 year contract in time for contract anniversary.

Contracts value breached/ extended at risk as a result of emergency/unforeseen circumstances (Nil)

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status

Other Non-Compliant Activity (4 Return)

This section details activities which were out of the Department/Health Board's control as a result of any of the following;

- Emergency activity
- Unforeseen/Unplanned circumstances
- Exemptions

Title	Value at Risk	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status
Legal Barrister Fees	£10,000.00	N/A	One off service	Executives	NWSSP Legal and Risk select barristers with no Procurement or Health Board involvement in appointment	In Process – Procurement ascertaining the length of the requirement
Caltta Radio System Emergency Work	£9,251.00	N/A	One off emergency works	Capital Planning, Estates and Facilities	Caltta radio system had a critical failure and went down - emergency works were required to ensure service was not affected.	Closed – one off emergency works
Legal Barrister Fees	£5,000.00	N/A	Ongoing case	Executives	NWSSP Legal and Risk select barristers with no Procurement or Health Board involvement in appointment	In Process – Procurement ascertaining the length of the requirement
Legal Barrister Fees	£30,387.40	N/A	One off service	Executives	NWSSP Legal and Risk select barristers with no Procurement or Health Board involvement in appointment	In Process – Procurement ascertaining the length of the requirement

Contracts engaged at risk as a result of Covid-19 requirements (Nil Return)

Contract Title	Value at Risk	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action/Status

Report of Single Tender/Quotations Actions

Retrospective – (1 Return)

The report outlines all SQA/STA (1 Return) requests during the period the 1st August 2023 to 30th September 2023.

Clinical Board	Supplier	Name of Project	Retrospective Value of Contract Excl VAT	STA Type
Surgery	Bluespier	Bluespier Trauma Management Whiteboards	£36,628.00	Sole Supplier of Goods or Services

Should Retrospective STA/SQA's occur a letter from the Director of Finance will be sent to the Clinical Director/Department Head and copied to the relevant Executive Director to seek assurance that measures will be put in place to ensure that a breach does not occur again. If repeated breaches continue this will be escalated to the CEO.

Prospective (within the permitted guidelines)

The report outlines all SQA/STA (12) requests during the period the 1st August 2023 to 30th September 2023. The volume processed was higher than normal activity, as a consequence of the following:-

1. Bevan Exemplar initiatives – WG approved
2. Year-end Monies/ Capital
3. National Programmes
4. Trials, Testing and Education Programmes
5. Bespoke software support and/or licences
6. Specialist Maintenance and Repairs
7. Partnership Arrangements
8. Compliance / Regulatory Requirements
9. Charitable Funds
10. Standardisation of goods or services
11. Covid-19/ Unforeseen circumstances/Emergencies
12. Exemptions

Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract excl VAT	Type
Surgery	Trisoft Healthcare	Theatreman Service and Maintenance	£38,754.47	Sole Supplier of Goods or Services
Executives	University of South Wales	University of South Wales - Network 75 Programme for Finance Trainees	£127,000.00	Sole Supplier of Goods or Services
Capital Planning, Estates and Facilities	Penion	Hire of Vacuum units	£14,544.00	Urgent Operational Requirement
Clinical Diagnostics and Therapies	Edinburgh University	MSc Clinical Microbiology and Infectious Diseases	£12,740.00	Sole Supplier of Goods or Services
Executives	Glamorgan Voluntary Services	Llantwit Food Project GVS Partnership	£42,036.00	Sole Supplier of Goods or Services
Executives	University of South Wales	Specialist Post Registration Education for Nurses and Midwives Certificate in Higher Education	£51,648.00	Sole Supplier of Goods or Services
Executives	Cardiff University	Specialist Post Registration Academic Clinical Education for Nurses and Midwives	£54,000.00	Sole Supplier of Goods or Services
Children and Women	Penknife Ltd	Seren Education Programme	£45,000.00	Capability with existing equipment or service
Mental Health	Stress Control Limited	Provision of CBT to large scale participants	£12,000.00	Sole Supplier of Goods or Services

Clinical Diagnostics and Therapies	Monday.com	Weqas Work Operating System	£39,200.00	Sole Supplier of Goods or Services
Specialist	Medela UK	Rental of Thopaz+ Chest Drains	£81,144.00	Sole Supplier of Goods or Services
Children and Women	Vapotherm	Purchase of Respiratory Equipment	£37,500.00	Sole Supplier of Goods or Services

Non-Compliant Activity / Contract Breach Summary

The below summary details all Boards who have been reported for non-compliant breaches and exemptions in this period alongside their previous statistics for comparative purposes.

Year	2022/23			2023/24		
Clinical Board	**Non-Compliant Breaches**	**Exemption**	**Covid-19**	**Non-Compliant Breaches**	**Exemption**	**Covid-19**
AWMGS	1	0	0	1	0	0
Children and Women	2	0	0	1	0	0
Capital Planning, Estates and Facilities	3	2	1	2	2	0
Clinical, Diagnostics and Therapies	2	0	0	6	1	0
Executives	8	5	0	13	8	0
Medicine	2	1	0	0	0	0
Mental Health	0	0	0	2	0	0
PCIC	0	0	0	2	0	0
Specialist	3	1	0	8	1	0
Surgery and Dental	9	1	0	6	0	0
TOTALS	**31**	**10**	**1**	**41**	**12**	**0**

Please note that in February 2021, the reporting of non-compliant activity was spilt into the above criteria to reflect accuracy in reporting the justifications behind certain breaches i.e., emergency works.

STA/SQA's by Department

	2021/22		2022/23		2023/24 (Year To Date)	
Clinical Board	**No. of SQA's/STA's**	**SQA/STA's Breached**	**No. of SQA's/STA's**	**SQA/STA's Breached**	**No. of SQA's/STA's**	**SQA/STA's Breached**
AWMGS	4	3	3	3	0	0
Children and Women	2	0	3	1	3	0
Capital Planning, Estates and Facilities	2	0	15	2	1	0
Clinical, Diagnostics and Therapies	14	1	26	2	21	0
Executives	9	3	23	1	8	2
Medicine	6	1	4	0	0	0
Mental Health	1	0	3	0	1	0
PCIC	2	0	11	3	1	0
Public Health Commissioning Team	1	0	7	0	0	0
Specialist Services	6	2	11	1	2	0
Surgery Services and Dental	5	1	11	0	3	1
Grand Total	**52**	**11**	**117**	**13**	**40**	**3**

Recommendation:
The Board / Committee are requested to: • **NOTE** the contents of the Report • **APPROVE / AGREE** the contents of the Report

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
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*									
Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk:
As outlined in the above section
Safety:
As outlined in the above section
Financial:
As outlined in the above section
Workforce:
As outlined in the above section
Legal:
As outlined in the above section
Reputational:
As outlined in the above section
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
06/11/2023 11:21:06

October 2023
Supplementary information for the Director of Finance - Report of Single Tender/Quotations Actions

Category reason for SQA/STA's

1. Bevan Exemplar initiatives – WG approved
2. Year-end Monies/ Capital
3. National Programmes
4. Trials, Testing and Education Programmes
5. Bespoke software support and/or licences
6. Specialist Maintenance and Repairs
7. Partnership Arrangements
8. Compliance / Regulatory Requirements
9. Charitable Funds
10. Standardisation of goods or services
11. Covid-19
12. Unforeseen/unplanned circumstances
13. Emergencies
14. Exemptions

Retrospective – (1 Return)

The report outlines all SQA/STA (1 Return) requests during the period the 1st August 2023 to 30th September 2023.

Clinical Board	Proposed Supplier	Name of Project	Value at Risk Excl VAT	Total Value of Contract (Excl VAT)	Type	Reason for STA	Reason Category
Surgery	Bluespier	Bluespier Trauma Management Whiteboards	£117,267.00	£117,267.00	Sole Supplier of Goods or Services	System in place within the Health Board and there is no other solution currently able to fulfil its function.	10

Prospective (within the permitted guidelines)

The report outlines all SQA/STA (12) requests during the period the 1st August 2023 to 30th September 2023.

The volume processed was as a consequence of the following:-

1. Bevan Exemplar initiatives – WG approved
2. Year-end Monies/ Capital
3. National Programmes
4. Trials, Testing and Education Programmes
5. Bespoke software support and/or licences
6. Specialist Maintenance and Repairs
7. Partnership Arrangements
8. Compliance / Regulatory Requirements
9. Charitable Funds
10. Standardisation of goods or services
11. Covid-19
12. Unforeseen/unplanned circumstances
13. Emergencies
14. Exemptions

Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract excl VAT	Type	Reason Detail for STA	Category
Surgery	Trisoft Healthcare	Theatreman Service and Maintenance	£38,754.47	Sole Supplier of Goods or Services	Sole supplier of software which is required for continuity of service within the Health Board	10
Executives	University of South Wales	University of South Wales - Network 75 Programme	£127,000.00	Sole Supplier of Goods or Services	This is a unique scheme provided locally by the University of South Wales, which has been successful throughout NHS Wales in a range of academic fields. The students will support recruitment planning for the Finance team and in the long term hopefully succession development.	10
Capital Planning, Estates and Facilities	Penion	Hire of Vacuum units	£14,544.00	Urgent Operational Requirement	Penion is the only supplier that can provide the required units during this timeframe	6
Clinical Diagnostics and Therapies	Edinburgh University	MSc Clinical Microbiology and Infectious Diseases	£12,740.00	Sole Supplier of Goods or Services	First year of course has been completed and therefore, there is no other Organisation that can provide the continuation of the 2nd and 3rd year.	10

Executives	Glamorgan Voluntary Services	Llantwit Food Project GVS Partnership	£42,036.00	Sole Supplier of Goods or Services	Glamorgan Voluntary Services (GVS) have been identified as the best-placed supplier for this action, based on the fact that they already run and manage an existing Food bank. This will allow the Health Board's funding to reach further than if a food bank was to be set up and run by C&V.	10
Executives	University of South Wales	Specialist Post Registration Education for Nurses and Midwives Certificate in Higher Education	£51,648.00	Sole Supplier of Goods or Services	USW are the only supplier who provides an MSc in Health and Public Service Management	10
Executives	Cardiff University	Specialist Post Registration Academic Clinical Education for Nurses and Midwives	£54,000.00	Sole Supplier of Goods or Services	Cardiff Uni are the only supplier who provides an MSc in Advanced Clinical practice	10
Children and Women	Penknife Ltd	Seren Education Programme	£45,000.00	Capability with existing equipment or service	Penknife are the sole supplier due to technical reasoning, current designs and data records have already been created by Penknife for the Seren Programme.	3
Mental Health	Stress Control Limited	Provision of CBT to large scale participants	£12,000.00	Sole Supplier of Goods or Services	Only supplier able to provide CBT for open access audience at large scale at any given time, with online access to materials to support the course.	5
Clinical Diagnostics and Therapies	Monday.com	Weqas Work Operating System	£39,200.00	Sole Supplier of Goods or Services	Deemed business critical by WEQAS and only suitable system following extension research	5
Specialist	Medela UK	Rental of Thopaz+ Chest Drains	£81,144.00	Sole Supplier of Goods or Services	This is the only supplier to provide chest drains to support NICE guidance and is essential to treat cardiothoracic surgical patients,	5
Children and Women	Vapotherm	Purchase of Respiratory Equipment	£37,500.00	Sole Supplier of Goods or Services	There are no alternative providers in the UK market that would provide the equivalent standard product for the same level of ventilation for this age group.	10

3

Report Title:	**Annual Audit Plan**				Agenda Item no.		
Meeting:	**Audit Committee**		Public		Meeting Date:		
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		x
Lead Executive:	Executive Medical Director and Executive Nurse Director						
Report Author (Title):	Assistant Directro of Quality and Patient Safety						

Main Report
Background and current situation:

In October 2021 the Health Board clinical audit processes were subject to internal audit and were awarded **limited assurance**.

The audit identified that

- there was adequate overall leadership of clinical audit within the Health Board however as a result of under resourcing of the audit team audit training was not being delivered
- the Health Board was missing key documents to direct, mandate and ensure constancy of clinical audit approach
- The Clinical audit team and the clinal boards were not provided with the adequate tools to effectively enable them to monitor clinical audit outcomes and the improvements taken.

While it was recognised that there was a significant amount of clinical audit underway across the UHB, the oversight and governance of this audit was lacking and the activity was not always focused on quality and patient safety priorities.

The development of a clinical audit policy and strategy has provided structure and direction to this activity and supports governance and oversight of audit activity.

Cardiff and Vale UHB clinical audit process operates on a tiered system:

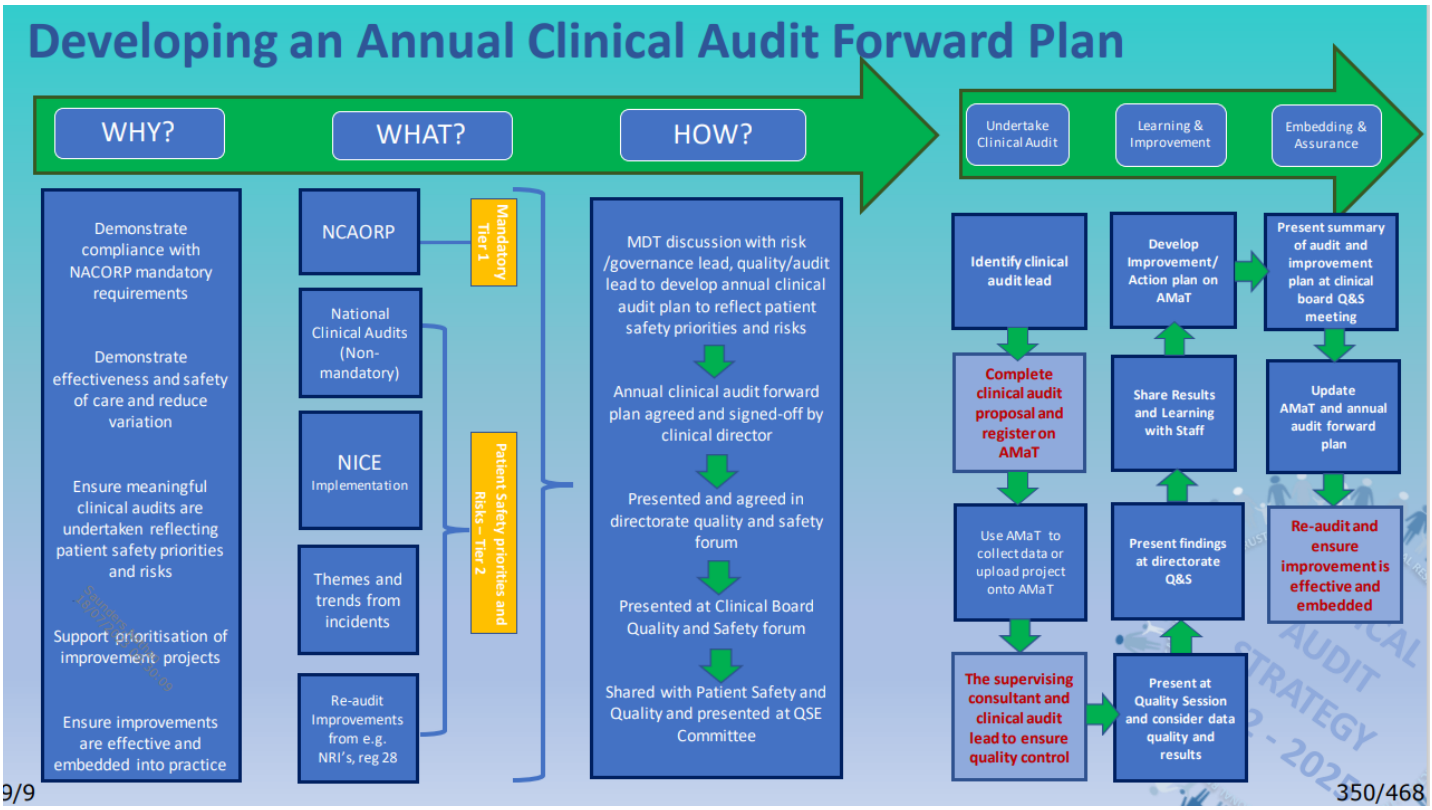
• Tier 1 – Mandatory national clinical audits – set out in the National Clinical Audit and Outcomes Review Programme (NCAORP).
• Tier 2 – All other national audits and local audits undertaken to address patient safety and quality agenda.
• Tier 3 – Local clinical audits undertaken for other reasons such as revalidation and CPD purposes

A re-audit of the clinical audit process by Internal audit has since awarded **substantial assurance**

The clinical audit forward plan incorporates all mandated national clinical audit as well as Tier 2 clinical audits undertaken to support assurance and inform quality improvement relating to quality and Patient Safety. Figure 1 is taken form the UHB clinical audit strategy and sets out guidance for clinical board when developing their clinical audit forward plan.

Appendix 1-7 demonstrate the clinical audit activity either underway or planned in each Clinical Board for 2023-2024. These plans are dynamic and continue to be added to in response to patient safety incidents and external inspection etc. The Quality and Patient Safety Team continues to support the Clinical Boards in developing these plans to inform a quality management system that drives improvement and supports quality assurance.

Figure 1



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

- **The UHB clinical audit process was assessed and awarded limited assurance in October 2021.**
- **Since then the development of a clinical audit policy and strategy and the procurement of a quality management system that supports oversight and governance of clinical audit has strengthened the governance of clinical audit**
- **A UHB Clinical Effectiveness Committee has been strengthened to support improved membership and engagement from Clinical Boards.**
- **A re-assessment of clinical audit in 2023 awarded Substantial Assurance**

Recommendation:

The Committee is asked to **NOTE** the assurance provided by the development of the clinical audit policy and strategy as well as the audit underway and planned for 2023/24

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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	
3.	All take responsibility for improving our health and wellbeing	x	8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4.	Offer services that deliver the population health our citizens are entitled to expect	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*									
Prevention		Long term		Integration	X	Collaboration	X	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
06/11/2023 11:21:06

Audit activity

Filters used

- **Forward plan year**: 2023-2024
- **Division**: Children & Women

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
1	Paediatric Respiratory Medicine (Inc CF)/SE/ 2023-24/03	14/09/2023	[Planned re-audit: 06/09/2023] Service Evaluation of Outpatient Follow-up of Paediatric Respiratory Patients in Children's Hospital for Wales								31/10/2023	Active
2	Midwifery/ CA/ 2023-24/05	11/10/2023	[Planned re-audit: 31/01/2024] Audit of the use of the Risk Assessment proforma for Aspirin in Pregnancy	✓	✓		✓	✓		29/03/2024 ✓	31/03/2024	Active
3	Obstetrics/ CA/ 2023-24/01	05/04/2023	[Planned re-audit: 31/03/2023] A Clinical Audit to Identify Timely Escalation of Transfer to Delivery Suite for Women With Spontaneous Rupture of Membranes Undergoing Induction of Labour	✓	✓	✓	✓	✓	✓	09/08/2023 ✓	30/09/2023 ✓	Closed
4	Neonatology/SE/ 2023-24/02	26/04/2023	A Review of Neonatal Surgery from 2020 to 2022	✓		✓	✓				30/06/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
5	Health Visiting and School Nursing/ CA/ 2023-24/01	01/09/2023	All Wales Health Visiting Supportive Practice Reviews	✓	✓						01/09/2024	Active
6	Midwifery/ CA/ 2023-24/06	11/10/2023	Assessing the Correct Administration of Vitamin K	✓	✓	✓				29/03/2024 ✓	31/03/2024	Active
7	Paediatric/ CA/ 2023-24/02	05/07/2023	Assessment of Adherence to Current Hypoglycaemia (HOG) Screening within Paediatric Admissions at UHW		✓		✓				31/08/2023	Active
8	Midwifery/ CA/ 2023-24/02	21/07/2023	Audit of Actions Undertaken when Community Midwife Appointment or Antenatal Clinic Appointment Missed by Patient	✓	✓		✓				31/08/2023	Active
9	Paediatric Audiology/ CA/ 2023-24/01	17/08/2023	Audit of Congenital Cytomegalovirus (cCMV) Protocol Compliance for Paediatric Patients		✓		✓				18/09/2023	Active
10	Paediatric Respiratory Medicine (Inc CF)/CA/ 2023-24/02	14/07/2023	Audit Project for Bronchiectasis in Children	✓	✓						31/12/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
11	Midwifery/ CA/ 2023-24/04	11/10/2023	Audit to Assess Documentation of Blood Pressure and Urinalysis Antenatally Through use of Maternity Early Warning Score (MEWS) Chart.	✓	✓		✓	✓		29/03/2024 ✓	31/03/2024	Active
12	Obstetrics/ CA/ 2023-24/09	10/10/2023	Audit to ensure compliance of asking the routine enquiry question (RE) antenatally.	✓	✓					29/03/2024 ✓	29/03/2024	Active
13	Obstetrics/ CA/ 2023-24/08	03/10/2023	Bare Below the Elbow and Uniform Compliance	✓	✓						03/07/2024	Active
14	Community Paediatrics/ CA/ 2023-24/01	29/06/2023	Cardiff and Vale Health Board: A Clinical Audit of Annual Reviews of Children with Neurofibromatosis Type 1	✓	✓						07/07/2023	Active
15	Obstetrics/ CA/ 2023-24/07	09/08/2023	Compliance to GAIN Guidance with Women in having Syntocinon Infusions to Induce or Augment their Labour	✓	✓	✓					01/11/2023	Active
16	Gynaecology/SE/ 2023-24/01	02/05/2023	Current Analgesic Practices in the Gynaecology Midline Laparotomy Patient Group								30/11/2023	Active
17	Obstetrics/ SE/ 2023-24/04	11/07/2023	current service evaluation of the management of suspected pre-eclampsia	✓	✓	✓	✓			31/08/2023 ✓	31/07/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
18	Paediatric Neurology/ CA/ 2023-24/01	05/04/2023	Epilepsy 12 Audit	✓	✓		✓			12/04/2023 ✓	31/05/2023	Active
19	Paediatric Oncology/ SE/ 2023-24/03	23/06/2023	Evaluating the use of MAPK Inhibitors in Patients with Paediatric Glioma				✓			22/12/2023 ✓	22/12/2023	Active
20	Paediatric Surgery/SE/ 2023-24/01	10/05/2023	Evaluation of Neonatal Inguinal Hernia Repair Outcome	✓							04/08/2023	Active
21	Obstetrics/ CA/ 2023-24/05	17/07/2023	Fluid Balance Chart use and completion in labour	✓	✓	✓	✓		✓		10/10/2023	Active
22	N/A	17/10/2023	Management and diagnosis of Ectopic Pregnancies	✓		✓					21/12/2023	Submitted
23	Neonatology/CA/ 2023-24/01	06/04/2023	MBRRACE - Mothers Babies Reducing Risk through Audits and Confidential Enquiries	✓	✓					12/04/2023 ✓	01/05/2023	Active
24	Paediatric Oncology/ CA/ 2023-24/01	18/05/2023	National Audit of TYA and Adult Neuroblastoma Cases	✓	✓						22/05/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
25	Paediatric Critical Care/SE/ 2023-24/02	13/10/2023	National Emergency Airway Registry for Children (NEAR4KIDS)								01/01/2025	Active
26	Midwifery/ CA/ 2023-24/01	04/04/2023	National Maternity and Perinatal Audit	✓	✓		✓	✓		12/04/2023 ✓	30/04/2023	Active
27	N/A	24/10/2023	National Myomap Project								05/02/2024	Submitted
28	CA/Tier 1 - National (Mandatory)/NPDA	29/09/2023	National Paediatric Diabetes Audit (NPDA)	✓	✓						31/05/2024	Active
29	Obstetrics/ CA/ 2023-24/02	11/04/2023	NCEPOD Endometriosis Study 2022	✓	✓						30/04/2024	Active
30	Paediatric Critical Care/CA/ 2023-24/01	11/04/2023	Paediatric Intensive Care Audit Network PICANet	✓						12/04/2023 ✓	30/04/2023	Active
31	N/A	15/06/2023	PANDA-PIC (Paediatric National Database of Airway Management - Paediatric Intensive and Critical Care Areas)	✓			✓			01/01/2025 ✓	15/06/2023	Submitted
32	Paediatric Oncology/ SE/ 2023-24/02	22/06/2023	Review of Vancomycin Dosing in Paediatric Haematology/Oncology Patients	✓	✓						01/10/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
33	Paediatric Respiratory Medicine (Inc CF)/SE/ 2023-24/01	01/06/2023	Service Evaluation of Outpatient Follow-up of Paediatric Respiratory Patients in Children's Hospital for Wales					✓	✓		16/06/2023 ✓	Closed
34	Paediatric Nephrology /SE/ 2023-24/01	30/04/2023	Service Improvement Project to Evaluate how Effective and Worthwhile Patients, Families and Healthcare Professionals (HCP) Perceive the R194 Genetic Screening for Familial Haematuria	✓							26/07/2023	Active
35	Obstetrics/ CA/ 2023-24/03	11/04/2023	Shoulder Dystocia Proforma Audit	✓	✓	✓	✓	✓		31/05/2023 ✓	30/06/2023 ✓	Active
36	N/A	23/09/2023	Single Centre, Retrospective, Observational Study of Ante-natal aspect of Single Ventricle Congenital Heart Disease in South Wales from 2000-2020	✓							31/10/2023	Submitted
37	Obstetrics/ CA/ 2023-24/06	25/07/2023	Third and Fourth Degree Perineal Tear Audit	✓	✓						31/12/2023	Active
38	Midwifery/ CA/ 2023-24/03	31/08/2023	Timing of CTG Reviews Following Admission to Delivery Suite	✓	✓	✓					30/09/2023	Active
39	Neonatolog /CA/ 2023-24/03	05/10/2023	To ascertain the number of correctly sited umbilical venous catheters based on the current Neonatal guidelines.	✓	✓	✓	✓			07/03/2024 ✓	07/03/2024	Active

Audit activity

Filters used

- **Forward plan year**: 2023-2024
- **Division**: Clinical Diagnostics & Therapeutics

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
1	Radiology/ SE/ 2023-24/02	23/06/2023	Accuracy of Patient Positioning in Abdominopelvic CT Examinations				✓				10/09/2023	Active
2	Radiology/ CA/ 2023-24/03	05/07/2023	An Audit of Stroke Imaging Times- Compliance with NICE Guidelines 2019 for Stroke Imaging in CT		✓						31/08/2023	Active
3	Pharmacy and Medicines Management/SE/ 2023-24/01	25/04/2023	An Evaluation of a Community of Practice Pilot Supporting Pharmacists in Wales to Credential against the Consultant Pharmacist Curriculum								31/07/2023	Active
4	Biochemistry/SE/ 2023-24/02	25/08/2023	Compliance of the Pre-analytical Requirements for Zn Analysis								31/08/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
5	N&D/CA/ 2023-24/01	25/04/2023	Evaluation of Ward-based Nutritional Screening Using NHS Wales WAASP Screening Tool Against Current Welsh Health and Care Standards	✓	✓		✓				01/05/2023	Active
6	Pharmacy and Medicines Management/SE/ 2023-24/02	28/05/2023	Exploration of Stakeholders' Views and Perceptions of Oral Antibacterial Drug Prescribing in all-Wales Primary Care Out-of-hours Services: a qualitative interview study.	✓							31/12/2023	Active
7	N&D/SE/ 2023-24/03	04/09/2023	Foodwise in Pregnancy app evaluation								31/03/2024	Active
8	Biochemistry/CA/ 2023-24/01	24/08/2023	Heavy Metals Result Reporting		✓					05/02/2024 ✓	17/09/2023	Active
9	N&D/SE/ 2023-24/02	31/05/2023	K.Vita Service Evaluation	✓							26/11/2023	Active
10	Radiology/ CA/ 2023-24/04	22/08/2023	MRI protocol and surveillance in Multiple Sclerosis (MS) patients receiving Tysabri		✓		✓				25/09/2023	Active
11	Radiology/ CA/ 2023-24/01	25/04/2023	Neuroimaging in the Work-up of Newly Diagnosed Patients with Non-small Cell Lung Cancer which are Considered for Radical Therapy		✓		✓				01/09/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
12	Physiotherapy/CA/2023-24/01	17/07/2023	Non Medical Referral Audit - Physiotherapy	✓	✓		✓	✓		21/03/2023 ✓	09/01/2024 ✓	Closed

Audit activity

Filters used

- **Forward plan year**: 2023-2024
- **Division**: Medicine

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
1	IM/SE/ 2023-24/01	03/04/2023	"Polyclinic" or Multiple Clinic Attendance in a Geriatric Population - a qualitative review								30/06/2023	Active
2	Gastroenterology/CA/ 2023-24/03	25/05/2023	A Clinical Audit of Microscopic Colitis Diagnosed in Cardiff and Vale Health Board Against the European Guidelines 2022	✓	✓		✓	✓	✓	24/07/2023 ✓	N/A	Closed
3	Memory Team/SE/ 2023-24/01	22/08/2023	A Service Evaluation into the Effectiveness of a 'Dementia Wellbeing' Group in Collaboration with the Alzheimer's Society	✓							23/08/2023	Active
4	Geriatric Medicine/ CA/ 2023-24/02	26/05/2023	An Audit to Assess Blood Pressure Measurements of Older Patients in Hospital (including postural BP concordance)	✓	✓	✓		✓	✓	31/08/2023 ✓	14/09/2023	Active
5	Cystic Fibrosis/SE/ 2023-24/02	12/10/2023	An exploration of the experiences of adults with Cystic Fibrosis unable to benefit from triple combination therapy, using Interpretative Phenomenological Analysis								30/10/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
6	EU/CA/ 2023-24/01	27/04/2023	Assessing Driving Status in the Emergency Department	✓	✓					31/05/2023 ✓	28/04/2023	Active
7	Diabetes & Endocrinology/CA/ 2023-24/01	26/09/2023	Assessment of Hyperglycemia in Patients Taking Steroids		✓		✓	✓			30/09/2023 ✓	Active
8	Geriatric Medicine/ CA/ 2023-24/03	10/07/2023	Documentation of Resuscitation Status at the UHL	✓	✓						03/08/2023	Active
9	EU/CA/ 2023-24/04	17/10/2023	Does the ED department give paracetamol via the IV route when it could be given orally?		✓					11/01/2024 ✓	02/11/2023	Active
10	Gastroenterology/SE/ 2023-24/01	11/04/2023	Evaluation of the Service Changes in Cardiff and Vale University Health Board Inflammatory Bowel Disease Clinics	✓							16/04/2023	Active
11	Geriatric Medicine/ CA/ 2023-24/01	25/04/2023	Fall and Fragility Fracture Audit Program	✓	✓		✓				07/11/2023	Active
12	CA/Tier 1 - National (Mandatory)/FFFAP	12/09/2023	Fracture Liaison Service Database (FLS-DB) FFAP	✓	✓		✓				31/12/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
13	Antibiotic Prescribing/ SE/ 2023-24/01	11/09/2023	How much do inpatients know about their antibiotic treatment?								30/11/2023	Active
14	Rheumatology/SE/ 2023-24/01	15/09/2023	Lupus staff and service user evaluation								01/04/2024	Active
15	N/A	03/10/2023	Mixed methods study of the impact of an e-triage intervention to optimise patient care in the Emergency Department using the Functional Resonance Analysis Method (FRAM)..	✓						10/04/2024 ✓	11/10/2023	Submitted
16	CA/Tier 1 - National (Mandatory)/NAIF	12/09/2023	National Audit of Inpatient Falls (NAIF) FFAP	✓	✓						31/12/2023	Active
17	Respiratory /CA/ 2023-24/01	11/04/2023	NCEPOD Community Acquired Pneumonia Study 2021	✓	✓						12/10/2023	Active
18	Gastroenterology/CA/ 2023-24/04	12/06/2023	Post-colonoscopy Colorectal Cancer JAG Quality Assurance Standard (rolling JAG requirement)	✓	✓		✓	✓	✓	31/07/2023 ✓	31/12/2023 ✓	Closed
19	EU/CA/ 2023-24/03	01/09/2023	Resuscitation Trolley Checklist - Adult Acute	✓		✓	✓				31/01/2024	Active
20	EU/CA/ 2023-24/02	26/05/2023	Resuscitation Trolley Checklist - Adult Acute	✓	✓	✓	✓				17/07/2023	Active

Audit activity

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
21	Acute Paeds ED/ SE/ 2023-24/01	10/09/2023	Review of Paediatric Emergency Department Poisoning Presentations								01/08/2024	Active
22	Gastroenterology/SE/ 2023-24/02	04/05/2023	Service evaluation of the Self-reported Change in Quality of Life in Patients with Short Bowel Syndrome Receiving Home Parenteral Support During the First year Initiated on Teduglutide	✓							04/05/2023	Active
23	Acute Medicine/ CA/ 2023-24/01	12/06/2023	Society of Acute Medicine Benchmarking Audit 2023	✓	✓						29/06/2023	Active
24	Cystic Fibrosis/SE/ 2023-24/01	28/04/2023	Transition from Generic Prescribed Fat Soluble Vitamin Products to CF Specific Products for Adult Patients with Cystic Fibrosis (PwCF)	✓	✓						28/04/2023	Active

Audit activity

Filters used

- **Forward plan year**: 2023-2024
- **Division**: Mental health

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
1	Psychology and Psychological Therapies/CA/2023-24/01	22/08/2023	An Audit of EDSOTT Against the TrACE Toolkit		✓		✓				30/11/2023	Active
2	Adult Mental Health/CA/2023-24/01	24/04/2023	Audit of Admission ECGs and Blood Tests on Cedar Ward HYC	✓	✓		✓			19/05/2023 ✓	12/06/2023 ✓	Closed
3	MHSOP/CA/2023-24/01	09/05/2023	Audit of Antipsychotic Prescribing for In-patients with Dementia at UHL to Look for Good Prescribing Practice in Line with NICE Guidelines	✓	✓		✓				31/07/2023	Active
4	Adult Mental Health/CA/2023-24/02	26/07/2023	Evaluation of Smoking Cessation Advice and Prescription of Nicotine Replacement Therapy in Hafan Y Coed Psychiatric Unit	✓	✓		✓				02/10/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
5	MHSOP/SE/ 2023-24/03	11/08/2023	Evaluation of Suicide Awareness and Mitigation Training								27/09/2023	Active
6	MHSOP/SE/ 2023-24/02	26/06/2023	Nursing Staff Perceptions of Factors Associated with Nurse-led Group Facilitation in an Older Adult Inpatient Setting								24/07/2023	Active

Audit activity

Filters used

- **Forward plan year**: 2023-2024
- **Division**: Primary Comm & Intermed Care

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
1	Dentists/ CA/ 2023-24/03	06/07/2023	A Retrospective Audit of Radiograph Quality for Maxillary Oblique Occlusal Radiographs Taken on Cleft Palate Patients		✓		✓			30/08/2023 ✓	31/08/2023	Active
2	Dentists/ SE/ 2023-24/01	11/05/2023	Access to Dental Care for Children Born with Cleft Lip and/or palate 2023	✓							01/12/2023	Active
3	Dentists/ SE/ 2023-24/02	30/06/2023	An Audit of the Inclusion of Radiographs in Referrals to IMOSS	✓			✓			16/06/2023 ✓	22/12/2023 ✓	Closed
4	Dentists/ SE/ 2023-24/04	29/06/2023	Assessment of Case Complexity of Root Canal Treatments Using Contemporary Complexity Grading Systems: a Clinical Service Evaluation		✓		✓				30/04/2024	Active
	ISH/CA/ 2023-24/01	24/05/2023	Audit Against the BASHH Standards for Partner Notification of Chlamydia and Gonorrhoea	✓	✓		✓			05/09/2023 ✓	03/07/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
6	PCIC/CA/ 2023-24/01	23/05/2023	Audit of Men Presenting with Urethritis to DOSH- Are we adhering to BASHH non-gonococcal urethritis guidelines?	✓	✓		✓			18/10/2023 ✓	08/08/2023	Active
7	Dentists/ SE/ 2023-24/05	25/09/2023	Decision-making for External Cervical Root Resorption using Cone Beam Computed Tomograms in a Welsh subpopulation: A Clinical Service Evaluation		✓		✓				31/07/2024	Active
8	ISH/SE/ 2023-24/02	31/05/2023	Evaluation of Antibiotic Usage in PrEP Users	✓	✓					12/09/2023 ✓	07/07/2023	Active
9	Dentists/ CA/ 2023-24/06	11/10/2023	Justifications of CBCT scans from the restorative dentistry department at Cardiff Dental Hospital: An audit		✓		✓				31/07/2024	Active
10	Community Pharmacy Services/SE/ 2023-24/01	01/06/2023	Key Stakeholders' Perceptions of Pharmacist Independent Prescribing within Community Pharmacy in Wales	✓							01/08/2023	Active
11	N/A	17/10/2023	Relationship of the palatal roots of the maxillary first and second molars to the greater palatine artery and the maxillary antrum in a Welsh subpopulation: A cone beam computed tomography service evaluation							24/07/2024 ✓	30/06/2024	Submitted

Audit activity

Filters used

- **Forward plan year**: 2023-2024
- **Division**: Specialist Services

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
1	Critical Care/CA/ 2023-24/08	08/09/2023	[Planned re-audit: 07/11/2023] Critical Care - Fundamentals of Respiratory Care	✓	✓		✓	✓			18/09/2023 ✓	Closed
2	Cardiac Services/ CA/ 2023-24/04	12/06/2023	[Planned re-audit: 16/05/2023] Lipid Management for Patients Admitted with Acute Coronary Syndrome for the Month of February 2023 at UHW as Recommended by NICE Guidelines	✓	✓		✓	✓			12/06/2024 ✓	Closed
3	Critical Care/SE/ 2023-24/06	21/08/2023	[Planned re-audit: 24/05/2023] Evaluation of Handover from Critical care to Wards	✓			✓				05/11/2023	Active
4	Haematology, Immunology & Metabolic Medicine/ CA/ 2023-24/01	11/09/2023	A 'Flash-Mob' UK National Audit of the use of Reversal Agents in Patients AntIcoagulated with Direct Oral Anticoagulants (HaemSTAR RAPIDO)	✓	✓						20/11/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
5	Neurology/ Physiology/ Spinal/CA/ 2023-24/03	28/09/2023	A Comparative Analysis of Local Care Practices Versus Consensus Guideline for the Standard of Care of Adults with Duchenne Muscular Dystrophy (DMD)		✓						30/11/2023	Active
6	Neurology/ Physiology/ Spinal/SE/ 2023-24/02	29/06/2023	A Multicentre Retrospective Audit of Multiple Sclerosis (MS) Diagnostic Pathways in the UK		✓		✓				04/10/2023	Active
7	Neurosurgery/SE/ 2023-24/02	05/10/2023	Alcohol management of neurosurgical patients								30/11/2023	Active
8	Cardiac Services/ CA/ 2023-24/01	06/04/2023	An Audit and Quality Improvement Programme of Peri-operative Care in Thoracic Surgery	✓	✓			✓		04/04/2023 ✓	30/09/2023 ✓	Active
9	Major Trauma/CA/ 2023-24/01	19/05/2023	ASIA Charting in Patients with Acute Spinal Cord Injury Admitted to the University Hospital of Wales		✓		✓	✓	✓	22/09/2023 ✓	01/10/2024 ✓	Active
10	Cardiac Services/SE/ 2023-24/03	02/06/2023	Assessment of Thoracic Surgery Theatre Instrument Trays for Anatomical Lung Resection	✓						24/07/2023 ✓	16/06/2023	Active
11	N/A	23/10/2023	Audit of verification of chemotherapy drug and dose against the prescription ordering system and the protocol (CART) 2023	✓	✓		✓			24/11/2023 ✓	24/11/2023	Submitted

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	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
12	N/A	23/10/2023	Audit of verification of chemotherapy drug and dose against the prescription ordering system and the protocol Stem Cell Transplant (Autologous and Allogeneic) 2023	✓	✓		✓			24/11/2023 ✓	24/11/2023	Submitted
13	N/A	23/10/2023	Audit of verification of chemotherapy drug and dose against the prescription ordering system and the protocol Stem Cell Transplant (Paediatric Autologous) 2023	✓	✓		✓			24/11/2023 ✓	24/11/2023	Submitted
14	Nephrology /CA/ 2023-24/01	26/04/2023	Audit to Assess the use of the PRE Cannulation Assessment Tool (BRS 2018): Recommendation D & Appendix 2.	✓	✓		✓				31/07/2023	Active
15	Neurology/ Physiology/ Spinal/SE/ 2023-24/01	28/06/2023	Completion of NeuroMS Screening Prior to MS Clinics				✓			06/09/2023 ✓	11/10/2023	Active
16	Cardiology/ SE/ 2023-24/01	30/05/2023	Could Early Thrombolysis at District Hospitals be a Better Option for STEMI Patients in the Current NHS Climate?	✓	✓						03/07/2023	Active
17	Critical Care/CA/ 2023-24/02	28/04/2023	DAS Airway Guidance in Critical Care	✓	✓					03/07/2023 ✓	03/07/2023	Active
18	Neurosurgery/CA/ 2023-24/01	05/10/2023	DVLA Advice for Neurosurgical Patients		✓		✓				30/11/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
19	Transplant/ CA/ 2023-24/01	06/06/2023	Evaluating the of Quality of Operative Notes within Renal Transplant Surgery	✓	✓		✓			16/05/2023 ✓	30/06/2023	Active
20	Haematology, Immunology & Metabolic Medicine/ SE/ 2023-24/03	10/10/2023	Evaluation of the effectiveness of a research nurse-led delivery of clinical trial activities to patient's home for People with Haemophilia A (PwHA) – A Process Evaluation	✓							19/09/2024	Active
21	Critical Care/CA/ 2023-24/03	30/04/2023	Eye Care in Critical Care	✓	✓	✓	✓			04/07/2023 ✓	04/07/2023	Active
22	Critical Care/CA/ 2023-24/07	23/08/2023	Family Updates in Critical Care Audit	✓	✓		✓			06/11/2023 ✓	31/10/2023	Active
23	Neurosurgery/SE/ 2023-24/05	07/10/2023	How well do we do? Functional Pituitary Tumour Resection Outcome in NHS Wales				✓				30/11/2023	Active
24	Haematology, Immunology & Metabolic Medicine/ CA/ 2023-24/02	03/10/2023	Indications for the use of IvIg in ITP, and adherence to UHB protocol, including consent process		✓						31/10/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
25	Critical Care/CA/ 2023-24/04	16/04/2023	Neuron Specific Enolase Assessment in Critical Care Out of Hospital Cardiac Arrest Patients - Are we taking this test and interpreting it appropriately?		✓						01/08/2023	Active
26	Cardiac Services/ CA/ 2023-24/02	17/04/2023	NICOR Cardiac Rhythm Management	✓	✓						13/11/2024	Active
27	Critical Care/CA/ 2023-24/01	19/04/2023	Nursing Care of Patients with NG Tubes Within Critical Care	✓	✓	✓	✓	✓	✓	05/06/2023 ✓	05/06/2023	Active
28	Critical Care/CA/ 2023-24/05	22/06/2023	Prescribing Practice in Critical Care	✓	✓		✓				04/12/2023	Active
29	Neurosurgery/SE/ 2023-24/04	05/10/2023	Recreational Drug Use among Neurosurgical Patients								30/11/2023	Active
30	Neurosurgery/SE/ 2023-24/03	05/10/2023	Smoking Status Among Neurosurgical Patients								30/11/2023	Active

Audit activity

Filters used

- **Forward plan year**: 2023-2024
- **Division**: Surgical

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
1	Trauma/CA/ 2023-24/07	19/07/2023	[Planned re-audit: 24/07/2023] Improving the Documentation of Tourniquet use in Trauma in Line with BOAST Guidelines		✓		✓	✓		13/09/2023 ✓	N/A	Closed
2	Theatres/ CA/ 2023-24/01	21/08/2023	[Planned re-audit: 30/06/2023] 5 steps to safer surgery WHO checklist in peri-operative care	✓	✓	✓	✓	✓		19/09/2023 ✓	19/09/2023	Active
3	peri-op/CA/ 2023-24/01	11/04/2023	5 steps to safer surgery WHO checklist in peri-operative care	✓	✓	✓	✓	✓	✓	30/06/2023 ✓	26/05/2023 ✓	Closed
4	N/A	26/09/2023	A Local Audit of the Accuracy of Study Models and Quality of Clinical Photographs for Orthodontic Records				✓			22/11/2023 ✓	02/10/2023	Submitted
5	Orthodontics/SE/ 2023-24/05	02/08/2023	A Project to Determine the Success of Treatment of Class II Malocclusion Using a Twin Block Appliance at the University Dental Hospital, Cardiff								10/09/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
6	ENT/SE/ 2023-24/02	13/09/2023	A Service Evaluation Project Assessing Post-operative Pain and Patient Reported Outcomes in Patients Undergoing Trans-oral Robotic Surgery (TORS) at the University Hospital of Wales (UHW)	✓							31/10/2023	Active
7	Orthopaedics/CA/ 2023-24/02	19/04/2023	A6 South Patient Risk Assessment Booklet Audit	✓	✓	✓					30/06/2023	Active
8	Anaesthetics/SE/ 2023-24/01	07/06/2023	ACCESS Study (Anaesthetic Management of Caesarean Section)								07/06/2023	Active
9	CDS/CA/ 2023-24/02	28/06/2023	An Audit to Assess Whether Clinicians are performing BPE examination as Stated in BSP BPE Guidelines	✓	✓		✓			06/12/2023 ✓	01/07/2023	Active
10	Restorative/ CA/ 2023-24/01	26/07/2023	An Audit to Determine if Oncology Patients Receiving Head and Neck Radiotherapy are given a Follow-up appointment in 3-4 Months	✓	✓					25/07/2023 ✓	25/10/2023	Active
11	Orthopaedics/CA/ 2023-24/05	06/10/2023	Anaesthetic Post-op Instructions Documentation in Neck of Femur Fracture Patients		✓					12/10/2023 ✓	13/10/2023	Active
12	Vascular/ CA/ 2023-24/01	27/04/2023	Are Vascular Surgery Inpatients on an Appropriate Dose of Statins for Reduction of CVD Risk?	✓	✓		✓			18/05/2023 ✓	01/12/2023 ✓	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
13	Trauma/SE/ 2023-24/06	19/06/2023	Assessing attitudes of radiation protection for trainees within Trauma and Orthopaedics		✓				✓	13/09/2023 ✓	31/07/2023 ✓	Closed
14	N/A	03/10/2023	Assessing the impact of Welsh Clinical Portal integrated electronic op notes for hepatopancreaticobiliary (HPB) patients at the University Hospital of Wales	✓			✓			31/10/2023 ✓	22/10/2023	Submitted
15	Orthodontics/CA/ 2023-24/07	27/09/2023	Audit Assessing the Compliance with a Newly Developed Local Standard Operating Procedure (SOP) for Management of Hypodontia Patients at the University Dental Hospital, Cardiff	✓	✓		✓				28/09/2023	Active
16	Breast/SE/ 2023-24/01	24/07/2023	Audit of Breast Pain Pathway and Service Delivery to that Particular Group to Evaluate the Effectiveness and Efficiency of Current Model in Light of Prudent Healthcare and Cardiff and Vale UHB Plan of Value Based Model of Service Delivery	✓							15/09/2023	Active
17	N/A	08/09/2023	Audit of PICO Single-Use Negative Pressure Wound Therapy Device in the Management of Groin Surgical Site Infections (SSIs)		✓		✓			31/05/2024 ✓	30/06/2024	Submitted
18	Max Fac/ CA/ 2023-24/01	09/10/2023	Audit on Free Flap Survival at the University Hospital Wales over the last 10 years		✓		✓				31/05/2024	Active
19	CDS/CA/ 2023-24/01	05/05/2023	Consent in Patients Undergoing Sedation in the Community Dental Service		✓		✓			05/09/2023 ✓	11/05/2023 ✓	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
20	ENT/SE/ 2023-24/01	02/05/2023	Developing a New Tonsillitis Pathway to Reduce Pressure on Front Door Services	✓							07/05/2023	Active
21	Orthodontics/SE/ 2023-24/06	20/08/2023	Efficiency of Secretary Letters	✓						31/10/2023 ✓	20/08/2023	Active
22	Orthopaedics/SE/ 2023-24/03	08/06/2023	Evaluating Survivorship and Patient Outcomes Following Implantation of the Zimmer RHK Hinged Knee Replacement				✓	✓	✓	19/07/2023 ✓	20/10/2023 ✓	Closed
23	CDS/CA/ 2023-24/03	05/07/2023	Evaluating the Assessment and Documentation of Tooth Wear During the Examination of Patients Within the Community Dental Service (CDS)		✓		✓			12/09/2023 ✓	08/09/2023 ✓	Closed
24	Orthodontics/SE/ 2023-24/04	01/08/2023	How do we Consent our Orthodontic Patients?				✓				13/08/2023	Active
25	N/A	23/08/2023	Impact of Corrective Spinal Surgery for Spinal Deformity on Obstetric Outcomes for these Patients	✓							30/11/2023	Submitted
26	Orthopaedics/SE/ 2023-24/04	10/06/2023	Impact of Season, Climate and COVID-19 on the Incidence of Acute Tendon Rupture	✓							12/06/2023	Active
27	Trauma/SE/ 2023-24/03	24/04/2023	Improving Performance for Patients who have Sustained a Hip Fracture by the Introduction of a Rapid Hip Fracture Pathway: A service Evaluation Project	✓	✓		✓				02/08/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
28	Trauma/CA/ 2023-24/01	11/04/2023	Improving the Documentation of Tourniquet use in Trauma in Line with BOAST Guidelines	✓	✓		✓	✓	✓		30/06/2023 ✓	Closed
29	Trauma/CA/ 2023-24/05	19/06/2023	Improving the Management of Stable Ankle Fractures Referred to Trauma and Orthopaedics	✓	✓						31/07/2023	Active
30	General Surgery/CA/ 2023-24/04	18/08/2023	Is dietary advice given to patients with diverticulitis as per NICE and RCS guidelines?		✓					12/10/2023 ✓	20/10/2023	Active
31	Orthodontics/SE/ 2023-24/02	25/06/2023	Issues with retainers - The use of Orthodontic Casual (emergency) Appointments	✓						09/08/2023 ✓	09/08/2023	Active
32	Trauma/SE/ 2023-24/04	14/04/2023	Management of Unstable Ankle Fractures in the Elderly - An Evaluation of Current Practice	✓			✓			06/03/2024 ✓	28/09/2023	Active
33	Orthodontics/SE/ 2023-24/01	02/05/2023	Measuring the patient waiting times for Orthognathic Surgery Waiting Times pre COVID-19 Pandemic and measuring the waiting time during and post Covid-19	✓							31/01/2024	Active
34	Endocrine/ CA/ 2023-24/01	09/05/2023	National Audit - The British Association of Endocrine & Thyroid Surgeons	✓	✓						01/01/2024	Active
35	Orthopaedics/CA/ 2023-24/01	05/04/2023	National Audit of Inpatient Falls (NAIF)	✓	✓		✓				31/12/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
36	CA/Tier 1 - National (Mandatory)/NBOCA	14/06/2023	National Bowel Cancer Audit (NBOCA)	✓	✓						07/02/2024	Active
37	CA/Tier 1 - National (Mandatory)/NLCA	18/07/2023	National Lung Cancer Audit (NLCA)	✓	✓		✓				31/12/2023	Active
38	Vascular/ CA/ 2023-24/02	04/05/2023	National Vascular Registry (NVR)	✓	✓						30/06/2023	Active
39	General Surgery/CA/ 2023-24/01	11/04/2023	NCEPOD Testicular Torsion Study 2022	✓	✓						01/01/2025	Active
40	Urology/ CA/ 2023-24/01	14/06/2023	Outcomes after Radical Risk-stratified Approach for Management of Upper Tract Urothelial Cancer: a Single-institution Observational Retrospective Cohort Study	✓	✓		✓				19/07/2023	Active
41	Orthodontics/SE/ 2023-24/08	30/08/2023	Patient Satisfaction with Orthodontic Treatment	✓			✓				11/09/2023	Active
42	Urology/SE/ 2023-24/02	31/08/2023	Percutaneous nephrostomy for malignant ureteric obstruction in Cardiff and Vale University Health Board/South Wales: contemporary practice and patient outcomes							11/09/2023 ✓	01/07/2024	Active

Audit activity

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
43	General Surgery/SE/ 2023-24/02	17/07/2023	Post-surgical Care for Upper GI patients - A Staff Survey	✓		✓	✓	✓	✓		16/10/2023 ✓	Active
44	Orthodontics/CA/ 2023-24/03	23/08/2023	Reporting OPGs Taken for Orthodontic Treatment at Cardiff Dental Hospital	✓	✓		✓				05/02/2024	Active
45	Resuscitation/CA/ 2023-24/01	16/06/2023	Resus Service Adult Advanced Trolley Audit	✓	✓		✓				18/09/2023	Active
46	Resuscitation/CA/ 2023-24/02	01/08/2023	Resuscitation DNACPR Audit 2023	✓	✓						31/08/2023	Active
47	Resuscitation/CA/ 2023-24/03	01/08/2023	Resuscitation NEWS Audit 2023	✓	✓						31/08/2023	Active
48	Resuscitation/CA/ 2023-24/04	01/08/2023	Resuscitation Spot-Check Audit 2023	✓	✓						31/08/2023	Active
49	Dental Paediatrics/CA/ 2023-24/01	02/07/2023	Retrospective Audit of Compliance with the Simplified and Conventional Basic Periodontal Examination in Paediatric and Orthodontic Dental New Patients	✓	✓		✓				19/09/2023	Active
50	Breast/SE/ 2023-24/02	24/07/2023	Retrospective audit of single surgeons non radiology breast pain clinic experience. Potential model to redefine and introduce community based breast pain clinic?	✓							31/08/2023	Active

	Audit code	Active date	Audit title	Forward plan	Guidance	Governance	Criteria	Key successes	Key concerns	Presentation	Action plan	Audit Status
51	Trauma/CA/ 2023-24/02	13/04/2023	Review of Post-Operative Patients With Neck of Femur Fractures	✓	✓	✓	✓	✓	✓	19/04/2023 ✓	04/07/2023 ✓	Active
52	Vascular/ CA/ 2023-24/03	25/09/2023	Surgical Site Infections in Major Lower Limb Amputation: A Multicentre Audit (SIMBA)		✓		✓				01/05/2024	Active
53	General Surgery/SE/ 2023-24/03	31/07/2023	The National Open Abdomen Audit				✓				01/08/2023	Active

Report Title:	Counter Fraud Progress Report				Agenda Item no.	2.13	
Meeting:	Audit Committee		Public	x	Meeting Date:	07/11/2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive:	Catherine Phillips						
Report Author (Title):	Gareth Lavington						

Main Report
Background and current situation:

The Counter Fraud Progress report seeks to provide assurance to members of the Audit Committee that the Counter Fraud work being undertaken is satisfactory, robust and compliant with NHS Counter Fraud Authority requirements.

The report provides information around key areas of work including, fraud awareness and learning, fraud risk assessment, investigation and reactive work, and promotional activity.

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

Progress made against the Annual Counter Fraud Plan
Promotional /Educational Activity
Summary of Investigations
Prevention activity
National Fraud Initiative work

Recommendation:

The Board / Committee are requested to: **note** the report

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.
Risk: Yes/~~No~~
Fraud is a risk to all organisations. Within the NHS should fraud occur then this can have financial and reputational impacts and ultimately negatively affect patient care.
Safety: ~~Yes~~/No
Financial: Yes/~~No~~
All fraud occurring in the organization has a financial loss to the organization.
Workforce: Yes/~~No~~
Reduction of available staff during investigations and sanctions; demotivation
Legal: Yes/No
Reputational: Yes/~~No~~
As at Risk
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
06/11/2023 11:21:06

NHS WALES

Counter Fraud Progress Report

19/08/2023-23/10/2023

Public

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

Table of Contents

1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists on behalf of the Health Board.

This report relates to activity for the reporting period 19/08/2023-23/10/2023.

2. Progress

Infrastructure/Annual Plan

Work has continued in maintaining the Counter Fraud infrastructure in order to maintain compliance with the Counter Fraud Plan for 2023-2024, and the NHS CFA functional standards. The below activity has taken place -

i. Continued maintenance and development of a comprehensive local activity database which is vital in maintaining a detailed and accurate record of work undertaken and activity reported in order to inform areas of future work.

ii. Continued maintenance of Counter Fraud digital platform – **Members of the Audit Committee are encouraged to visit the site at the link/QR code here**

Counter Fraud - Home (sharepoint.com)

Promotion and Awareness and Educational Activity

Corporate Induction– The first Corporate Induction event to be held at the UHW site on 26th October 2023. Counter Fraud Team in attendance.

Webinar Events – During this period a total of 4 webinar events have been held. These sessions are held once a month and are advertised for staff to book into. Two sessions are held – General fraud Awareness and Mandate Specific Fraud Awareness. No members of staff from CAVUHB has attended a webinar in this period.

Intranet Site- during this period the intranet site has received 102 visits.

Other/Ad Hoc/Trial promotional activity- A further newsletter has been produced, disseminated and published on the intranet site. This, and historic newsletters, can be found at the following link - News & Recent Cases (sharepoint.com) or via the QR Code provided above.

E- Learning – The new e-Learning package is now Live on the ESR system and available to staff. This is not mandatory learning at the organisation. Since launch **36** members of staff at CAVUHB have completed the learning. During the same time period across NHS Wales as a whole, **4590** members of staff have completed the learning.

Prevention

Local Bulletins – No local bulletins have been issued during this period.

FPN / IBURN – (issued by NHSCFA)

1 x FPN has been issued. Relating to the impersonation of Medical Professionals. FPN disseminated to key stakeholders and support material supplied. Local Proactive work in relation to this subject area commenced. No issues identified to date. Work continues.

1 x IBURN – Employment on a skilled worker visa. The individuals named on the IBURN have been investigated and have had no connection to CAVUHB.

LPE –

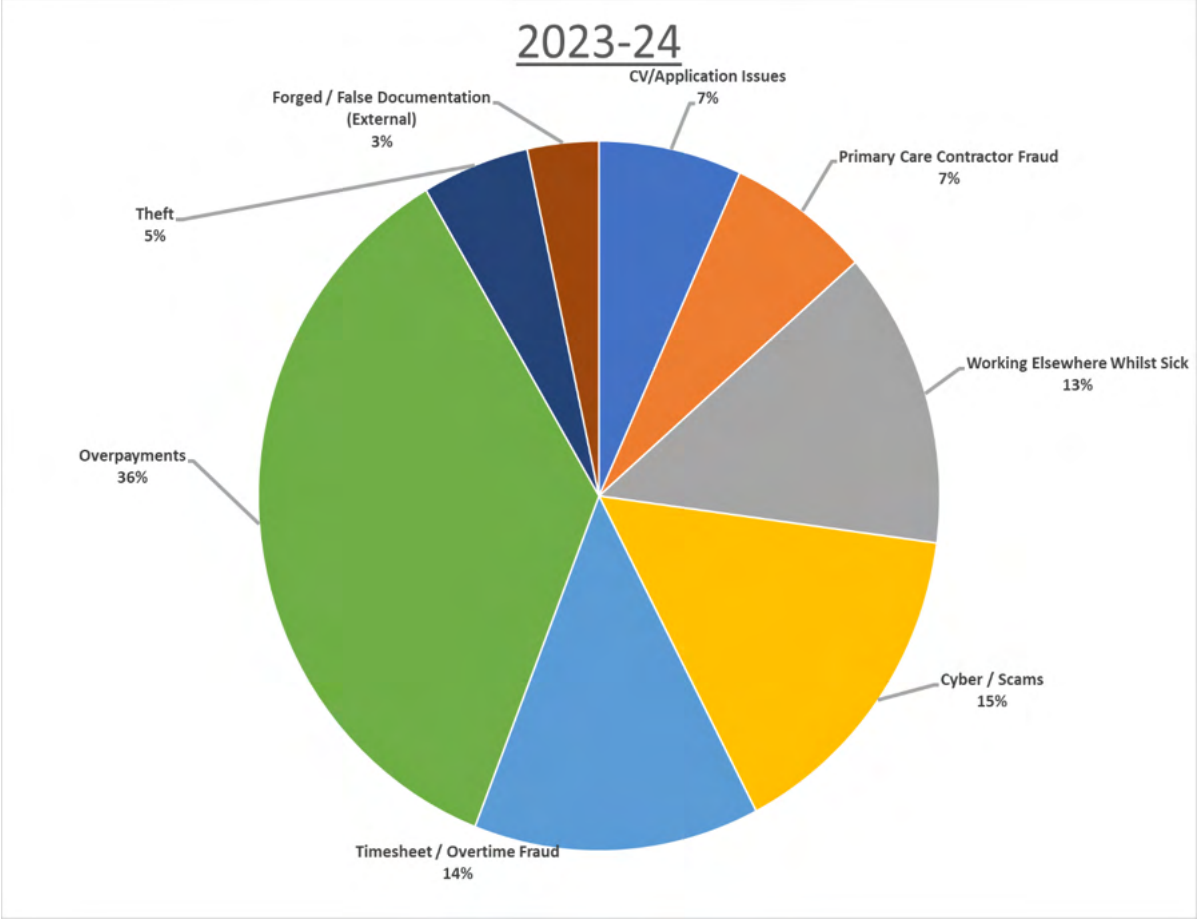
1. Job / Planning and rostering review of staff in Integrated Medicine department. Processes involving distribution of resource in relation to research grants. Informed by investigation into suspicious claims for overtime payments. (Investigation details provided in private report)

2. Ongoing random checking of agency workers supplied to wards to ensure identity and that policy being followed – as a result of FPN in relation to Impersonation of medical professional. To date no issues identified.

Referrals

During this reporting period there have been a total of 17 referrals made to the team. (Of the 17 referrals received, 9 have been closed with no further action required, and 8 have been promoted to formal investigation)

A thematic breakdown of the referral areas for the 2023-24 year to date is shown below.



Investigations

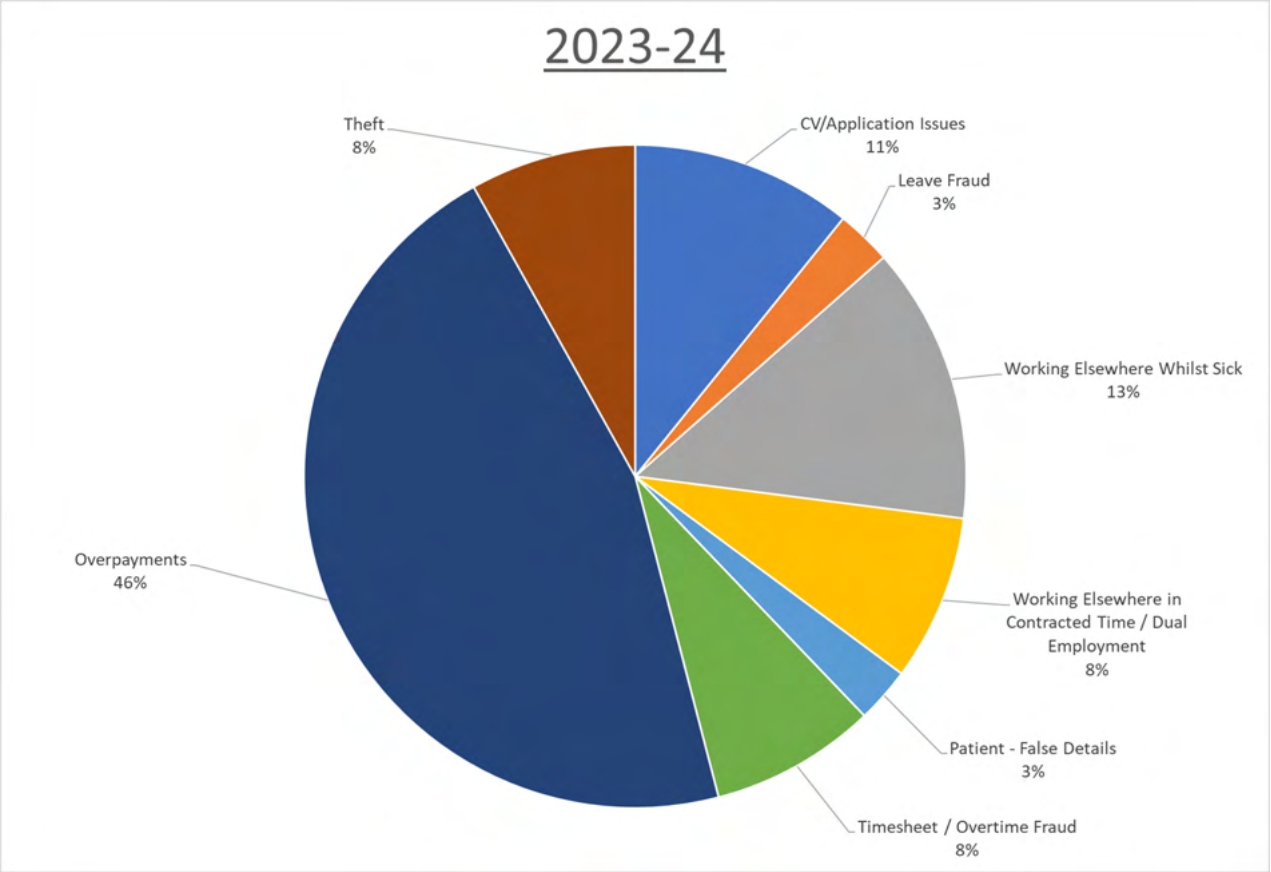
A total of 8 formal Investigations have been commenced this period. A summary of the investigations for 23-24 are provided below. There are currently 21 CAVUHB investigations open and being investigated by the team at this time. Summary of 23/24 investigations provided below.

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/22/00730	False On Call Claims	CARRIED OVER - 24/06/2022		
INV/22/01558	False Bereavement	CARRIED OVER - 25/10/2022	04/07/2023	Subject has been dismissed for Gross Misconduct following Disciplinary Hearing. Financial Recovery made of £520.61
INV/23/00079	Staff Over Payment	CARRIED OVER - 10/01/2023		
INV/23/00096	Overpayment of Salary - Non Starter	CARRIED OVER - 12/01/2023		
INV/23/00113	Suspected Overtime Fraud (EW)	CARRIED OVER - 13/01/2023		
INV/23/00263	Working elsewhere during HB Hours	CARRIED OVER - 06/02/2023	02/05/2023	No fraud identified, all avenues of investigation completed under available powers.
INV/23/00412	Patient letters to different address	CARRIED OVER - 28/02/2023	04/07/2023	Reported in good faith, no offences identified.
INV/23/00415	Working whilst sick / NFI match	CARRIED OVER - 27/02/2023	23/06/2023	Case transferred to National Investigations Team NHSCFA - outcome awaited
INV/23/00646	Theft of Cyclizine	03/04/2023	02/05/2023	Evidence of theft to the value of £11.33, passed evidential test however did not pass public interest test for criminal prosecution. Subject work with organisation terminated.
INV/23/00648	Overpayment Of Salary - Career Break	03/04/2023	01/06/2023	Non Fraud Recovery £10,847.74. Subject on career break out of the country, civil recovery only.
INV/23/00702	Overpayment / On-Call Banding error	06/04/2023	18/05/2023	Disciplinary hearing completed - written warning issued in relation to nonfraud offences. No losses to fraud identified.
INV/23/00737	Salary Overpayment Following Termination	18/04/2023		

INV/23/00764	Salary Overpayment Following Termination	21/04/2023	04/07/2023	Non fraud recovery - £5,525.37. Subject no longer employed by organisation.
INV/23/00824	Salary Overpayment Following Termination	02/05/2023	04/07/2023	Non Fraud recovery - £2,967.57. Subject no longer employed by organisation.
INV/23/00825	Salary Overpayment for Sick Pay	02/05/2023		
INV/23/00826	Salary Overpayment Reduction in Hours	02/05/2023		
INV/23/00827	Salary Overpayment Following Termination	02/05/2023		
INV/23/00828	False Reference - Bank Worker	02/05/2023	18/05/2023	Subjects recruitment with the organisation was terminated. Intelligence shared with counter parts across Wales regarding Subject.
INV/23/00884	Overpayment of Salary - Career Break	10/05/2023		
INV/23/00896	Overpayment of Salary - Late termination	11/05/2023	04/07/2023	Non Fraud Recovery - £6,589.22. Subject no longer in employment
INV/23/00991	CV Issues	23/05/2023	30/05/2023	Investigation complete, no issues found
INV/23/01060	Falsified managers signature on training form	02/06/2023	14/07/2023	Internal Disiplinary sanction / closed
INV/23/01204	Suspicious Claiming Activity	21/06/2023	18/10/2023	Visit conducted no fraud identified
INV/23/01228	CV Issues	27/06/2023	27/06/2023	Duplicate of INV/23/00991
INV/23/01310	Working elsewhere in contracted time	05/07/2023	05/07/2023	Enquiries completed, no fraud issues identified, matters reported have already been dealt with historically at managerial level. DOI to be submitted regarding voluntary work.
INV/23/01403	Overpayment of Salary - Late Termination	18/07/2023		
INV/23/01578	Mis use of Research Budget	01/08/2023	06/10/2023	no offences identified
INV/23/01619	Sending prescription overseas	03/08/2023	06/09/2023	No fraud identified
INV/23/01633	Agency Worker False Timsheets	03/08/2023	04/10/2023	Internal Disciplinary anction - Removed from Bank staff list and restricted from any future agency work with the organisation. No financial loss to the organisation.
INV/23/01634	Salary Sacrifice Vehicle not transfered when	03/08/2023		

	subject left organisation, no further deductions/payments made			
INV/23/01636	Suspect has been carrying out UBER work whilst off sick from HB with chronic Back issues	07/08/2023		
INV/23/01681	Optical Claim Fraud	10/08/2023	16/08/2023	No offences identified
INV/23/01680	Optical Claim Fraud	10/08/2023	25/09/2023	No fraud identified, measures put in place to reduce risk of future occurrence
INV/23/01679	Optical Claim Fraud	10/08/2023		
INV/23/01696	No Termination	14/08/2023		
INV/23/01703	Intel report re staff at St Davids acting nepotistically	14/08/2023	30/08/2023	No offences identified
INV/23/01644	Intel from CFA	14/08/2023	30/08/2023	Suspected malicious report, no issues identified
INV/23/01732	Slary Overpayment	16/08/2023		
INV/23/01736	Salary Overpayment	16/08/2023	16/08/2023	Transferred to CFS WALES
INV/23/01806	Working elsewhere in contracted time	24/08/2023	14/09/2023	No offences identified
INV/23/01968	Referral form from directorate - staff member working abroad whilst of sick	13/09/2023		
INV/23/02002	Staff member stealing CD's from Omnicell	15/09/2023		
INV/23/02137	Administrator at GP created false prescriptons	28/09/2023	04/10/2023	Disciplinary sanction - subjects work within the GP practice terminated.
INV/23/02182	Dual claims for optom services	03/10/2023		
INV/23/02097	Altered prescriptions	26/09/2023		
INV/23/02207	Working Eslewhere whilst sick	12/10/2023		
INV/23/02286	Working elsewhere whilst sick	12/10/2023		

A thematic breakdown of the investigation areas for the 2023-24 year to date is shown below.



Fraud Risk

A total of 5 Fraud Risk Assessments have been commenced in this period. These are incomplete at this time and will be reported upon further when complete.

The areas that the risk assessments have been commenced:

1. Staff Governance – Integrated Medicine Directorate
2. Omnicell (Medicine Cabinet) – Processes
3. Impersonating a medical professional
4. Petty Cash processes
5. Claims vs H

National Fraud Initiative

Work has continued into the latest NFI data dump. The below table provides the total matches that are addressed by the Counter Fraud Team.

Report Type	Total No. of Matches	No. Cleared
Payroll to Payroll - NI	311	161
Payroll to Payroll - Tel. No.	54	53
Payroll to Payroll - Email	1	1
Payroll to Pension	132	132
Payroll to Company Director/Trade Creditor	116	45
Payroll to Creditor	190	146

3. Other

NA

Report Title:	**Internal Audit Reports for Information**				Agenda Item no.	4.1	
Meeting:	Audit & Assurance Committee		Public	X	Meeting Date:	07/11/23	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		X
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Head of Internal Audit						

Main Report

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 annual plan, which is prepared following a detailed planning process, including consultation with the Executive Directors, and is 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 engagement process established with the UHB.

As individual audit reviews are completed, the final reports are submitted to the Committee for assurance and information.

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

The following audit reports have been finalised since the last meeting of the Committee:

- Refresh of the Health Board's Strategy - (Substantial Assurance)
- Urgent and Emergency Care – Welsh Government Six Goals Programme – (Substantial Assurance)
- PARIS System – (Reasonable Assurance)
- Follow-up: Chemocare IT System – (Reasonable Assurance)
- Surgery CB - Consultant Job Plans – (Limited Assurance)
- Leadership and Management Training and Development (Advisory)
- Quality, Safety and Experience Governance (Advisory)

Recommendation:

The Audit & Assurance Committee are requested to:

• **Consider and note** the final Internal Audit reports.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

4. Offer services that deliver the population health our citizens are entitled to expect	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	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term	x	Integration	x	Collaboration	x	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/~~No~~
The finalised audit reports provide assurance around a number highlighted risks and also identify areas requiring improvement.
Safety: ~~Yes~~/No
A number of the finalized audits provide assurance around quality and safety risks.
Financial: ~~Yes~~/No
Workforce: ~~Yes~~/No
A number of the finalized audits provide assurance around workforce risks
Legal: ~~Yes~~/No
Reputational: Yes/~~No~~
One of the finalised audits provides assurance around reputational risks.
Socio Economic: ~~Yes~~/No
One of the finalized audits provides assurance around socio economic risks.
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
06/11/2023 11:21:06

Refresh of the Health Board's Strategy

Final Internal Audit Report

Cardiff & Vale University Health Board

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

Contents

Review reference:	CVU 2324-18
Report status:	Draft Report
Fieldwork commencement:	11 July 2023
Fieldwork completion:	27 September 2023
Debrief meeting:	20 September 2023
Draft report issued:	29 September 2023
Management response received:	6 October 2023
Final report issued:	9 October 2023
Auditors:	Olubanke Ajayi-Olaoye, Principal Auditor Lucy Jugessur, Interim Deputy Head of Internal Audit
Executive sign-off:	Abigail Harris, Executive Director of Strategic Planning
Distribution:	Marie Davies, Deputy Director of Strategic Planning Caitlin Thomas, Capital Planning Programme Support Manager
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 Chartered Institute of Public Finance & Accountancy in April 2023.

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

Executive Summary

Purpose

Review of the Health Board's approach in undertaking engagement with all stakeholders to inform the development of the refreshed 10-year strategy.

Overview

We have issued substantial assurance on this area.

The matter requiring management attention include:

- The risk register did not have the required fields completed and updates were not reflected within it.

Report Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Assurance summary

	Objectives	Assurance
1	There is a Health Board framework which sets out the approach in ensuring the application of good and effective public engagement practice	Substantial
2	A stakeholder engagement programme plan is in place which sets out the approach for how the engagement is to be conducted and a timetable for the refresh of the Health Board's Strategy	Substantial
3	Key stakeholders have been adequately identified and continuously involved in the engagement process of refreshing the Health Board Strategy	Substantial
4	Results/ outcomes of public engagements undertaken are assessed and incorporated to inform the refreshed Health Board's Strategy	Substantial
5	There are appropriate governance arrangements, which provide effective oversight of the stakeholder engagement process for the refresh of the Health Board's Strategy	Substantial
6	Risks relating to stakeholder engagement are appropriately considered and monitored	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Format and updating of the risk register	6	Operation	Medium

1. Introduction

1.1 Our audit review of the Refresh of the Health Board's Strategy was completed in line with the 2023/24 internal audit plan for Cardiff and Vale University Health Board (the 'Health Board').

1.2 The Health Board has a ten-year strategy from 2015-2025, 'Shaping our Future Wellbeing', outlining the organisation's strategic and operational objectives. It was developed between 2013 and 2015 and was approved by the Board in September 2015. The IMTPs three-year cycles have been the channels through which key actions have progressed.

1.3 A Strategy refresh was undertaken to take into account the accelerating pace of transformation in responding to the challenges of today, learning from the COVID pandemic, and ensuring that the Health Board is future proofed.[1] This will ensure that priorities are set for action enabling to deliver the absolute best quality of care for the population.[2]

1.4 The strategy refresh was classified into two key phases for the engagement process:

- Phase 1 Engagement: This phase was launched January 2023 and had a planned conclusion date of 20th March 2023. This Engagement phase was to target all internal and external stakeholders to seek their input on the vision, purpose and key strategic priorities.
- Phase 2 Engagement: It was proposed to commence this phase on 1st May and conclude on 26th June 2023. Phase 2 is to seek feedback on the draft strategy document.

1.5 The refreshed Strategy was taken to the Strategy Refresh Steering Group, Senior Leadership Board (SLB) and formally endorsed at the Board meeting on the 27th of July 2023.

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

1.7 The potential risks considered for this review were as follows:

- The health board fails to comply with legislation and guidance on public consultation engagement practice; and
- The health board does not implement an effective and continuous approach in engaging with the stakeholders, therefore undermining development of the Health Board's strategic priorities.

[1] cavuhb.nhs.wales/files/board-and-committees/strategy-and-delivery-committee-2022-23/2022-05-17-sandd-papers-v6pdf/
[2] cavuhb.nhs.wales/files/board-and-committees/board-2022-23/2022-09-29-public-board-papers-v10pdf/

2. Detailed Audit Findings

Objective 1: There is a Health Board framework which sets out the approach in ensuring the application of good and effective public engagement practice.

2.1 Welsh Government 'Guidance for engagement and consultation on changes to Health services' was published in April 2023 following the establishment of Llais. This is a service change guidance for NHS organisations outlining principles and prompts to consider as organisations undergo service change.

2.2 The Health Board has produced an Engagement Framework in line with the Welsh Government guidance. It is currently in draft but is in the process of being approved. This has been developed to ensure a consistent approach of engaging effectively and efficiently across the organisation. In addition, the Framework details ten principles to be followed to ensure the engagement work to be carried out is good, qualitative, open and consistent.

Conclusion:

2.3 The Engagement Framework was under review at the time of audit fieldwork and awaiting comments from the Consultation Institute. It has been scheduled to go to the Board in November 2023. It highlights the approach required for an effective engagement process with stakeholders. ***(Substantial Assurance)***

Objective 2: A stakeholder engagement programme plan is in place which sets out the approach for how the engagement is to be conducted and a timetable for the refresh of the Health Board's Strategy.

2.4 A detailed Communication and Engagement Plan (for phase one and two) was developed to ensure staff across the organisation could assist in shaping the next iteration of the strategy and engaging widely with key stakeholders. The Communication and Engagement Plan included revised timelines, and a description of the engagement plan and activity. This was approved by the Strategy Steering Group in October 2022 and shared with the Health Board Executives and the Senior Leadership Board (SLB).

2.5 The phases for the development of the strategy were:

- Internal pre-engagement (co-production) October 2022 - December 2022.
- Phase 1 Initial Engagement – January 2023 - March 2023.
- Phase 2 Final Engagement – May 2023 - June 2023.
- Phase 3 Launch of Refreshed Strategy – July 2023

2.6 We reviewed a sample of stakeholder's engagement deliverables detailed within the Communications and Engagement Plan to ensure that they were undertaken

in line with the agreed timelines, and all had been carried out in the required timescales.

Conclusion:

2.7 The Communication and Engagement plan highlighted all the key stakeholders required to be engaged with during the programme, the activities to be undertaken, materials to be used and the expected timelines for each set milestone for the refresh of the Health Board's strategy. ***(Substantial Assurance)***

Objective 3: Key stakeholders have been adequately identified and continuously involved in the engagement process of refreshing the Health Board Strategy.

2.8 Staff from across the organisation were required to undertake engagement events, host workshops and promote a range of ways in which people could share their views to ensure the engagement process was successful. The continuous stakeholder engagement process enabled staff, patients and key partners in the co-production, developing and shaping of the Health Board's strategy.

2.9 There was a challenge at the start of the refresh process due to the change from the Community Health Council (CHC) to 'Llais' which resulted in a drop in attendance and participation of the CHC in the consultation process. As a result, public meetings that were to be hosted by the Health Board and CHC were carried out by the Health Board.

2.10 The Health Board holds a database of key stakeholders which was used to inform the process/plan. This was utilised to ensure the Health Board contacted as many stakeholders as possible.

2.11 There were various forms of stakeholder engagement during the key stages of the refresh of the Strategy. Information and feedback sessions were held requesting people to confirm what was important to them so that it could be considered for inclusion within the strategy.

2.12 In order to engage with a wide range of staff, stakeholders and members of the public, the Health Board worked towards ensuring that engagement materials were accessible to all via a number of mediums.

2.13 A number of processes were undertaken to ensure surveys were communicated to key stakeholders such as:

- The Survey was available on the Health Board's dedicated webpage;
- Members of staff were sent emails;
- Emails were sent to other key stakeholders including other Health Boards, Councillors, Llais/CHC and C3SC to complete the online survey; and
- A number of patients who had recently used the Health Board's services were contacted by text message to complete the online survey.

2.14 The Health Board ensured the continuous involvement of key stakeholders by having regular meetings with them to ensure effective communication and engagement. The methods of communication included:

- marketing campaigns at Capital radio and the hospital radio;
- posters located at train stations and local supermarkets;
- communications via the Health Board's website. A dedicated webpage was launched and promoted;
- internal communications via staff emails and SharePoint; and
- staff informed via computer screensavers and ESR.

2.15 External resource to support the engagement process was sourced from:

- Cardiff Third Sector Council (C3SC) and Glamorgan Voluntary Services who commissioned work with third sector organisations to ensure they reached a wide range of audiences.
- Hello Starling, a marketing agency, which helped deliver posters to the train station and Capital radio station.

2.16 The Steering Group reviewed progress on the 15th March 2023 and concluded that the coverage and feedback received was robust and that a further extension to the phase of engagement was not required.

Conclusion:

2.17 The Health Board engaged with a wide range of stakeholders, utilising a co-production approach so that stakeholders were involved in shaping the strategy. In order to ensure the continuous and adequate engagement of both internal and external stakeholders, engagement events and activities took place, promoting a range of ways in which people were able to share their views. ***(Substantial Assurance)***

Objective 4: Results/ outcomes of public engagements undertaken are assessed and incorporated to inform the refreshed Health Board's Strategy.

2.18 A number of staff and public engagement sessions (face to face and virtual) were held and the Mentimeter feedback tool was used to support these events. This tool enables users to share real time feedback with interactive presentations, by adding questions or polls in meetings and other group activity. Clinical boards and corporate departments undertook staff engagement events, and feedback was collated.

2.19 A report was produced following the first and second phase to present key themes to be included within the final report. For the first and second phase, a feedback survey was launched when the webpage went live and was used to update and

provide information for stakeholders. This was the means by which the majority of the feedback was collected.

2.20 Stakeholders were able to feed in their views via in person events, online events, through the completion of surveys and via social media platforms. The Communications Team provided significant input to support the engagement work.

2.21 Feedback from the website survey was collated through the Engagement Headquarters whilst feedback from the text message survey to patients direct was collated by CIVICA and results were merged by the analysis tool- NVivo.

2.22 The Phase one & Phase two (C3SC) reports were prepared by the C3SC Facilitator. This report was presented as an annex to the general survey power point presentation and shared with the Strategy Refresh Steering Group, Board Development, SLB and Strategic Communications & Engagement Steering Group.

2.23 The Consultation Institute provided positive assurance on the Health Board's processes as they reviewed the approach undertaken in phase one. The Institute intends to also provide a comprehensive report on compliance with best practice after phase two but this was not available at the time of the audit fieldwork.

Conclusion:

2.24 Feedback analysis was collated from the results and outcomes received from the stakeholders for phase one and two. These highlighted key themes and observations indicating how this would be incorporated into the refreshed Health Board strategy. ***(Substantial Assurance)***

Objective 5: There are appropriate governance arrangements, which provide effective oversight of the stakeholder engagement process for the refresh of the Health Board's Strategy.

2.25 A working group was in place which reported into the Strategy Steering Group which subsequently reports into the SLB and the Board.

2.26 The progress against the stakeholder Communication and Engagement plan and the achievement of milestones was monitored during the weekly working group meetings via updating of the plan. Performance against the milestones were reported regularly to the Strategy Steering Group meetings.

2.27 The Strategy Steering group met twice a month and were responsible for developing the detailed communication and engagement plans and materials. The Strategy Steering Group oversaw the general programme to ensure effective engagement and governance in the production of a refreshed strategy for the Health Board.

2.28 There have been regular updates of the refresh of Shaping Our Future Wellbeing 2015 – 2025 through briefings in Board development sessions and regular reporting on progress to the Board.

Conclusion:

2.29 There was a good reporting system in place whereby the Health Board had the relevant governance arrangement channels. Regular updates were provided giving a general oversight on the position of the refresh of the Health Board's strategy. ***(Substantial Assurance)***

Objective 6: Risks relating to stakeholder engagement are appropriately considered and monitored.

2.30 A risk register was presented at the Strategy Steering Group as a standing agenda item for review. One risk register was maintained throughout the programme; however, the risk register did not include relevant fields and updates were not provided. ***(Matter Arising 1 – Medium Priority)***

Conclusion:

2.31 A risk register was kept for the course of the programme; however, it did not contain key fields and updates of the risks. ***(Reasonable Assurance)***

Appendix A: Management Action Plan

Matter Arising 1: Format and updating of the risk register (Operation)			**Impact**
The risk register was a standing agenda at the Strategy Steering Group meeting. It was presented and reviewed at the meeting, however, the latest risk register provided did not evidence any form of update. The risk register did not have mandatory fields such as the ID number, date entered, risk description, risk owners and there was no update on the current position when reviewed.			Potential risk of: • The health board fails to comply with legislation and guidance on public consultation engagement practice.
Recommendations			**Priority**
1.1	Management should ensure a risk register is adequately maintained to include all relevant fields and is updated regularly with the progress and date of progress for future programmes and projects.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	This will be reflected in the planning toolkit that will be developed in response to the UHB's strategic programme governance review.	Dec 2023	Marie Davies

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.
	**Unsatisfactory 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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Urgent and Emergency Care – Welsh Government Six Goals Programme

Final Internal Audit Report

October 2023

Cardiff & Vale University Health Board

Contents

Review reference:	CVU 2223-22
Report status:	Final Report
Fieldwork commencement:	3rd August 2023
Fieldwork completion:	5th October 2023
Debrief meeting:	12th October 2023
Draft report issued:	12th October 2023
Management response received:	19th October 2023
Final report issued:	19th October 2023
Auditors:	Lucy Jugessur, Stuart Bodman
Executive sign-off:	Paul Bostock, Chief Operating Officer
Distribution:	Mike Bond, Managing Director for Acute Service Dr Katja Empson, Clinical Director for Six Goals Programme Alex Bridgman, Programme Lead, Six Goals Programme Cath Doman, Programme Director, Regional Partnership Board @home Programme Lisa Dunsford, Director of Operations, PCIC Clinical Board Louise Platt, Director of Operations, Medicine Clinical Board Rachel Sian Thomas, Director of Operations, Surgery Clinical Board
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 Chartered Institute of Public Finance & Accountancy in April 2023.

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

Executive Summary

Purpose

The overall objective of our audit was to review the development of controls and actions relating to the governance arrangements for the implementation of the Welsh Government 'Six Goals for Urgent and Emergency Care' Programme.

Overview

We have issued substantial assurance on this area.

The Health Board has developed robust governance arrangements around the on-going implementation of the Six Goals Programme, including an overarching Delivery Board and four Workstream Project Groups.

The governance arrangements facilitate effective and regular monitoring and reporting of progress towards delivery of the Programme, and management and mitigation of key Programme risks.

We have identified two low priority recommendations which are detailed within Section 2 and Appendix A of the report.

Report Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Assurance summary[1]

	Objectives	Assurance
1	The Health Board's four Workstreams effectively align with the aims of the Welsh Government's 'Six Goals for Urgent and Emergency Care'	Substantial
2	The Health Board has appropriate governance arrangements in place for the four Workstreams	Substantial
3	Active monitoring and reporting on progress delivery for the stated priorities within each Workstream	Substantial
4	Sharing of progress and learning is being undertaken between the four Workstreams	Substantial
5	Risks in relation to delivery of the four workstreams have been identified and are being monitored	Substantial

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

1. Introduction

1.1 The audit of the Urgent and Emergency Care – Welsh Government Six Goals Programme was undertaken and completed in line with the 2023/24 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board')

1.2 The 'Six Goals for Urgent and Emergency Care' Programme 2021-2026[1] is a Welsh Government Strategy for improving urgent and emergency care to enable people to get the right care, in the right place, first time for physical and mental health. This will be achieved through the delivery of Six Goals for Urgent and Emergency Care which are:

1. Population Planning and Support.
2. Signposting – Right Place, Right Time.
3. Alternatives to Admission.
4. Rapid Response.
5. Optimal Hospital Care and Discharge.
6. Home First.

1.3 The Health Board has created four priority Workstreams which encapsulate the implementation of the Six Goals Programme as the optimal way to deliver the required changes and these are:

- Community Workstream.
- Urgent Primary Care.
- Alternatives to Admission.
- Inpatient Flow, Discharge and Front Door.

1.4 The potential risks considered in this review were as follows:

- Strategic aims for the Welsh Government Six Goals Programme are not being complied with.
- The priorities within the four Workstreams are not being monitored, reviewed and implemented in line with agreed milestones.
- Reputational damage to the Health Board if the stated improvement changes are not made.

1.5 The Executive lead for this audit is the Chief Operating Officer.

[1] Right care, right place, first time: Six Goals for Urgent and Emergency Care - A policy handbook 2021-2026 (gov.wales)

2. Detailed Audit Findings

Objective 1: The Health Board's four workstreams effectively align with the aims of the Welsh Government's 'Six Goals for Urgent and Emergency Care'.

2.1 The stated objectives for the Welsh Government Six Goals are mapped to and are in alignment with the Health Board's overarching approach to their delivery via the four workstreams. This is undertaken through the distillation of all Six Goals into the following three key questions that allow for their relevant application and delivery within the respective four workstreams:

1. How do we keep people at home in the community?
2. People need safe and effective alternatives to admission, what are they and how do we provide them?
3. How do we provide the best care within hospital and get people home ASAP?

2.2 Our review of all four workstreams identified that where relevant and applicable, the Welsh Government Six Goals are mapped into their respective objectives and delivery plans.

Conclusion:

2.3 The delivery objectives of the four Six Goals Programme workstreams are in alignment with the requirements of the Welsh Government's Six Goals for Urgent and Emergency Care. **(Substantial Assurance)**

Objective 2: The Health Board has appropriate governance arrangements in place for the four workstreams.

2.4 All four workstreams are supported by a monthly Project Delivery Group whose objectives, roles, responsibilities, membership, and reporting processes are documented within a current and approved terms of reference. Their activities are also formally supported by monthly agendas, meeting notes and progress action plans.

2.5 Workstream Project Delivery Group meetings held from inauguration in January 2023 through to September 2023 (August to September 2023 for Workstreams 3 and 4 due to their more recent implementation in comparison to Workstreams 1 and 2) were quorate and could evidence regular attendance by members.

2.6 Central overarching oversight of the four workstream Project Delivery Groups is provided by a monthly Six Goals Delivery Board whose objectives, roles, responsibilities, membership, and reporting processes are confirmed in a current and approved terms of reference.

2.7 A review of the Six Goals Delivery Board meetings for the period January to September 2023 confirmed that they were formally supported by agendas, meeting notes and a project workbook which comprised action plans and progress

updates submitted from each of the four workstreams, as well as an overview of the overall delivery of the Health Board Six Goals Programme.

2.8 Our testing identified that all Six Goals Delivery Board monthly meetings for the period from January to September 2023 were quorate, but a review of the corresponding monthly meeting notes identified that two members had not attended any meetings since its commencement in January 2023. **(Matter Arising 1 - Low Priority)**

2.9 Workstream 1 Community @home Programme, also known as the Regional Partnership Board @home programme, is a sole and unique part of the Health Board's Six Goals Programme in that it is directly managed by the Cardiff and Vale Regional Partnership Board (RPB), an external body comprised of NHS, Local Authority, Third Sector, Volunteers and Carers bodies.

2.10 Project group governance documentation for workstream 1 Community @home Programme outlines sound arrangements that fully appraise the Health Board Six Goals Delivery Board of its management, oversight, and decision-making outcomes. This is further strengthened by the membership of the Workstream Project Group consisting of the Health Board's Director of Planning & Strategy as the Chair, and the Primary, Community and Intermediate Care (PCIC) Senior Management Triumvirate.

Conclusion:

2.11 All four Workstreams Project Groups and the overarching Six Goals Delivery Board are supported by appropriate, current, and fully documented governance arrangements. However, attendance by all Six Goals Delivery Board membership is not always apparent. **(Substantial Assurance)**

Objective 3: There is active monitoring on progress delivery for the stated priorities within each workstream and reporting is provided to the Senior Leadership Board, appropriate Committee and Board, with actions taken where necessary to ensure effective delivery.

2.12 Our review of each of the four Workstream Project Groups identified that their respective workplan action plans are subject to monitoring on a monthly basis by the Six Goals Delivery Board, and there is documented scrutiny of progress updates being undertaken within their agendas, meeting notes and project workbooks. Workstream action plans are also supported by progress/delivery timescales.

2.13 Monthly Six Goals Delivery Board agendas, meeting notes and supporting papers formally document monitoring of all workstream progress reports and action plans.

2.14 Additionally, there is no evidence of any material Workstream Project Group progress delays to date that warranted recording and escalation to the Six Goals Delivery Board for further discussion.

2.15 We note that Workstream 1 Community @home Programme Project Group documentation and monitoring reports provided to the Health Board Six Goals

Delivery Board on a monthly basis are identical in content to those provided to the RPB.

2.16 The Chief Operating Officer provides a Six Goals Delivery Board update to the Health Board Management Executive on a weekly basis. In addition, a six monthly update is provided to the Board with the next one occurring in November 2023.

Conclusion:

2.17 All four Workstream Project Groups regularly review, monitor and report progress delivery to the Six Goals Delivery Board. In addition, the Chief Operating Officer provides weekly updates to the Health Board Management Executive. **(Substantial Assurance)**

Objective 4: Sharing of progress and learning is being undertaken between the four workstreams.

2.18 Currently, there is no formalised sharing of progress and learning between the four workstreams which forms an agenda item within their respective Project Group meetings. However, relevant learning themes relating to all workstreams are discussed at Six Goals Delivery Board meetings. **(Matter Arising 2 - Low Priority)**

2.19 We acknowledge that the Six Goals Programme is still in its early stages, and as such any learning outcomes identified so far are not necessarily of substance to be shared and implemented.

2.20 It is of note that there is an inherent sharing of progress between workstreams 1 and 2 due to the interconnectedness of their core delivery objectives.

Conclusion:

2.21 Sharing of learning and progress across Project Workstream Groups is being undertaken but is currently informal. **(Substantial Assurance)**

Objective 5: Risks in relation to delivery of the four workstreams have been identified and are being monitored.

2.22 Workstream risks are identified and appropriately recorded on their respective Project Group risk logs and are subject to monthly monitoring and updating supported by documented mitigation actions. This is also the case in respect of the Six Goals Delivery Board which maintains a central record of risks pertinent to the overall delivery of the Health Board's Six Goals Programme.

2.23 Workstream risks are escalated to inform the Six Goals Delivery Board risk register which also states risks that are common to all workstreams.

Conclusion:

2.24 The Health Board Six Goals Programme is supported by appropriate and documented risk management processes that includes regular monitoring,

reporting and risk mitigation at both Project Workstream and Six Goals Delivery Board levels. **(Substantial Assurance)**

Appendix A: Management Action Plan

Matter Arising 1: Six Goals Delivery Board - Membership Absence. (Operation)	**Impact**
Whilst all Six Goals Delivery Board meetings for the period of January to September 2023 were quorate, a review of the corresponding monthly meeting notes identified that two members of the Delivery Board had not attended any meetings since its commencement in January 2023. Additionally, in July 2023 three of the eleven core members as stated within the terms of reference did not attend without apologies being provided.	Strategic aims for the Welsh Government Six Goals Programme are not being complied with.

	Recommendations	**Priority**
1.1	Any lengthy and ongoing absence of Six Goals Delivery Board core members should be monitored by the secretariat to ascertain the reasons for absence and have other named representatives when they are unable to attend the meetings. The secretariat of the Six Goals Delivery Board should also ensure that all membership absences are supported wherever possible by an apology for absence.	**Low**

	Agreed Management Action	**Target Date**	**Responsible Officer**
1.1	Ongoing absence will be picked up with the members of the board where appropriate or addressed through the workstreams.	30/10/23	Alex Bridgman

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Matter Arising 2: Sharing of progress and learning between the four Workstreams (Operation)			**Impact**
At the time of our audit the sharing of progress and learning between the four workstreams is not a formal agenda item at each project group meeting. We note that given that Six Goals Programme is in its early stages, any learning outcomes so far are not necessarily tangible enough to be shared in full. However, there is anecdotal evidence that crossover themes relating to all workstreams are shared and discussed within the monthly Six Goals Delivery Board meetings via each Workstream Lead. This is especially evident between Workstreams 1 and 2 due to the natural interconnection of their core objectives.			The priorities within the four workstreams are not being monitored, reviewed, and implemented in line with agreed milestones.
Recommendation			**Priority**
2.1	As the objectives of each workstream approach maturity, sharing of learning should be formalised and documented within Workstream and Six Goals Delivery Board meeting notes so as to maximise their respective interrelationships and help to ensure relevant crossover of key delivery aims.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	A quarterly or twice yearly sharing of learning meeting will be created for the workstream leads to cross reference and learn from each other.	23/01/24	Alex Bridgman

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06/11/2023 11:21:06

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.
	**Unsatisfactory 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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PARIS System
Final Internal Audit Report

October 2023

Cardiff & Vale University Health Board

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

Contents

Review reference:	CVU 2324-12
Report status:	Final
Fieldwork commencement:	23 June 2023
Fieldwork completion:	04 September 2023
Draft Report issued:	14 & 28 September 2023
Debrief Meeting:	27 September 2023
Management response received:	02 October 2023
Final report issued:	09 October 2023
Auditors:	Martyn Lewis, IT Audit Manager Ken Hughes, Lead Auditor
Executive sign-off:	David Thomas, Director of Digital & Health Intelligence
Distribution:	Mark Cahalane, Head of Digital Services Management Dan Hegarty, Application Support Manager
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 Chartered Institute of Public Finance & Accountancy in April 2023.

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

Executive Summary

Purpose

The overall objective of the audit was to provide the Health Board with assurance that data held within the system is accurate, secure from unauthorised access and loss, and that the system fits the needs of the service.

Overview

We have issued reasonable assurance on this area. The matters requiring management attention include:

- The Civica Service Report is not fully developed or being received regularly.
- The monthly leavers report from the IT Security team is no longer being received.
- The criteria for locking down dormant accounts is in need of review.
- System back-ups are presently being stored with the servers.

Other recommendations / advisory points are contained within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Governance & change management	Reasonable
2	Database controls	Substantial
3	Application controls	Reasonable
4	Data input	Substantial
5	Outputs, alerts, reports & interfaces	Reasonable
6	Audit log	Substantial
7	BCP and disaster recovery	Limited

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Civica Service Report	1	Operation	Medium
2	Dormant Accounts	3	Operation	Medium
3	Leavers Report	3	Operation	Medium
6	System Back-ups	7	Operation	High

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1. Introduction

1.1 Our review of the PARIS IT system was completed in line with the 2023/24 Internal Audit Plan for Cardiff and Value UHB (the 'Health Board'). The opinion provided through this review is a key component, which will inform the Head of Internal Audit's Annual Opinion.

1.2 PARIS is an electronic patient record system that is used for non-acute care within the health board. The system has over 4,800 active users across 5 clinical boards and enables access to up to the minute patient care records.

1.3 The system has recently moved to version 7.1 with improved functionality and a refreshed look and has also deployed a digital booking service.

1.4 The risks considered during this review were as follows:

- Inappropriate access to the system / data;
- Inaccurate data held in the system;
- Inaccurate data reported from the system; and
- Loss of processing / data.

1.5 The relevant lead director for the review is the Director of Digital and Health Intelligence.

2. Detailed Audit Findings

Objective 1: An appropriate governance process is in place for the system and any changes.

2.1 There is a contract in place for the provision of services including data storage and system maintenance. The contract with Civica is dated September 2004, but a number of Change Control Notices (CCN's) have been issued since then to reflect changes to the service agreement.

2.2 The availability of data is covered in the Services Agreement contract, and monitoring performance is the responsibility of Civica. This requires the service to be available for at least 99.5% of the time each month. Where service availability falls below 99.5% in any given month, a deduction can be made from the monthly fee on a sliding scale based on the availability percentage.

2.3 Where availability falls below 95% no monthly fee is payable. The availability of the system, excluding planned maintenance work, is recorded in the Cardiff Paris Service Report provided by Civica. This shows that the system was available 100% of the time for the six-month period Jan to June 2023. We note that the Service Report provides a range of useful monitoring information but was not complete and in need of further development. The Service Report provided was issue 1 and appears to have been produced in response to our audit. We note that no issues have been raised regarding availability or response of the system, however

ensuring a monitoring process is in place will identify these issues should they occur in the future **(Matter Arising 1 - Med Priority)**.

2.4 There are a number of internal service specific Paris User Groups (PUGs) and Digital User Groups (DUGs) in place which are managed by the relevant service coordinator, and these groups drive changes and improvements to the system.

2.5 There are two types of changes that can be made to the system. Core changes are those that need to be carried out by Civica and can incur a cost. Non-core changes can be made by the in-house IT development team. We were informed that the majority of changes are non-core changes.

2.6 There is a documented Change Control Process in place. Any requests for changes are initially submitted via e-mail to the Programme Manager within Digital Services Management who will assess the request to ensure it is feasible. If the request is deemed suitable, a request is then raised through the Avanti on-line portal, and the change is actioned through the documented Change Control Process.

2.7 We were informed that external user groups had been in place prior to Covid, but these had stopped and have not re-started. However, there are established processes in place to raise queries or issues and also provide feedback to Civica.

Conclusion:

2.8 There is an up-to-date contract in place covering the services provided by Civica and maintenance of the system. Performance indicators are included in the contract, and these are monitored by Civica and reported through the Service Report, although this was not being done prior to our audit. There is a defined change control procedure with suggested changes and system improvements being generated through the various staff user groups. We have provided reasonable assurance for this objective.

Objective 2: Appropriate control is maintained over the database.

2.9 The database currently in use is Oracle 12, but work is ongoing by the system providers Civica to upgrade the system to Oracle 19, with the non-live system being tested at the time of our audit. We note that support for Oracle 12 ended in 2022.

2.10 New users requiring access to the system must submit a request through the Avanti self-service portal by completing a standard user access form. This details the area and level of access required, and must be approved by their line manager.

2.11 The new user must then complete the required training, and access is not granted until the line manager has confirmed that the training has been completed.

2.12 All database maintenance is undertaken by Civica. There are automated daily checks run against all Oracle databases with the results being analysed by the Database Administrator (DBA) team, such that any anomalies or problems can be quickly acted upon. The database, datafiles, backups and indexes are all included in this.

Conclusion:

2.13 The database is currently being upgraded to the latest version. Access is appropriately controlled with patching and checking the integrity of the database being undertaken by the system providers. We have provided substantial assurance for this objective.

Objective 3: Proper control is exercised over access to application systems.

2.14 All requests for access to the system must be submitted via the Avanti Self Service Portal using a standard template form. This collects all necessary information including the new user's Nadex user-name, job title, where they work, who their line manager is and the level of access required.

2.15 The new user then has to complete induction and user training specific to their role. This is carried out locally by their team management and must be confirmed via e-mail by their line manager as having been satisfactorily completed before access is granted. Access is restricted to the teams / areas requested, and functionality is restricted by permission levels.

2.16 A sample of current users was selected from the list of users provided, and testing was carried out to check that in each case there was evidence of their request for access, that this had been fully completed and that the necessary training had been completed prior to access being granted. Testing was also carried out on a sample of users that had not recently logged on to the system to ensure they were still employed by the Health Board.

2.17 Review of the list of current users confirmed that generic user accounts are not generally set up, other than a couple of exceptions, i.e. Civica Support account which had system administrator access, and a 'Crystal Reports Scheduler' account with system administrator access, but this account was locked.

2.18 Our review of the list of current live users identified 308 users with a status of Open and full details present, but no date of last login. Our understanding is that these accounts should be closed due to lack of activity. We were informed by the Application Support Manager that these are a mixture of accounts that have been created but never logged into and accounts that exist for caseloads to be allocated to named staff members **(Matter Arising 2 - Med Priority).**

2.1 We were informed that leavers are notified to IT via a monthly email from IT Security with a Leavers Report attached generated from the ESR system. Notifications can also be received directly from team managers when staff leave or change jobs. However, upon further investigation, it was identified that the most recent Leavers Report provided was in January 2021, and this had lapsed due to retirement **(Matter Arising 3 - Med Priority)**.

2.2 Once notified of a leaver, the PARIS account is manually closed. Accounts are also automatically locked after 90 days of inactivity, and after 450 days of inactivity user accounts are automatically closed. Accounts are also automatically locked down after five failed log-in attempts.

2.3 Once access has been granted the system is accessed through a desktop PARIS icon. The user must enter their user-name which is their Nadex log in and a password. Passwords must be a minimum of 6 characters in length, cannot be one of the previous 5 passwords used, must be changed every 60 days (forced change). Passwords do not have to be complex, but simple passwords are blocked, for example the word password, days of the week, months etc. Passwords are also masked on entry.

Conclusion:

2.4 Access to the system for new users is well controlled and all users must complete training before they can access the system. User access is password controlled and restricted to the individual user's team and by functionality. However, access is not presently being removed promptly from leavers. We have provided reasonable assurance for this objective.

Objective 4: Input is authorised, complete, accurate, timely and input only once.

2.5 The system has in-built controls to help ensure data quality. These include ranges and limits on numerical data, format checks, duplicate detection, mandated fields and the selection of pre-populated data from drop down menus.

2.6 Regular data quality reports are run by the PARIS team to identify data quality issues such as duplicate records, clients with no GP, missing postcodes, missing NHS numbers etc. These are then used to improve the data by producing data quality statistics and obtaining missing information or investigating and deleting duplicates as appropriate.

2.7 To help maintain data quality and help ensure users understand how to use the system properly, all new users must undertake localised training within their team, and their line manager must confirm that the training has been completed before the PARIS team will grant access to the system.

2.8 Classroom training is also available on request. This is provided by the PARIS team and can be booked on-line through Sharepoint. There are also a range of e-learning modules that can be accessed on Sharepoint. All training provided, either classroom or through the completion of e-learning modules is recorded on the users individual training record.

Conclusion:

2.9 Access to the system is not granted unless users have undertaken training and are deemed to be competent in using the system. Additional training is also available on-line and on request from the PARIS team. The system has a number of in-built controls that help ensure data quality, and data quality is monitored and where possible corrected by the PARIS team. We have provided substantial assurance for this objective.

Objective 5: Controls ensure the accuracy, completeness, confidentiality and timeliness of output, alerts, reports and interfaces.

2.10 A wide range of standard reports are available to be run on the system. These include statutory reports for reporting to Welsh Government, for example waiting list figures, the number of referrals received and referral sources, and management reports such as caseload reports. Access to run reports is controlled via the individual's user profile. Report parameters vary depending on the type of report being run, and these can be set by the user. Where user parameters have been set, the report produced clearly states these, together with the date of the report.

2.11 Testing was undertaken on a sample of reports, and this confirmed that report parameters can be set by the user. Reports reviewed included the date they were run and where appropriate totals are identified, for example the number of patient records included in the report.

2.12 Once reports have been run, the system allows the data to be printed or converted to a PDF file. This can then be forwarded on by email or transferred to physical media such as a memory stick. Whilst this significantly increases the risk of data loss, it is a Health Board wide issue rather than a PARIS issue. Default printers are set up for reports, although this can be changed by the user prior to printing.

2.13 We were informed that one-way interfaces are in place that import data from the Patient Management System (PMS) into PARIS. For CRT referrals, the Application Support Manager receives an alert report that checks that referrals have come through, and incoming Diagnostic & Therapies referrals are monitored by the integrations team via Kafka monitoring. However, for recent admissions and discharges, there are presently no controls to identify interfaces that fail **(Matter Arising 4 - Low Priority).**

Conclusion:

2.14 Overall, we have found that there are controls in place to ensure the accuracy, completeness and confidentiality of outputs from the system. However, controls over the importing of data from the PMS could be improved. We have provided reasonable assurance for this objective.

Objective 6: An audit log is maintained which enables data points to be tracked to source.

2.15 The system is used primarily for recording patient case notes and automatically records the user details for all entries made. This enables various reports to be run. For example, a report can be produced showing all the patient records that a particular user or group of users have accessed within a specified time period, and the screens that they accessed.

2.1 Security incidents are monitored by Civica and details of any incidents are now included in the Service Review Report. As per the June 2023 Service Review Report, there were no security incidents recorded for the period 1st to 30th June 2023.

2.2 The Care Computer Emergency Response Team (CareCert) is a national service from NHS Digital that helps health and care organisations to improve their cyber security defences by sending out information about cyber threats in the form of CareCerts. There were 9 CareCerts issued in June 2023 which were reviewed by Civica and resulted in no action required.

Conclusion:

2.3 Logging is enabled on the system to ensure key entries and changes can be tracked to users, and to identify security errors to facilitate incident handling. We have provided substantial assurance for this objective.

Objective 7: Appropriate business continuity arrangements are in place which include backing up copies of data programs, storing and retaining them securely and recovering them in the event of failure.

2.4 Although the database servers are stored in the main server room at UHW, they are maintained by Civica and Health Board staff do not have ready access to the servers. We were informed that the database servers are physical and are not clustered. Civica have REP as a daily copy of Live which is effectively a second copy of the live database. The app servers are in a resilient cluster and they are virtual so can be quickly recovered.

2.5 There is a PARIS Business Continuity Plan (BCP) in place should the system become unexpectedly unavailable. The plan is accessed from the PARIS Sharepoint page and users are able to access their services core supported PARIS documents such as assessments, case notes and demographic templates. Once an outage has been resolved services are responsible for ensuring that all manually recorded information is added to the relevant PARIS records.

2.6 The PARIS BCP was reviewed and found to provide users with guidance on the actions that would be taken by the PARIS Team in the event of an unplanned outage, and the actions that users would need to take.

2.7 Disaster Recovery (DR) is the responsibility of Civica who informed us that there is hardware cover in place for the platform 24/7, although we were unable to verify this. In addition, we were unable to determine the Recovery Time Objective (RTO) and Recovery Point Objective (RPO) for the system **(Matter Arising 5 - Low Priority).**

2.8 System back-ups are also the responsibility of Civica. We were informed that Civica have back-ups in two locations within the CAV network, and this provides a high level of resilience. Back-ups are not presently tested. However, at the same time as the back-ups are created a clone called PARISREP is generated, and this refreshes every 24 hours. This is used on a daily basis for reporting extracts and also for testing with 'real world esk' data, and this ensures the validity of the data in the back-ups.

2.9 However, we note that both back-ups are stored within the server room within UHW. We were informed that this is currently a managed risk that is monitored by

the Mental Health & Community Systems (MHCS) Board. However this is not in line with best practice and exposes the HB to the risk of data loss **(Matter Arising 6 - High Priority).**

Conclusion:

2.10 The system architecture has in-built resilience to ensure 24/7 availability and there are documented business continuity arrangements in place to cover short periods of unplanned down time. There is hardware cover in place for the platform which is the responsibility of Civica, and the system is regularly backed up. However, backups are currently being stored on-site with the system servers. We have provided limited assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Civica Service Report (Operation)			**Impact**
The contract with Civica includes a range of performance measures and Key Performance Indicator's, with Civica responsible for performance monitoring. We were provided with a June 2023 Service Report dated the 06/07/23, which covered the period January 2023 to June 2023. This included data on service availability, the type and number of incidents raised, security incidents, change management, the number of system users and the database size. However, we note that there is no data in respect of Transaction Response Times or Service Resolution Times. We also note that the report was issue number 1 and is likely to be the first service monitoring report received.			Performance indicators set out in the contract are not effectively monitored and under performance by the system provider is not readily identified and addressed.
Recommendations			**Priority**
1.1	Management should work with Civica to further develop the Service Report to include data in respect of Transaction Response Times and Service Resolution Times which can be used to monitor performance. Civica should be requested to provide the Service Report on a monthly basis.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Will work with Civica pending publication of this report to include transaction response times and service resolution times into the service report and also ensure that the service report is received monthly.	31/10/2023	Application Support Manager

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Matter Arising 2: Closure / Lock Down of Accounts (Operation)	**Impact**
Review of the list of current live users identified 308 users with a status of Open and full details present, but no date of last login. Our understanding is that these accounts should be closed due to lack of activity. We were informed by the Application Support Manager that these are a mixture of accounts that have been created but never logged into, and accounts that exist for caseloads to be allocated to named staff members, although the number of accounts does appear to be high.	Live accounts are used to gain unauthorised access to the system.

Recommendations		**Priority**
2.1	The accounts identified should be investigated and the script that auto locks / closes accounts reviewed and if necessary the criteria for locking / closing accounts should be adjusted appropriately.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	We will look into the script that automatically closes accounts and review as to why some of these accounts are not included as they appear to meet the criteria for closure. Please do however note that there are occasions where an account like this exists for genuine reasons e.g. temporary caseload transfer for when a staff member leaves the organisation etc. In most of the occasions these are essentially dummy accounts which do not have an oracle account. We will also introduce a documented process to capture these exclusions.	31/10/2023	Application Support Manager

Matter Arising 3: Leavers Report (Operation)			**Impact**
We were informed that leavers are notified to IT via a monthly email from IT Security with a Leavers Report attached generated from the ESR system. Notifications can also be received directly from team managers when staff leave or change jobs. The PARIS account is then manually closed. Accounts are also automatically locked after 90 days of inactivity, and after 450 days of inactivity user accounts are automatically closed. However, upon further investigation, it was identified that the most recent Leavers Report provided was in January 2021, and this had lapsed due to retirement.			User access is not promptly removed from leavers leading to inappropriate access to the system.
Recommendations			**Priority**
3.1	The monthly Leavers Report provided by the IT Security team should be re-instated as soon as possible. Alternatively management should liaise with Workforce colleagues to obtain a weekly leavers report. Receipt of the Leavers Report each week should be monitored.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	The monthly leavers report is not an accurate source of information due to there being no link with NADEX accounts. For example, Joe Bloggs has left the organisation but there are 4 Joe Bloggs on the PARIS system, it could be impossible to determine which one. However, we do agree with the recommendations but note that they affect most digital systems in the UHB, I will work with departmental colleagues to resolve the issue department wide.	31/10/2023	Application Support Manager

Matter Arising 4: PMS interface (Operation)			**Impact**
We were informed that one-way interfaces are in place that import data from the Patient Management System (PMS) into PARIS. For CRT referrals, the Application Support Manager receives an alert report that checks that referrals have come through, and incoming D & T referrals are monitored by the integrations team via Kafka monitoring. However, for recent admissions and discharges, there are presently no controls to identify interfaces that fail.			The HB is unaware of failed interfaces which adversely impacts the integrity and quality of data held.
Recommendations			**Priority**
4.1	Controls should be developed to ensure that any failed interfaces from the PMS into PARIS in respect of admissions and discharges are identified.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Will work with development colleagues with the PMS and PARIS teams to ensure that a mechanism to alert of any issues with this interface is put into place.	31/12/2023	Application Support Manager

Matter Arising 5: Recovery Time / Point Objectives (Design)			**Impact**
When a system suffers a catastrophic failure, the Recovery Time Objective (RCO) is the target the organisation sets for the maximum time it should take to restore normal operations. Similarly, the Recovery Point Objective (RPO) is the goal for the maximum amount of data the organisation can tolerate losing. This is measured in time, from the moment the failure occurs to the last data back-up. Both the RTO and RPO should be part of the organisations Disaster Recovery Plan. Although Disaster Recovery is the responsibility of Civica, we could not find reference to the RTO or RPO in any of the documentation reviewed.			Loss of system that adversely impacts the care that the Health Board are able to provide.
Recommendations			**Priority**
5.1	The Health Board should determine the RTO and RPO for the system and ensure that this is appropriate for the service.		**LOW**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	We are currently within the contract renewal phase and will use this recommendation to ensure that the RTO and RPO are reflected within. We will also liaise with PARIS services and the head of digital operations to determine these targets.	31/03/2024	Application Support Manager

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Matter Arising 6: System Back-ups (Operation)			**Impact**
System back-ups are the responsibility of Civica. We were informed that Civica have back-ups in two locations within the CAV network, and this provides a high level of resilience. However, both back-ups are presently being stored on-site with the system servers. We were informed that this risk is presently being monitored by the Mental Health & Community Systems (MHCS) Board. However, this is not in line with best practice and exposes the HB to the risk of data loss.			Loss of data that adversely impacts the care that the Health Board are able to provide.
Recommendations			**Priority**
6.1	Management should liaise with Civica with a view to moving system back-ups off-site.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	We strongly agree with this recommendation, in fact it was identified during a recent hardware refresh but no suitable offsite location was found due to numerous reasons (CRI lacking capacity and Woodlands House lacking redundant power). We will use this recommendation as a springboard to address the matter urgently however, the target date will be within 6 months due to factors such as complexity, availability and financial constraints. We will work with the head of digital operations and Civica to identify a suitable offsite backup location and relocate. We will also look to identify if there are any immediate actions that we can take to mitigate the risk in the meantime.	01/04/2024	Application Support Manager

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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.
	**Unsatisfactory 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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06/11/2023 11:21:06

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Follow-up: Chemocare IT System
Final Internal Audit Report

October 2023

Cardiff & Vale University Health Board

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

Contents

Review reference:	CVUHB-2324-36
Report status:	Final
Fieldwork commencement:	4th July 2023
Fieldwork completion:	26th September 2023
Draft report issued:	27th September 2023
Debrief meeting:	
Management response received:	23rd October 2023
Final report issued:	24th October 2023
Auditors:	Martyn Lewis, IT Audit Manager
Executive sign-off:	David Thomas, Director of Digital & Health Intelligence
Distribution:	David Trigg, Lead for Implementation of ChemoCare (Adult)
Committee:	Audit and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

Disclaimer notice - please note

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Cardiff & Vale University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system

Executive Summary

Purpose

To provide the Health Board with assurance regarding the implementation of the agreed management actions from the Chemocare IT system (2122-21) review that was reported as part of our 2021/22 work programme.

Overview of findings

Good progress has been made in addressing the recommendations contained within the original report.

The system has been upgraded to version 6, and as part of this the database and servers have been upgraded to a newer, more secure version.

There are enhanced controls in place for user access and training is fully recorded.

We note that two items are still in progress. The first relates to the development of a Business Continuity plan, which by necessity required the upgrade to be completed and changes to operating procedures made first. The second relates to implementing an automated alert process in the event of interface failures.

The two on-going recommendations will be monitored via the Health Board's Internal Audit Recommendation Tracker until fully complete.

Follow-up Report Classification

		Trend
Reasonable 	**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.	⇧

Progress Summary

	Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Performance Monitoring	Medium	⇧	Closed
2	Database Security	High	⇧	Closed
3	User Training Logs	Low	⇧	Closed
4	User Management	Medium	⇧	Closed
5	Password Controls	Medium	⇧	Closed
6	Interface Failure Alerts	Medium	⇔	Medium
7	Hosting and Backup Agreements	Medium	⇧	Closed
8	Business Continuity Plan	Medium	⇔	Medium

1. Introduction

1.1 The follow-up review of the Chemocare IT system has been completed in line with the 2023/24 Internal Audit Plan for Cardiff and Vale UHB (the 'health board').

1.2 The audit was a follow-up review of the original report that was issued in May 2022. This identified eight issues and resulted in an overall assurance rating of 'Limited Assurance'.

1.3 The relevant lead director for the review is the Director of Digital and Health Intelligence.

1.4 The risks considered as part of the original audit work were:

- inappropriate access to system / data;
- inaccurate data held in system;
- inaccurate data reported from system;
- loss of processing / data; and
- the Health Board may not maximise the benefits from the system.

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

1.6 The areas that the review seeks 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.

2. Findings

2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	1	1		
Medium	6	4	2	
Low	1	1		
Total	**8**	**6**	**2**	**-**

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

Appendix A: Management Action Plan

Previous Matter Arising 6: Interface Failure Alerts		
Original Recommendation		Original Priority
System owners should coordinate with both IT department and CIS to configure an auto alert system or an exception report to timely identify interface failures.		**Medium**
Management Response	Target Date	Responsible Officer
Will look at this as part of the V6 upgrade and ensure an auto alert system is in place.	July 2022	Eleri Connick (paeds system) David Trigg (Adult Haematology)
Current findings		**Residual Risk**
This wasn't discussed as part of the upgrade process and there has been no move towards automated alerts. The issue has been raised at the project board for discussion, but as yet no action is underway. **Conclusion:** In Progress		Frequent interface failures might not be identified leading to service disruptions and manual work for the staff.
New Recommendations		**Priority**
1.1 System owners should coordinate with both IT department and CIS to configure an auto alert system or an exception report to timely identify interface failures.		**Medium**
Management Response	**Target Date**	**Responsible Officer**
1.1 Discussions are still ongoing, as there is a lack of clarity over where alerts should come from with the position being monitored via regular discussions with suppler and IT.	January 2024	David Trigg (Adult Haematology)

Previous Matter Arising 8: Business Continuity Plan		
Original Recommendation		Original Priority
The identified gaps should be taken into consideration at the time of the next BCP update once the version 6 goes live.		**Medium**
Management Response	Target Date	Responsible Officer
BCP will be reviewed as recommended.	August 2022	Eleri Connick (paeds system) David Trigg (Adult Haematology)
Current findings		**Residual Risk**
The upgrade to version 6 has recently been completed. as a first priority following this the operating procedures have been reviewed and updated. The BCP is currently being reviewed and updated. **Conclusion:** In Progress		Noncomprehensive BCP can limit the ability to continue the business in case of system unavailability due to any adverse event.
New Recommendation(s)		**Priority**
2.1 Finalise the review of the BCP.		**Medium**
Management Response	**Target Date**	**Responsible Officer**
2.1 Agreed. The BCP will be completed.	January 2024	David Trigg (Adult Haematology) Eleri Connick (Paeds system)

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. **Follow up:** All recommendations implemented and operating as expected
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

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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Surgery CB - Consultant Job Plans
Final Internal Audit Report

October 2023

Cardiff & Vale University Health Board

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Partneriaeth Cydwasanaethau
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Review reference:	CVU 2223-32
Report status:	Final Report
Fieldwork commencement:	20 April 2023
Fieldwork completion:	20 June 2023
Debrief meeting:	18 July 2023 & 02 August 2023
Draft report issued:	10 August 2023
Management response received:	16 October 2023
Final report issued:	17 October 2023
Auditors:	Ken Hughes, Audit Manager
Executive sign-off:	Paul Bostock, Chief Operating Officer
Distribution:	Matt Temby, Managing Director for Planned Care Rachel Thomas, Director of Operations Alun John, Orthopaedics Clinical Director Michael Stechman, General Surgery Clinical Director Emma Wilkins, General Surgery Directorate Manager Antonio Riccioli, Orthopaedics General Manager (Interim)
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 Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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Executive Summary

Purpose

The purpose of our audit is to provide assurance to the Board that there are effective arrangements in place to manage the risks associated with consultant job planning within selected areas of the Surgery Clinical Board.

Overview

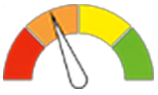
We have issued limited assurance on this area. The significant matters which require management attention include:

- Not all job plans were on the Allocate e-job planning system.
- All job plans were out of date or not agreed and fully signed off.
- No evidence to confirm additional approval of job plans with over 12 sessions per week.
- Personal outcomes were not being recorded.
- The monitoring of the delivery of agreed sessions is not being done, or not being evidenced.
- Annual reviews are not being undertaken when due.

Further matters arising concerning the areas for refinement and further development have also been noted in Appendix A.

Report Opinion

Limited



More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	All consultants have up to date, agreed job plans in place	Limited
2	Job plans include personal outcomes that are linked to the HB's objectives	Limited
3	There is effective monitoring to ensure planned sessions are being delivered	Reasonable
4	Job Plans are reviewed annually or more frequently if circumstances change	Limited
5	Team job plans are used where appropriate	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Job plans not on Allocate for all consultants	1	Operation	Medium
2	Job Plans out of date or not signed off	1	Operation	High
3	Approval of Additional Sessions	1	Operation	Medium
4	Recording of Personal outcomes	2	Operation	High
5	Monitoring of delivery of agreed sessions	3	Operation	Medium
6	Annual Reviews	4	Operation	High

1. Introduction

1.1 A job plan can be described as a prospective, professional agreement that sets out the duties, responsibilities, accountabilities and expected outcomes of the consultant and the support and resources provided by the employer for the coming year.

1.2 Job planning is mandatory and provides an opportunity to align the objectives of the NHS, the organisation and clinical teams with individually agreed outcomes in order to allow consultants, clinical academics, managers and the wider NHS team to plan and deliver innovative, safe, responsive, efficient and high-quality care.

1.3 The Allocate e-job planning system has recently been implemented across the Health Board to help facilitate the job planning process. Our review focussed on the process for setting and agreeing job plans, and for monitoring delivery of the plans within two areas, Orthopaedics and General Surgery.

1.4 The Chief Operating Officer is the Lead Executive for this review.

1.5 The potential risks considered as part of the review were:

- Consultants do not have job plans, or job plans may not be developed by mutual consent and do not reflect actual working patterns; and
- Sessions worked may not be sufficient to allow for adequate provision of the service.

2. Detailed Audit Findings

Objective 1: All consultants have up to date, accurate and agreed job plans in place that reflect the Clinical Board and Health Board's activity requirements.

2.1 All Consultant Job Plans should now be recorded on the Allocate e-Job Plan system. This is a web-based system that can be accessed by consultants on any suitable device such as a desktop pc, laptop or tablet. It was however identified during testing that not all job plans were on the Allocate system **(Matter Arising 1 - Medium Priority).**

2.2 Progress reports were run from the Allocate system on the 24th of May 2023 showing the current status of all Orthopaedic and General Surgery job plans currently on the system. Only 15 of the 55 job plans reviewed had been agreed and fully signed off (11 Orthopaedics and 4 General Surgery). However, all were over 12 months old and are now out of date. The remaining 40 job plans were either in discussion or awaiting sign off, but all were more than 12 months old.

2.3 The long delays in agreeing and signing off job plans has resulted in some job plans becoming out of date before they are signed off. Therefore, at the time of our audit none of the 55 Consultants in Orthopaedics or General Surgery had up to date, agreed and fully signed off job plans in place. **(Matter Arising 2 - High Priority).**

2.4 The Allocate system allows consultants to record Service (Clinical Board) outcomes and Health Board outcomes as part of the job planning process. This should be carried out to ensure that job plans reflect the requirements of both the Clinical Board and the Health Board.

2.5 All 55 job plans on the system had recorded Health Board outcomes. These were 'generic' outcomes which have been added to the job plan template and were the same for all job plans. However, none of the Job Plans had recorded any Service (Clinical Board) outcomes **(Matter Arising 2 - High Priority).**

2.6 It is the expectation of the Health Board that Consultants will not be job planned above 12 sessions per week without the prior approval of the Assistant Medical Director (AMD) for Workforce and Revalidation or the Executive Medical Director. However, although 28 of the 55 job plans reviewed had more than 12 sessions, the additional approval was not recorded on the Allocate system. **(Matter Arising 3 - Medium Priority).**

2.7 Our review also identified some data quality issues with the General Surgery Job Plans **(Matter Arising 7 - Low Priority).**

Conclusion:

We were advised that all Consultants had job plans on the Allocate system, but none of the job plans on the system were up to date, agreed and fully signed off. In addition, although all job plans included Health Board outcomes, Clinical Board (Service) outcomes had not been recorded on any of the job plans. We have provided limited assurance for this objective.

Objective 2: Job plans include personal outcomes that are linked to the Health Board's organisational objectives, and the level of achievement is subject to appropriate assessment.

2.8 The Consultant Job Planning procedure states that personal outcomes can be the same as those agreed as part of the Consultant's annual appraisal. These should then be linked to Service (Clinical Board) outcomes in accordance with job planning guidance.

2.9 However, personal outcomes had only been recorded on 3/55 job plans reviewed. For the three Consultants that had recorded personal outcomes, none had been linked to service outcomes.

2.10 Given that only three job plans included personal outcomes, and no service objectives were recorded for any of the job plans, it is clear that there is no monitoring taking place in respect of the level of achievement of personal, service or health board outcomes **(Matter Arising 4 - High Priority).**

Conclusion:

Only three of the 58 job plans reviewed contained personal outcomes, none of which had been linked to service outcomes as required. Although all job plans had Health Board outcomes, none of the job plans contained service outcomes. There was no evidence

that the achievement of outcomes is being monitored at any level (personal, service or Health Board). We have provided limited assurance for this objective.

Objective 3: An effective process is in place for periodic monitoring of performance against agreed job plans to ensure planned sessions are being delivered.

2.11 The working week for a full-time Consultant consists of 10 timetabled sessions with an average value of 3.75 hours each. There is scope within the National Consultant Contract in Wales 2003 for variation up and down in the length of individual sessions, but the 10 sessions should total 37.5 hours per week.

2.12 Each session can consist of Direct Clinical Care (DCC), Supporting Professional Activity (SPA) or other activities such as additional NHS responsibilities or external duties. Once job plans have been agreed, Directorates should have a system in place to monitor the delivery of all sessions agreed in each job plan.

2.13 We were informed by the General Surgery Directorate Manager that a process had been developed for monitoring performance against agreed job plans. This consists of a spreadsheet template which is populated using data taken from various time allocation systems such as the Patient Management System (PMS) and Pasplus. However, monitoring is not presently being undertaken. **(Matter Arising 5 - Medium Priority).**

2.14 We were informed by the Orthopedic Surgery General Manager that spreadsheet templates were in use to track Consultant activity. The templates used reflect the clinical activity with patients (DCC sessions) within job plans, and these are matched to various time allocation systems. For example, theatre activity is recorded in the BlueSpier system, and the outpatient room allocation tool and PMS is used to record time booked to clinics. However, we were unable to obtain evidence that monitoring is being undertaken for all Consultants on a regular basis **(Matter Arising 5 - Medium Priority).**

Conclusion:

Although the basis of an effective process for monitoring the delivery of planned sessions by consultants has been developed for both the Orthopedic and General Surgery Directorates, monitoring is not currently being undertaken within General Surgery, and there was no evidence that monitoring was being undertaken regularly for all Consultants within Orthopedics. We have provided reasonable assurance for this objective.

Objective 4: Job plans are subject to effective review on an annual basis or more regularly where changes in circumstances require.

2.15 As job planning is an annual process, all Consultants should have a job plan that has been agreed or reviewed within the last 12 months. When a job plan is reviewed, a new job plan is created on the system and the agreement and sign-off process commences again.

2.16 Review of the job plans for the two Directorates selected identified that the vast majority of plans were valid from various dates in 2021 or 2022. For the very few job plans that were dated within the last 12 months, none of these had been agreed and signed off.

2.17 We were informed that when a job plan is agreed and fully signed off, the end date is either entered or set to 'on-going'. Only one of the 55 job plans reviewed had an end date, and this has now expired.

2.18 New job plans had been created in May and June 2022 for seven out of 33 Orthopedic Consultants, and these represent annual reviews for these Consultants. However, none had been agreed and signed off, and are all now out of date. There were no Consultants with more than one job plan within General Surgery, so none of the Consultants had been subject to an annual review.

2.19 Testing has identified long delays between job plans being created and being fully signed off. In many cases this has resulted in job plans, including annual reviews, being out of date before they have been agreed and signed off. **(Matter Arising 6 - High Priority).**

Conclusion:

There was evidence that annual reviews had only commenced for seven of the 58 Consultants, none of which have been agreed and signed off. These are all now out of date as the start dates were in May and early June 2022. We have provided limited assurance for this objective.

Objective 5: An effective team-based approach to job planning is utilised to support individual job plans where appropriate and beneficial.

2.20 Discussions with the General Surgery Directorate Manager and Orthopaedics General Manager indicated that although some Consultants work in teams, team job plans are not currently utilised. Review of the job plans on the Allocate system showed that none of the job plans were marked as 'Team' job plans. This can also be seen on the Progress Reports where the Team field was blank in each case. **(Matter Arising 8 - Low Priority)**

2.21 Conclusion:

Discussions with the Directorate Manager and General Manager indicated that team job plans are not currently utilised. We have provided reasonable assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Not all Job Plans were on Allocate (Operation)	**Impact**
Orthopaedics Directorate Job Planning guidance now requires all consultant job plans to be recorded on the Allocate e-Job Planning system. However, during testing it was identified that job plans for two locum consultants and an additional three Consultants from the Orthopaedics directorate were not on the system at the time of our audit. We were informed by the Directorate General Manager that job plans had been completed but had not yet been put on the system.	Consultants do not have job plans, or job plans may not be developed by mutual consent and do not reflect actual working patterns.

Recommendations		**Priority**
1	The Directorate General Manager should ensure that there is a job plan on the Allocate e-Job Planning system for all Consultants.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1	Orthopaedics Missing consultants are currently being added to eAllocate, and their job plans will be signed off by 30/09/2023.	30/09/2023	Antonio Riccioli, Orthopaedics General Manager (Interim)

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Matter Arising 2: Out of Date Job Plans (Operation)	**Impact**
We were informed that the Consultant Job Planning Process was suspended due to the Covid 19 pandemic at the agreement of the Medical Director, but that job planning meetings have since resumed in May 2022. At the time of our audit, there were 55 job plans (33 Orthopaedic Surgery job plans and 22 General Surgery job plans) on the Allocate System. These were reviewed to ascertain whether job plans were up to date, were fully populated and reflected the Clinical Board and Health Board's activity requirements. <u>Orthopaedics</u> 11 of the 33 Orthopaedics job plans had been agreed and fully signed off and all the other job plans were over 12 months and are now out of date. The remaining 22 job plans were either in discussion or awaiting sign off, but all were more than 12 months old. Once the job plans have been agreed, Consultants are required to sign off their job plans electronically on the Allocate system. However, we note that at the time of our audit, 10 off the 33 Consultants had never logged on to the Allocate system. All 33 job plans on the system had recorded Health Board outcomes. These were 'generic' outcomes which have been added to the job plan template and were the same for all job plans. However, none of the job plans had recorded any service (Clinical Board) outcomes. <u>General Surgery</u> Four of the 22 job plans had been agreed and fully signed off and all the other job plans were over 12 months and are now out of date. The remaining 18 job plans were either in discussion or awaiting sign off, but all were more than 12 months old. Once the job plans have been agreed, Consultants are required to sign off their job plans electronically on the Allocate system. However, we note that at the time of our audit, three off the 22 Consultants had never logged on to the Allocate system. All 22 job plans on the system had recorded Health Board outcomes. These were 'generic' outcomes which have been added to the job plan template and were the same for all job plans. However, none of the job plans had recorded any service (Clinical Board) outcomes.	Consultants do not have job plans, or job plans may not be developed by mutual consent and do not reflect actual working patterns.

The long delays in agreeing and signing off job plans has resulted in some job plans becoming out of date before they are signed off. Therefore, at the time of our audit none of the 55 Consultants in Orthopaedics and General Surgery had up to date, agreed and fully signed off job plans in place.		
Recommendations		**Priority**
2a	Orthopaedics and General Surgery Directorate management should review the current process for agreeing and signing off Consultant job plans with a view to streamlining the process. Arrangements should be put in place to ensure that all Consultants within Orthopaedics and General Surgery have up to date, signed off job plans as soon as practicably possible. Given the delays in agreeing and signing off job plans, consideration should be given to the feasibility of recording the end date of job plans as 12 months from the date they were agreed and signed off, rather than 'ongoing'.	**High**
2b	Orthopaedics and General Surgery All job plans should include Clinical Board (service outcomes), the achievement of which should be subject to annual assessment.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
2a	Orthopaedics All job plans will be signed off by the 31/10/2023, including the newly added ones. End dates will be set up so that a reminder of job plan renewal and update will be triggered after 12 months of sign-off date. Because of the recent changes in the service, numerous consultants are still in the process of signing off. Saunders,Nathan 06/11/2023 11:21:06	31/10/2023	Antonio Riccioli, Orthopaedics General Manager (Interim) Alun John, Consultant Orthopaedic Surgeon Sashin Ahuja, Consultant Orthopaedic Surgeon Khitish Mohanty, Consultant Orthopaedic Surgeon

2b	Orthopaedics Outcomes and objectives will be assigned to each job plan, and will be aligned to the clinical board deliverables for the current financial year.	31/10/2023	Antonio Riccioli, Orthopaedics General Manager (Interim) Alun John, Consultant Orthopaedic Surgeon Sashin Ahuja, Consultant Orthopaedic Surgeon Khitish Mohanty, Consultant Orthopaedic Surgeon
2a	General Surgery In General Surgery there is a process in place for job plan sign off, however not all job plans have been straightforward and have been complicated by enforced regionalisation. Start dates on the Allocate system were incorrect, this has been rectified by the project manager for Allocate. All job plan meetings had taken place (8 signed off, 6 consultant need to send through but still haven't this has been chased on numerous occasions, 2 HEIW unsigned because sessions don't match payments, 2 MoD added complications, NK locked system error (escalated to Allocate), 2 with external sessions query over payment and whether the sessions should be in Allocate, MMD additional external sessions).	31/12/23	Rachel Thomas, Director of Operations
2b	General Surgery Clinical Board triumvirate to set objectives.	31/12/23	Rachel Thomas, Director of Operations

Matter Arising 3: Approval of Additional Sessions (Operation)	**Impact**
In line with the Consultant Job Planning Procedure, it is the expectation of the Health Board that Consultants will not be job planned above 12 sessions per week without the prior approval of the AMD for Workforce and Revalidation or the Executive Medical Director. Orthopaedics and Our review of job plans identified that 10 out of 33 had more than 12 sessions but there was no evidence of any additional approval for the extra sessions in the management signoffs. General Surgery Our review of job plans identified that 18 out of the 22 had more than 12 sessions but there was no evidence of any additional approval for the extra sessions in the management signoffs.	Job plans do not ensure consultants contribute towards the achievement of the Health Board's organisational objectives.

Recommendations		**Priority**
3	Orthopaedics and General Surgery All Consultant job plans with more than 12 sessions per week should be approved in line with the Consultant Job planning Procedure. The approval should be evidenced on the Allocate system using the third sign off field.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
3	Orthopaedics Consultants who are working on a 12 sessions job plan were authorised in previous years, and as service changes did not impact their sessional allocation, it has not been changed. However, as per the audit team request, we will action 12.1 a and b and make sure a third sign-off function is enabled.	30/11/2023	Antonio Riccioli, Orthopaedics General Manager (Interim) Alun John, Consultant Orthopaedic Surgeon Sashin Ahuja, Consultant Orthopaedic Surgeon

			Khitish Mohanty, Consultant Orthopaedic Surgeon
3	General Surgery Discussed with the CBD and the AMD for workforce, this was fed back on many occasions to the MD's office. A number of General Surgeons also have extra sessions in their job plans for external duties/responsibilities with Welsh Government, MoD and the University.	31/12/23	Rachel Thomas, Director of Operations

Matter Arising 4: Personal Outcomes (Operation)	**Impact**
The Consultant Job Planning Procedure details that the job plans should include relevant UHB and Service (Clinical Board) objectives and relevant personal objectives. In accordance with Consultant Job Planning Procedure, personal outcomes can be those agreed as part of the annual appraisal process. Orthopaedics The Allocate system enables personal outcomes to be linked directly to service outcomes. However, only two of the 33 job plans reviewed contained personal outcomes, none of which had been linked to service (Clinical Board) outcomes as required in job planning guidance. General Surgery The Allocate system enables personal outcomes to be linked directly to service outcomes. However, only one of the 22 job plans reviewed contained personal outcomes, none of which had been linked to service (Clinical Board) outcomes as required in job planning guidance.	Job plans do not ensure consultants contribute towards the achievement of the Health Board's organisational objectives.

Recommendations		**Priority**
4	Orthopaedics and General Surgery Directorate management should ensure that all Consultant job plans include personal outcomes and service (Clinical Board) outcomes, and that personal outcomes are linked to service outcomes.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
4	Orthopaedics Once clinical board outcomes are assigned to each consultant, the personal outcomes will be specified and attached to them.	30/11/2023	Antonio Riccioli, Orthopaedics General Manager (Interim) Alun John, Consultant Orthopaedic Surgeon

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			Sashin Ahuja, Consultant Orthopaedic Surgeon Khitish Mohanty, Consultant Orthopaedic Surgeon
4	General Surgery Clinical Board Outcomes to be set by Clinical Board Triumvirate. Team job planning will inform the service outcomes along with expectations for delivery following annualization.	01/04/2024	Rachel Thomas, Director of Operations

Matter Arising 5: Monitoring Delivery of Agreed Sessions (Operation)	**Impact**
General Surgery We were informed by the General Surgery Directorate Manager that a process has been developed for monitoring performance against agreed job plans. This consists of a spreadsheet template which is populated using data taken from various time allocation systems such as the Patient Management System (PMS) and Pasplus. However, monitoring is not presently being undertaken. We were informed that this is due to the lack of an Administrator to extract and sense check the data and populate the spreadsheets, and monitoring would commence once an Administrator has been recruited. Orthopaedics We were informed by the Orthopaedic Surgery General Manager that spreadsheet templates were in use to track Consultant activity. We note that these are different to the templates used by General Surgery. The templates used reflect the clinical activity with patients (DCC sessions) within job plans, and these are matched to various time allocation systems. For example, theatre activity is recorded in the BlueSpier system and the outpatient room allocation tool and PMS is used to record time booked to clinics. However, we were unable to obtain evidence that monitoring is being undertaken for all Consultants on a regular basis	Job planned sessions may not be delivered leading to inefficient use of resources and patient harm.

Recommendations		**Priority**
5a	General Surgery The General Surgery Directorate Manager should consider whether the Administrator role could be allocated to existing Directorate staff on a temporary basis, until a permanent Administrator is recruited, to ensure that monitoring of delivery of agreed sessions is undertaken.	**Medium**

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5b	Orthopaedics The Orthopaedic Surgery General Manager should ensure that the monitoring of Consultant activity is undertaken regularly for all Consultants, and a record is maintained to evidence all monitoring undertaken.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
5a	General Surgery Monitoring exercise complete. Includes data from other clinical boards, where activity also takes place.	Complete	Laura Jones, Assistant Service Manager
5b	Orthopaedics I don't necessarily agree with the following: "we were unable to obtain evidence that monitoring is being undertaken for all Consultants on a regular basis". Monitoring is performed every week within the 6-week planning cycle. Consultants, unless on leave, will be booked for all their clinical commitments, and said schedule won't change unless there is sickness or emergency leave. If a consultant's session cannot be delivered as expected, it will be converted in something else that is of good use for the service. It is a "never event" that a consultant does not deliver their DCC despite being scheduled for them. It has happened on rare occasions in the past, and disciplinary procedures were triggered immediately. The recommendation was referring to the fact that an audit trail of the monitoring is not kept retrospectively. We agreed that we will link with General Surgery and will implement their template.	31/10/2023	Antonio Riccioli, Orthopaedics General Manager (Interim)

Matter Arising 6: Annual Reviews (Operation)	**Impact**
Job planning, which resumed in May 2022, is an annual process, and all Consultants should have a job plan that commenced or was reviewed within the last 12 months. Review of the job plans for the two areas selected for testing (Orthopaedics and General Surgery) identified that the vast majority of plans were valid from dates in 2021 or 2022 with most having no end date. We were informed that when a job plan is agreed and fully signed off, the end date is either entered or set to 'on-going'. <u>Orthopaedics and General Surgery</u> Only one (General Surgery) of the 55 job plans reviewed had an end date, and this has now expired. When an existing job plan is reviewed, a new job plan is created and the sign off process re-starts. New job plans had been created in May and June 2022 for seven of the 33 Orthopaedic Consultants, and these represent annual reviews for these Consultants. However, none had been agreed and signed off, and these are all now out of date. <u>General Surgery</u> There were no Consultants with more than one job plan for General Surgery, and therefore none of the Consultants had been subject to an annual review. Our testing identified long delays between job plans being created and being fully signed off. In many cases this has resulted in job plans going out of date before they have been agreed and signed off. The lack of annual reviews could be attributed to the longer-term effects of Covid, and the pressure on clinical services of getting back to 'business as usual'. However, job planning is an important process, and greater efforts should now be made to get Consultant job planning back on track by agreeing new job plans promptly and undertaking and agreeing annual reviews when they are due. Saunders.Nathan 06/11/2023 11:21:06	Consultants do not have job valid plans, or job plans that reflect actual working patterns.

Recommendations		Priority
6	Orthopaedics and General Surgery Whilst it is acknowledged that Covid has had an adverse impact on Consultant job planning, it is an important process, and greater efforts should now be made to get Consultant job planning back on track through the undertaking of annual reviews when they become due.	**High**

Agreed Management Action		Target Date	Responsible Officer
6	Orthopaedics The current service changes have slowed down this process and we are now catching up with updating all of them on eAllocate.	31/10/2023	Antonio Riccioli, Orthopaedics General Manager (Interim)
6	General Surgery Consultants were job planned between May 2022 and September 2022, the new round of job planning is currently taking place. Need to have 1 year of monitoring to be able to inform the job plan discussion. Unable to rectify appropriate start date. There was also a transition in practice for the emergency work as SDEC was opened in July last year which is why job plans weren't signed off straight away as this needed to be agreed by the consultant body and the clinical board.	01/10/2023	Laura Jones, Assistant Service Manager

Matter Arising 7: Data Quality (Operation)			**Impact**
General Surgery Review of the job plans for the General Surgery Directorate identified the following data quality issues: • One job plan had no data, other than the Consultant's name; • Potential duplicate job plans were identified for one Consultant; and • No unique Clinical Board reference number had been recorded for four Consultants.			Inaccurate job planning records maintained on the Allocate system.
Recommendations			**Priority**
7	The General Surgery Directorate Manager should review the data quality issues identified and update the Allocate system as necessary.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
7	General Surgery Rectified, there were historical consultants job plans on Allocate, including a test job plan. Job plans belonging to locums that had only just joined the HB, plus the locum job plans are specifically not fixed so that the service can maximise capacity use and backfilling. These job plans are managed within the Directorate and adhere to a 9:1 split.	Complete	Laura Jones, Assistant Service Manager

Matter Arising 8: Lack of Team job plans (Operation)	**Impact**
Orthopaedics and General Surgery The Consultant Job Planning Procedure details that "Consultant teams are encouraged to work to team annualised Job Plans where appropriate and will be supported to develop robust plans." However, it was confirmed by the General Surgery Directorate Manager and Orthopaedics General Manager that although some Consultants work in teams, team job plans are not currently utilised. Review of the job plans on the Allocate system showed that none of the job plans were marked as 'Team' job plans. This can also be seen on the Progress Reports where the Team field was blank in each case	Inaccurate job planning records maintained on the Allocate system.

Recommendations		**Priority**
8	Consideration should be taken to assess whether Consultant team job plans can be utilised within the two Directorates.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
8	Orthopaedics We will try to implement this function within the Spines Team first, and then extend it to Orthopaedics.	31/12/2023	Antonio Riccioli, Orthopaedics General Manager (Interim) Alun John, Consultant Orthopaedic Surgeon Sashin Ahuja, Consultant Orthopaedic Surgeon Khitish Mohanty, Consultant Orthopaedic Surgeon

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8	<u>General Surgery</u> Going forward within the next round of job planning, team job plans will be considered for managing delivery of capacity along with the annualization process. However this cannot be the only form of job planning as there are individual considerations for each job plan including those who have contracts externally to the HB e.g. Cardiff University, Welsh Government and the MoD.	01/04/2024	CD & Directorate Manager Michael Stechman & Laura Jones

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.
	**Unsatisfactory 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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Leadership and Management Training and Development

Final Internal Audit Report (Advisory)

October 2023

Cardiff & Vale University Health Board

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

Contents

Review reference:	CVU 2324-10
Report status:	Final Report
Fieldwork commencement:	19th May 2023
Fieldwork completion:	13th July 2023
Debrief meeting:	24th July 2023
Draft report issued:	25th July 2023
Draft report reissued:	21st September 2023
Management response received:	2nd October 2023
Final report issued:	3rd October 2023
Auditors:	Lucy Jugessur, Stuart Bodman
Executive sign-off:	Rachel Gidman, Executive Director of People & Culture
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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 Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

Executive Summary

Purpose

An advisory review of the on-going work to develop leadership and management training and development within the Health Board.

Overview

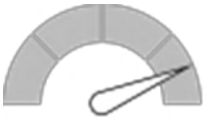
This is an advisory review to support management, rather than an assurance report, we therefore offer no assurance rating.

In contrast to internal audit recommendations, which address the design and operation of the control environment we propose opportunities that the Health Board may wish to take forward. The opportunities outlined in this report (see Appendix A), if taken forward will help to enable the Health Board to further the strategic and managerial oversight and delivery of leadership and management training and development across the Health Board.

Whilst there are strategic intentions in place to support the delivery of leadership and management training and development, these are not fully formalised. Once finalised they should be actualised and delivered through a formal project management-based approach that engages with Clinical Boards and is sufficiently resourced accordingly.

Report Classification

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.

Advisory Audit Objectives

Our review sought to ascertain and evaluate if:

1	The Health Board develops a Leadership Development Framework following engagement with staff and management.
2	Project management processes and plans are in place for the design, instigation and delivery of Leadership Development and Management Programmes, in line with the Leadership and Culture Plan 2022-2025 and principles of compassionate leadership.
3	Suitable resources have been identified to ensure delivery of the Programmes.
4	Engagement and planning is undertaken with Clinical Board senior management to ensure awareness of Leadership and Management Programmes.
5	There are appropriate completion rates of the Programmes and attendees are providing user feedback.
6	The Leadership and Management Programmes are being appropriately evaluated to ensure their aims and objectives are being achieved.
7	Monitoring and Progress Reporting to the People and Culture Committee and Board.

Opportunities:		Audit Objective
1	Leadership Framework outlines the leadership and management training strategic objectives in alignment with Health Board IMTP.	1
2	Future Programmes should be planned and implemented via a project management methodology ensuring engagement across all Clinical Boards.	2
3	Future leadership and management programmes are appropriately funded to attract qualified and experienced staff and expedite effective course delivery.	3
4	Clinical Boards should be engaged with regularly to ascertain what future courses/programmes can be provided based upon their respective staff needs.	4
5	The level of uptake of Programmes across the Clinical Board's Directorates should be identified and used to target areas to maximise awareness and promotion of the leadership and management courses available.	4
6	When Education, Culture & Organisational Development (ECOD) staff capacity allows, student progress updates should be periodically submitted to line management.	5
7	Consideration should be given to introducing measures to improve student feedback returns and reasonably implementing suggestions and any identified 'lessons learned'.	5
8	Implement a teaching checklist that assists in ensuring that each programme set of learning objectives are being met, and periodically evaluate current programme objectives to ensure that they meet student needs.	6
9	Continuation of benchmarking with other Health Bodies to ascertain other approaches and practices and adopt shared learning of best practice where appropriate and applicable.	6
10	Progress reporting to the People and Culture Committee relating to the work being undertaken on the Leadership Framework and the Leadership/ Management training programmes should be provided.	7

1. Introduction

1.1 Our advisory audit of leadership and management training and development was undertaken and completed in line with the 2023/24 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').

1.2 One of the themes within the Health Board's People and Culture Plan 2022-25[1] is "Leadership and Succession" confirming that "we want to have leaders in the health care system who embody inclusive, collective and compassionate leadership." It was highlighted within the Plan that "great leadership development improves leadership behaviours and skills, which results in higher levels of colleague engagement which leads to better patient care, experience and outcomes."

1.3 Currently, the Health Board is administering two leadership and two management development Programmes:

Leadership Programmes

- Acceler8 - Senior Management Leadership Programme
- Collabor8 - Middle Management staff Leadership Programme

Management Programmes

- First Steps to Management Programme
- Essential Management Skills Programme

1.4 The actions incorporated into these Programmes have been developed from the "Learning from Canterbury Model with a Model Experiential Leadership Programme" and underpinned by the Principles of Compassionate Leadership, developed by HEIW, to ensure that the management within the organisation are suitably equipped to meet future challenges and opportunities.

1.5 The Executive Director of People & Culture is the lead for this review.

Advisory Audit Risks

1.6 The potential risks considered in this review are as follows:

- The organisation fails to deliver leadership and management training to develop staff within the Health Board.
- Non delivery of programme objectives may impact on management morale, recruitment and retention of staff.

[1] cavuhb.nhs.wales/files/publications/people-and-culture-plan-2022-25/

2. Detailed Audit Findings

Objective 1: The Health Board develops a Leadership Development Framework following engagement with staff and management.

2.1 We were provided with a copy of a Leadership Management Framework at the time of the audit. However, we were advised that the document is to be replaced by a Leadership Framework which will support the requirements of Theme 6 of the People and Culture Plan 2022-2025 and inform the Health Board's IMTP. At the time of our review the work is ongoing, with a view to submission to the Senior Leadership Board and People and Culture Committee for review and approval in late 2023.

2.2 As the development of the Leadership Framework has yet to start, there has been no engagement with Health Board senior management or Clinical Board services in respect of their contribution to their development, although this is planned. (*Opportunity 1*)

Conclusion:

2.3 Whilst we acknowledge the forthcoming Leadership Framework will replace the legacy Leadership Management Framework, its content and outcomes may not be fully informed and implemented without the input of Health Board senior management and Clinical Boards.

Objective 2: Project management processes and plans are in place for the design, instigation and delivery of Leadership Development and Management Programmes, in line with the Leadership and Culture Plan 2022-2025 and principles of compassionate leadership.

2.4 Project management processes and plans were not in place for the design, instigation, and delivery of the four Leadership and Management programmes that we reviewed. Delivery of the two management programmes is currently planned to meet the demand from the 'waiting list' approach of staff wishing to undertake management development. The Leadership programmes were advertised as opportunities and individuals self nominated. (*Opportunity 2*)

2.5 Our review confirmed that current leadership and management training provision across the four programmes is being undertaken in accordance with Theme 6 of the Leadership and Culture Plan 2022-2025, the criteria of which being:

- Defining what excellent leaders look like at different levels;
- Signposting employees to relevant developmental opportunities;
- Offering a breadth of accessible development opportunities; and
- Identifying development pathways for under-represented groups.

2.6 The principles and application of compassionate leadership forms part of the training provided within all four programmes. It was evidenced that there was a greater emphasis of compassionate leadership training within the leadership programmes, however, it was also provided within the management programmes.

Conclusion:

2.7 None of the four leadership and management programmes currently in place were subject to a project management approach or methodology at the time of their inception through to implementation. All four programmes are being undertaken in alignment with the Leadership and Culture Plan 2022-2025 objectives and each includes training in respect of compassionate leadership principles.

2.8 **Objective 3: Suitable resources have been identified to ensure delivery of the Programmes.**

2.9 We note that the training and administrative delivery of current programmes is being satisfactorily undertaken by the existing ECOD Department staff. However, we were advised by ECOD Management that any future expansion in training and teaching arising from the implementation of the Leadership Framework and People and Culture Plan 2022-2025 may not be effectively advanced without additional appropriately qualified and experienced staffing resource. However, it is acknowledged by Senior Management that changes to means of delivery and approach may negate additional resources. (*Opportunity 3*)

2.10 We also note that no additional funding to that of the existing ECOD staffing budget was provided to support the delivery of the four programmes, and it is not known whether additional funding will be obtained to support any future additional management and leadership programmes. (*Opportunity 3*)

Conclusion:

2.11 Whilst we acknowledge that the ECOD Department has sufficient staff to support the current delivery level of leadership and management programmes, future provision of additional services may only be attainable if supported by additional educational resource and change in delivery approach and style.

Objective 4: Engagement and planning is undertaken with Clinical Board senior management to ensure awareness of Management and Leadership Programmes.

2.12 We were advised that Clinical Board senior management were engaged with during the creation of the four current leadership and management programmes. However, there is no evidence of their direct involvement regarding awareness of available courses at the present time. (*Opportunity 4*)

2.13 We were advised by ECOD management that they have discussed the need to contact Clinical Board management to directly ascertain their staff's management and leadership training requirements.

2.14 The ECOD department has a Leadership & Development intranet page which states current programmes available and contact information to enable potential enrollment.

2.15 Our review of the uptake of all the leadership and management programmes across all seven Clinical Boards for the period of February 2021 to May 2023 identified that staff from the Clinical Diagnostics and Therapeutic (CDT) and Medicine Clinical Boards attended the most, with Primary Community and Intermediate Care (PCIC) Clinical Board staff attending the least. (*Opportunity 5*)

Conclusion:

2.16 Currently, there is no formal training needs analysis for the year ahead for the Leadership and Management Programmes.

Objective 5: There are appropriate completion rates of the programmes and attendees are providing user feedback.

2.17 A comprehensive database is maintained that records programme attendance and facilitates the progress of the modules undertaken and completed for each of the staff cohorts. It was evidenced that the completion rates for each programme is high.

2.18 A student's knowledge is checked as the programmes progress, for example on the Essential Management Skills programme students are required to produce a five-minute presentation during module 5, and on both Collabor8 and Acceler8 students are invited to implement a change.

2.19 When staff are not able to fully undertake a programme, they have the flexibility to transfer to another cohort of the same programme or enrol onto another programme which is more convenient for them in terms of the impact on their job. This flexibility allows staff to undertake different modules across programmes as a means of improving a specific skill set.

2.20 Line managers who release staff from duties to attend training are not currently informed of student participation and progress due to a lack of ECOD staff time to undertake this. We note that ECOD Management acknowledge this as being a potential shortfall in the overall process, however they stress the ownership and responsibility of the individual attending the learning to keep their manager updated and of the manager to discuss with their team. (*Opportunity 6*)

2.21 We note that student feedback is gathered via a Microsoft Office feedback form on completion of the programmes. Whilst this information is recorded, it is not currently being utilised. Also, we identified that the feedback response rate at

the time of the audit across the four programmes was less than 8%. It is deemed by ECOD Management that the low response rate does not currently warrant course evaluation and potential revision, but our review of the feedback comments identifies that the requests are quite generic and could be adopted without change to course content. (*Opportunity 7*)

2.22 Additionally, 'lessons learned' improvements are not recorded to aid potential programme improvements, and as such there is no potential to upwardly report feedback and 'lessons learned' provided by students. (*Opportunity 7*)

Conclusion:

2.23 All Leadership and Management programmes have high completion rates, and these are recorded and monitored accordingly, supported by records of attendance and flexible means of course transfer if required. Additionally, during the period of study there is periodic progress assessment. However, there are currently no progress updates provided to attendee line management and student feedback and 'lessons learned' derived from feedback is not being fully evaluated.

Objective 6: The Leadership and Management Programmes are being appropriately evaluated to ensure their aims and objectives are being achieved.

2.24 Currently there is no formally prescribed process in place that facilitates the monitoring and/or review of the delivery of programme objectives in order to ensure that key learning objectives are being met. However, ECOD Management and external Programme Instructors review the objectives of modules at the time of teaching to ensure coverage of learning points. (*Opportunity 8*)

2.25 Benchmarking has been undertaken nationally and with other Welsh Health Board Learning and OD colleagues in respect of leadership and management programmes. We acknowledge that ECOD Management will continue to review this in the future. *(Opportunity 9)*

Conclusion:

2.26 None of the Leadership and Management programmes are undergoing evaluation to ensure that course content is delivered completely.

Objective 7: Monitoring and Progress Reporting to the People and Culture Committee and Board.

2.27 Currently, no Leadership and Management programmes progress outcomes are being presented to the People and Culture Committee, but we acknowledge this is a newly formed Committee and has only met once in May 2023. However, there is clear evidence that progress delivery updates relating to both

Leadership programmes (Acceler8 and Collabor8) were provided to the legacy Strategy and Delivery Committee.

2.28 There is however no evidence that progress updates in respect of the two Management programmes (First Steps to Management and Essential Management Skills) were provided to the Strategy and Delivery Committee. *(Opportunity 10)*

2.29 We do acknowledge that work on the Leadership Framework is in its embryonic stages and as such there is nothing formally to report. Regular discussions are held with the Executive Director of People and Culture, but these discussions are currently not formally recorded. *(Opportunity 10)*

2.30 We were advised that the ECOD Team are currently looking at ways that the Workforce Dashboard may be used to support the reporting of programme delivery performance. *(Opportunity 10)*

Conclusion:

2.31 Progress reporting in respect of the delivery and outcomes of leadership and management programmes, and Leadership Framework development activity are not currently being formally reported within the organisation.

Appendix A: Opportunities for improvement and development

Finding 1: Leadership Framework	Residual Risk
A copy of the Leadership Management Framework was provided at the time of the audit but it was only partly complete, was undated and had no version control, and there were actions to be implemented in 2020. We were advised that the Leadership Management Framework legacy document is to be superseded by a Leadership Framework rather than a Strategy. This will support the requirements of Theme 6 of the People and Culture Plan 2022-2025, that will in turn support the Workforce & OD element of the Health Board IMTP. The Leadership Framework is to be presented to the Workforce Partnership Group and Local Partnership Forum in quarter 2 2023/24, in readiness to take to the Senior Leadership Board and People and Culture Committee in quarter 3 or 4 with an aim to take to the Board meeting of 30th November 2023 if Senior Leadership Board deems that it requires Board approval. As the Leadership Framework has yet to be produced there has been little engagement and input with Health Board senior management (i.e., Chief Operating Officer, Deputy Chief Operating Officers, and Clinical Board Directors of Operations) but we were advised by ECOD management that there is an intention to do so in the near future.	The organisation fails to deliver leadership and management training to develop staff within the Health Board.
Opportunity 1	**Priority**
The Leadership Framework should be aligned with the principles and objectives stated within the Health Board IMTP and the People and Culture Plan. Management should ensure collaborative engagement with Health Board senior management and staff ensuring a broad coverage of all Service Boards and Clinical Board services that include Medical staff groups.	**N/A - Advisory Review**
Management Response 1	**Target Date** / **Responsible Officer**

The People and Culture Directorate are currently refreshing priorities and objectives in light of the current Shaping Our Future Wellbeing refresh, the challenging financial and workforce pressures, and in collaboration and partnership with Clinical and Service Boards IMTP development. The themes of the People and Culture Plan, which are established to reflect the national picture, will continue to be used to frame this work.	October 2023	Deputy Director of People and Culture Assistant Director of OD, Wellbeing & Culture Assistant Director of People Resourcing
Part of this work will involve the engagement and participation necessary to co-design the UHBs Leadership Framework. This will be with Clinical Boards, Service Boards, Trade Union Partners, Staff Networks, staff groups, external partners (e.g. HEIW), and through opportunities including: • Information and insights obtained via the implementation of the Culture and Leadership Programme • As above – NHS Wales Staff Survey • Leadership Summit events, workshops and focus groups • Attendance at Network meetings, Senior Leadership Board, CB executive Reviews, Feedback from HoPC	December 2023 - April 2024	Assistant Director of OD, Wellbeing and Culture.
Framework to be agreed via People & Culture Committee and Board. (To date it is important to note that programme design has been developed based upon evidence-based national principles (e.g. HEIW Leadership Principles for Health and Social Care), collaborative working with Canterbury and via Amplify events, and previous frameworks including the NHS Wales Management Competencies.)	April 2024	Assistant Director of OD, Wellbeing and Culture.

Finding 2: Project Management Plans and Processes	Residual Risk
It was evident that none of the content for the four below programmes were formulated and structured as a result of any project management methodology and planning process: • Essential Management Skills Programme - providing training suitable for Band 7 and Junior Management staff; • First Steps to Management Programme - providing training suitable for Supervisory staff; • Collabor8 – Middle Management staff Leadership Programme; and • Acceler8 - Senior Management staff Leadership Programme. Additionally, demand and delivery of the two management development programmes is currently reactive and based largely on a 'waiting list' of staff who intend to undertake management and/or leadership training.	Non delivery of programme objectives may impact on management morale, recruitment and retention of staff.
Opportunity 2	**Priority**
All future programmes should be planned and compiled from inception to completion via a project management methodology that ensures the effective capture and delivery of ideas from all interested parties across all Clinical Boards and their respective staffing groups.	**N/A - Advisory Review**

Management Response 2	Target Date	Responsible Officer
Although a 'project management methodology' approach was not evident, it is important to note that the delivery of programmes was planned to ensure appropriate capability and capacity to deliver. The 'rolling programme' of the two management development programmes was identified as a priority following a period of limited development during the pandemic, and the support required for those in management positions (both newly appointed and longer term). The resulting waiting lists and demand continues to be influenced by this.		

Work is already underway to develop a programme management approach to the design, delivery and evaluation of Leadership and Management Development. This includes: Support to the Head of ECOD and wider ECOD Team from the Change Hub to develop an appropriate programme planning approach. Engagement in Leadership Framework as in Finding 1	September 2023 – December 2023 April 2024	Assistant Director of OD, Wellbeing and Culture

Finding 3: Resources identified to ensure delivery of programmes	Residual Risk
The Education, Culture and OD Manager provides the training for the Essential Management Skills programme and First Steps to Management programme, whilst the Senior Education, Culture and OD Manager takes the lead on delivering the Collabor8 programme. In the event of any absence however, both Managers provide cross-cover across their respective programmes. Currently, the programmes are being overseen and administratively managed by the Education, Culture and OD Manager and a Band 4 Administration Support Officer. The existing staff resource within the Education, Culture & Organisational Development (ECOD) Department are satisfactorily delivering the current programmes in place. However, there is not enough appropriately qualified and experienced staff within the department to be able to meet any expansion in delivery of future programmes in addition to those presently being offered. We note that given the absence of evidence of any project planning processes underpinning the creation and implementation of the four programmes, it is not known whether resourcing of these programmes, and the implications of inadequate resourcing were considered at the time. Furthermore, ECOD management confirmed that no additional funding external to that of the existing ECOD budget has been made available to support the four programmes. It is not currently known by ECOD management whether, and where further funding will be sourced relating to additional staffing resources as detailed above to deliver and support any future management and leadership programmes.	Non delivery of programme objectives may impact on management morale, recruitment and retention of staff.
Opportunity 3	**Priority**
Future project management planning relating to the creation and implementation of additional Leadership and Management programmes will likely require appropriate funding to attract experienced resources to the ECOD Department to be able to deliver these programmes or change the delivery implementation. Without sufficient resources there is a potential risk that the objectives of the Leadership Framework and Leadership and Culture Plan 2022-2025 may not be fully realised.	**N/A - Advisory Review**

Management Response 3	Target Date	Responsible Officer
As part of the programme design, leadership principle review and ongoing culture and leadership programme work across the UHB, challenges will be identified in delivering effective leadership management development, but also opportunities, which may include changes in delivery models and methods. Management recognise that additional resources may be required, and this may include: • Staffing • External delivery / support • Training / upskilling of existing staff This will be confirmed as part of the commitment to the leadership principle development, engagement across the UHB, and via benchmarking and evidenced based research.	April 2024	Assistant Director of OD, Wellbeing and Culture
The ECOD Team have recently changed in structure and leadership, and opportunities for greater whole team involvement in leadership and management development is being explored as the capacity and skills of the team changes. This includes opportunities while developing roles such as the following (please note this is not a complete list): ECOD Manager for Digital Learning ECOD Manager for Wellbeing and Engagement ECOD Manager for Coaching and Talent Management Senior ECOD Manager – Nursing and Midwifery Opportunities to develop programmes in partnership with other areas is also part of the leadership Framework engagement, e.g. Medical Education, PCIC Academy It is important to note the appointment into the Digital Learning post which will assist in developing a broader means of delivery and approach. (e.g. webinars; TEDtalks; VR; Simulation etc)	April 2024	Head of ECOD

Finding 4: Absence of Engagement with Clinical Board senior management.		Residual Risk
We were advised that Clinical Board senior management were engaged with during the planning and compilation of the four Leadership and Management programmes currently provided. We acknowledge that initial discussions have taken place within the ECOD Department about the need to approach Clinical Board management to identify what types of future course content /programmes they would like or need to meet their staff management and leadership training requirements.		The organisation fails to deliver leadership and management training to develop staff within the Health Board.
Opportunity 4		**Priority**
Clinical Boards should be engaged with regularly to ascertain what future leadership and management training courses/programmes can be provided based upon their respective staff needs. Additionally, engagement should also be sought on a periodic basis to identify potential improvement changes to existing programmes available.		**N/A - Advisory Review**
Management Response 4	**Target Date**	**Responsible Officer**
The CBs will be engaged with to develop and shape the Leadership Framework (as per detail under other sections). The ECOD team have informal mechanisms currently of engaging with CB Senior Teams, namely through attending DoNs Meetings, DoOps Meetings etc. The Programme Management approach with explicitly include a more formalised approach to engagement including mechanisms by which programmes can be designed, planned and implemented. Since the review was undertaken, and with a new leadership structure embedding into ECOD, we are already seeing more engagement with CBs in some areas through the Directors of Ops.	April 2024 March 2024	Assistant Director of OD, Wellbeing and Culture Head of ECOD

Once leadership framework has been developed, the UHB will be in a better place to undertake a leadership and management TNA – which will be undertaken at CB level. This will help identify areas of strength, areas for development, and gaps in provision.	June 2024	
The work commencing on the Culture and Leadership Programme will also feed into the ECOD Team and identify areas for support, development and competencies requiring attention.	December 2023	
Evaluation of leadership and management development will follow the Kirkpatrick model, and engagement with the CBs SMTs will be integral and built into this approach under the programme structure.	March 2024	
It is important to note, that need will also be shaped by engagement with Board Members, Executive Team, SLB, Trade Unions and other stakeholders.	March 2024	

Finding 5: Uptake of Leadership and Management programmes across Clinical Boards.	Residual Risk
ECOD Management highlighted that no exercise has been undertaken to ascertain the uptake of management and leadership programmes across the Clinical Boards and their respective Directorates or determine the staff that have not undertaken leadership and management training. We were provided with an ESR report that showed all staff enrolment and attendance by Clinical Board within each of the four programmes covering the period February 2021 to May 2023. Our key observations being: • The majority of staff attending the First Steps to Management and Essential Management Skills are from the CDT Clinical Board and Medicine Clinical Board. • PCIC Clinical Board have the least staff attending all four programmes. • No staff from Medicine Clinical Board, PCIC Clinical Board and Children & Women Clinical Board have taken the Acceler8 programme. • No staff from Medicine Clinical Board and Mental Health Clinical Board have taken the Collabor8 programme. However, we acknowledge that there has only been one pilot run of this Programme.	The organisation fails to deliver leadership and management training to develop staff within the Health Board.

Opportunity 5	Priority
Work should be undertaken to ascertain the level of uptake of programmes across the Clinical Boards and their respective Directorates and identify those areas that have not undertaken leadership and management training and target them to maximise awareness and promotion of the leadership and management courses available.	**N/A - Advisory Review**

Management Response 5	Target Date	Responsible Officer
The ECOD Team continue to record and monitor attendance on all training and development programmes and have effective record management in place. To date, engagement with Clinical Board has been predominantly the responsibility of the Head of		

ECOD, and Senior ECOD Manager, through routes including Director of Ops Meetings; Director of Nursing Meetings.		
The Head of ECOD and Senior Manager will develop a workforce dashboard as part of the programme management that will report upon engagement and attendance on programmes on a quarterly basis. This information will be provided to Heads of People and Culture to discuss at a local level and at Clinical Board Executive Reviews.	March 2024	Head of ECOD
Recent progress also includes the development of a stronger relationship between the team and the Directors of Ops which will be utilised to share information.	October 2023	Senior Manager ECOD
The Head of ECOD is currently working with PCIC CB in the development of the PCIC Learning Academy to ensure there are clear links and alignment with the educational academy development within ECOD (e.g. Leadership Academy). This also includes work identifying ways to engage leaders and managers in PCIC in UHB Leadership and Management development opportunities.	April 2024	Head of ECOD
In 2023 the team introduced a new role – ECOD Manager for Leadership and Management Development, and while the initial focus of this role has been to design and deliver effective Management Development Programmes and respond to the need of the UHB, this role is integral to the engagement in the development of the Leadership Framework, effective evaluation (using the Kirkpatrick Model), and design and delivery of leadership and management development.		

Finding 6: Student progress updates to Line Management	Residual Risk
Currently, line managers who release staff from duties to attend training are not kept informed of either the student progress, non-attendance and/or completion of the programmes. We were informed by ECOD Management that this is not carried out due to a lack of ECOD staff capacity. ECOD Management acknowledged that this is a shortfall in the current process for managing programmes. Additionally, updating line management of their staff members progress will help assist in the completion of Values Based Appraisals (VBA).	Non delivery of programme objectives may impact on management morale, recruitment and retention of staff.
Opportunity 6	**Priority**
Management should consider implementing a process in the future to enable managers to verify the progress of their staff on the courses.	**N/A - Advisory Review**

Management Response 6	Target Date	Responsible Officer
It is important to note both the learner and line manager responsibility around learning and development, and maintaining regular conversations around progress, challenges, learning and next steps. To reinforce the above, learner and manager contracts are in development to outline personal responsibilities of both parties when nominated to, and participating in leadership and management development programmes. This will include: Signatures to agree: • Support and release to attend • To undertake regular conversations around progress and learning • To attend final presentations or any other modules required (Line Manager) • To provide feedback and reflect upon impact of the learning	April 2024	Head of ECOD

• (This list is not exhaustive) As part of the programme management, reporting mechanisms will be built into each programme. The ECOD Manager – Digital Learning, role will be fundamental in identifying and developing effective means by which to record, monitor and report upon individual progress using a systemic, digitalised approach.	April 2024	

Finding 7: Programme student feedback	Residual Risk
The current means of formal attendee feedback for Leadership and Management programmes is via a Microsoft Office feedback form. At the time of our review 51 out of 670 attendees across the four programmes provided formal feedback in this manner, the response rate received equates to 7.61%. There is a perception that there is not enough feedback responses to currently warrant any formal programme course evaluation and potential revision. However, our review of student feedback comments identified that some of them are quite generic and could easily be adopted across all programmes without impacting on any specific course content. Furthermore, there is no process in place to record and implement any informal or 'lessons learned' improvements for incorporation into the current programmes, or upward reporting of feedback and 'lessons learned' provided by students	Non delivery of programme objectives may impact on management morale, recruitment and retention of staff.
Opportunity 7	**Priority**
Consideration should be given to introducing measures to attempt to increase student feedback returns to maximise the benefit of responses provided. Feedback responses should be implemented wherever possible and if appropriate to improve the student experience and enhance the current programme provision or content. Any 'lessons learned' identified from student feedback should also be incorporated into programmes content or their delivery.	**N/A - Advisory Review**

Management Response 7	Target Date	Responsible Officer

Much of the feedback from programmes received by the ECOD Team has been through end of programme discussions, and it is noted that this has not been recorded effectively to evidence changes to content, delivery or experience.		
The ECOD Team are developing monitoring and evaluation of all programmes using the Kirkpatrick model, which will include collating effective feedback on modules / workshops and programmes.	March 2024	Head of ECOD Senior ECOD Manager
Completion of 'paper' evaluations has continued to be problematic, as has distributing evaluation forms via email, each resulting in a low response rate. The team are already looking at creative and innovative ways to capture feedback that can be used to provide valuable insights. (e.g. the use of mentimeter as part of a session to capture feedback then and there; agreement to provide feedback and evaluation as part of the agreement to attend; focus groups and leadership alumni events). This will be built into the programme management to ensure all learner experiences are captured.	April 2024	

Finding 8: Review of programmes to ensure delivery of course module objectives	Residual Risk
There are no processes in place to monitor and review delivery progress of each programme thereby ensuring that each module's set of learning objectives are being met. ECOD Management, along with External Programme Instructors, do review the objectives of modules at the time of teaching to ensure coverage of learning points.	The organisation fails to deliver leadership and management training to develop staff within the Health Board.

Opportunity 8	Priority
A checklist could be introduced that aids delivery progress of each programme thereby ensuring that each module's set of learning objectives are being met. Additionally, periodic evaluation of current programme objectives should be undertaken and revisions made accordingly to ensure relevance and that student needs are being met.	**N/A - Advisory Review**

Management Response 8	Target Date	Responsible Officer
Leadership and Management Development Programme Leads are aware of the objectives of their modules and ensure that delivery covers the aims of every session, with individuals having their own way of ensuring this. They also ensure external speakers / delivery are aligned and meet the required objectives.		
It is recognised that a consistent approach is required, and the team will develop checklists that accompany their delivery / session plans.	November 2023	Head of ECOD
Evaluation will be undertaken on a quarterly basis as part of the programme management approach.	March 2023	

Finding 9: Benchmarking to improve programme content and delivery		Residual Risk
Benchmarking has been undertaken nationally and with other Welsh Health Boards in respect of programme delivery and outcomes for improvement, and consideration should be taken by ECOD Management to take this further forward.		The organisation fails to deliver leadership and management training to develop staff within the Health Board.
Opportunity 9		**Priority**
ECOD Management should continue to contact their peers in other Health Bodies to ascertain other approaches and practices and adopt shared learning of best practice.		**N/A - Advisory Review**
Management Response 9	**Target Date**	**Responsible Officer**
The ECOD Team has representation across a range of National and local educational groups and networks. This ranges from attending as an observer, through to Chairing Networks leading on strategic cultural and educational development. As leadership and management development plays an integral role in staff engagement, motivation and performance, which ultimately impacts upon the patient experience, the team ensure that research underpins design and delivery, ensuring an evidence based approach. CAVUHB are also represented on strategic groups influencing the direction of leadership and management development in the health and social care sector across Wales.	Ongoing	Assistant Director of OD, Wellbeing and Culture Head of ECOD Senior ECOD Manager ECOD Manager, Leadership and Management Development

Finding 10: Monitoring and progress reporting to the People and Culture Committee	Residual Risk
At the time of our review, no Leadership and Management programmes progress outcomes have been presented to the People and Culture Committee, but we acknowledge that its inaugural meeting was only held in May 2023. However, progress delivery updates relating to the Acceler8, and Collabor8 Leadership programmes were historically provided to the legacy Strategic and Delivery Committee meetings in September and November 2022. We reviewed the Strategic and Delivery Committee minutes for the period September 2022 – March 2023 (four meetings) and no progress updates in respect of the two Management programmes (First Steps to Management and Essential Management Skills) were provided. Whilst we acknowledge that work on the Leadership Framework is in its embryonic stages, and as such there is nothing yet to formally report, we note that regular discussions are held with the Executive Director of People and Culture, but these discussions are currently not formally recorded. We were advised by the ECOD Team that they are also currently looking at ways that the Workforce Dashboard may be used to support the reporting of future Leadership and Management programme delivery performance.	Non delivery of programme objectives may impact on management morale, recruitment and retention of staff.
Opportunity 10:	**Priority**
Ongoing work being undertaken on the Leadership Framework and progress delivery relating to the Leadership and Management programmes should be periodically reported to future People and Culture Committee meetings.	**N/A - Advisory Review**

Management Response 10	Target Date	Responsible Officer
As mentioned in previous sections, developing and embedding the programme management approach to delivery of leadership and management development,	April 2024	Assistant Director of OD, Wellbeing and Culture.

including the development of leadership framework, will require engagement at every level, including People and Culture Committee.		Head of ECOD
As part of the reporting on the progress of the People and Culture Plan, the ECOD team will work with P&C Colleagues to influence content of the workforce dashboards – to include progress on leadership and management development (e.g. numbers, participation, completion by CB).	October 2023 – March 2024	
More substantial engagement will be required for the development of the leadership framework, and the Assistant Director for OD, Wellbeing and Culture will meet with the Head of People Assurance and Experience to schedule the L&M Development updates for P&C Committee.	October 2023	

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.
	**Unsatisfactory 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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Quality, Safety & Experience Governance

Final Internal Audit Report (Advisory)

October 2023

Cardiff & Vale University Health Board

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

Contents

Review reference:	CVU 2223-28
Report status:	Final Report
Fieldwork commencement:	2nd June 2023
Fieldwork completion:	9th August 2023
Debrief meeting:	9th August 2023
Draft report issued:	17th August 2023
Management response received:	12st October 2023
Final report issued:	13th October 2023
Auditors:	John Cundy, Principal Internal Auditor Lucy Jugessur, Interim Deputy Head of Internal Audit
Executive sign-off:	Professor Meriel Jenney, Executive Medical Director Jason Roberts, Executive Nurse Director
Distribution:	Alexandra Scott, Assistant Director of Quality and Patient Safety
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 Chartered Institute of Public Finance & Accountancy in April 2023.

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

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales 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 & 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.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Cardiff & Vale University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

This was an advisory review of the Health Boards Quality & Safety Governance arrangements and any supporting implementation programmes to ensure compliance with the requirements set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Overview

This is an advisory review to support management, rather than an assurance report, and no assurance rating is provided.

In contrast to internal audit recommendations, which address the design and operation of the control environment we propose opportunities that the Health Board may wish to take forward. The opportunities outlined in this report (see Appendix A), if taken forward will help to enable the Health Board to further embed the Quality, Safety and Experience Framework across the Health Board.

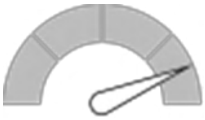
The Quality and Engagement Act came into force on the 1st April 2023 which placed a Duty of Quality on all Welsh Health Boards and included a requirement to report on this duty, at least annually.

To support their compliance with this Act the Health Board adopted a Quality safety and Experience Framework 2021 – 2026 in September 2021.

We consider that good progress has been made in implementing the QSEF and placing quality at the heart of patient care but acknowledge that quality processes and controls will always be subject to opportunities for improvement and evolutionary change.

Report Opinion

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.

Advisory Audit Objectives

Our review sought to ascertain and evaluate if:

1	The 'Quality Governance Priority' set out within the Quality, Safety and Experience Framework (2021 – 2026) is being taken forward by the Health Board.
2	The Quality, Safety and Experience Committee is kept informed of progress of implementing the Quality, Safety and Experience Framework (2021 – 2026) and any issues are highlighted for scrutiny.

Opportunities:		Audit Objective
1	Establishment of the Organisational Learning Committee	1
2	Reviewing and updating the Clinical Effectiveness Committee and Clinical Safety Group TOR	1

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1. Introduction

1.1 Our advisory review of 'Quality, Safety and Experience Governance' (CVU 2324.28) was completed in line with the 2023/24 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').

1.2 Quality should be at the heart of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare.

1.3 The Quality, Safety and Experience Committee approved the 'Quality, Safety and Experience Framework 2021-26' (QSEF) on 15th September 2021.[1] The Framework describes the interlinked priorities that need to work together to ensure continuous improvement in quality. The Framework is divided into eight key priorities: 1) Safety culture; 2) Leadership and the prioritisation of QSE; 3) Patient experience and involvement; 4) Patient safety learning and communication; 5) Staff engagement and involvement; 6) Data and insight; 7) Professionalism of QSE; and 8) Quality governance arrangements.

1.4 In June 2022 Audit Wales issued a report, 'Review of Quality Governance Arrangements – Cardiff and Vale University Health Board', which was presented to the Audit and Assurance Committee in July 2022.[2] The outcome of the review will inform our advisory review.

1.5 The Duty of Quality, as part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, came into force in April 2023. The Duty requires NHS bodies to think and act differently by applying the concept of "quality" across all functions. The Health Board will need to consider quality within the context of the health service and health needs of its population.

1.6 The Executive Medical Director and Executive Nurse Director are the leads for this review.

Advisory Audit Risks

1.7 The potential risks considered in this review are as follows:

- Quality, Safety and Experience Framework is not being complied with;
- Quality, safety and patient experience issues are not addressed if there are no governance arrangements in place to review and progress quality, safety and patient experience issues; and

[1] https://cavuhb.nhs.wales/files/board-and-committees/quality-safety-and-patient-experience-committee-2021-22/2021-09-15-final-qse-papers-v2-pdf/ (Item 2.3)

[2] https://cavuhb.nhs.wales/files/board-and-committees/audit-assurance-committee-2022-23/2022-07-05-audit-committee-papers-v3pdf/ (Item 7.4)

- Current and future quality, safety and patient experience risks impacting the Health Board are not being addressed.

2. Detailed Audit Findings

Objective 1: The 'Quality Governance Priority' set out within the Quality, Safety and Experience Framework (2021 – 2026) is being taken forward by the Health Board.

2.1 There is a well-established patient safety and quality team within the Health Board. The responsibility for quality sits with the Executive Nurse Director and the Medical Director who are both Executive members of the Board.

2.2 The Health Board have joined with other Welsh Health Boards to form the Duty of Quality Implementation Group which meets every two months and provides oversight of quality improvement across all the Health Boards in Wales. They have jointly produced a roadmap with 14 key milestones to ensure the statutory Duty of Quality continues to be delivered. We note that the Health Board have reported good progress in delivering the roadmap milestones to date and as of June 2023 they had fully implemented six of the 14 milestones.

2.3 A Statutory Duty of Quality report will be required to be produced on an annual basis from next year.

2.4 Quality is primarily controlled and reported through the Quality, Safety and Experience Committee (QSEC), which is a subcommittee of the main Board. The Committee produces an annual workplan confirming all key quality areas that are to be reviewed and reported on.

2.5 There is a well-established quality reporting process; with QSEC reporting to the Board several times per year on performance against defined quality indicators e.g., falls, incidents, etc. All quality reports are published on the Health Board website. Since August 2023, the Quality Indicators Report has been updated.

2.6 'Delivering Quality' is included in section 3 of the IMTP for 2023-24 including a plan with a number of high-level objectives. By the end of the first year (March 2024) the Board has committed to achieving a designed and tested approach to continuous improvement in the quality of its services.

2.7 There is an Assistant Director for Quality, and an Assistant Director for Patient Experience both of whom are responsible in delivering the Quality Safety & Experience Framework (QSEF).

2.8 The QESF has 50 priorities across eight key areas which are detailed within the Introduction of this report. It was evidenced that some of these priorities are easily measurable and quantifiable, whilst others are less so. We note that the approach to quality development and improvement is appropriately agile and flexible to be able to react to changing circumstances.

2.9 The QSEF structure mandates three subcommittees, namely:

- The Clinical Effectiveness Committee (CEC) that reviews the Clinical Audit programme and receives assurance that clinical services are regularly reviewed and audited. They also ensure clinical effectiveness where clinical services are delivered through monitoring of implementation plans of national and local evidence, guidelines and standards.
- The Clinical Safety Group (CSG) receives assurance from each of the operational groups listed in the QSEF governance structure such as falls and medicines management, on a cyclical basis.
- The Organisational Learning Committee which has yet to be established. We were advised by the newly appointed lead for organisational learning that they are looking to launch this group in September 2023. *(Opportunity 1*)

2.10 Both the CEC and the CSG are operating as per their terms of reference. Their meetings have agendas, minutes, action points and owners. The TOR for both groups state that they report into the QSEC and it has been agreed that the CEC produce a bi annual report to go to QSEC with the first being scheduled for September 2023. In addition, the CSG minutes will be reported to the September or October QSEC. However, we note that the review date for the CEC and CSG terms of reference have both lapsed. *(Opportunity 2)*

2.11 We note that the CSG terms of reference includes a specific responsibility for delivering the QSEF i.e. 'Approve and monitor implementation of the Quality, Safety and Experience Framework and oversee the necessary developments to deliver the eight identified workstreams'.

2.12 All Clinical Boards report to the CSG bimonthly with an assurance report detailing their outstanding risks, and issues/concerns and challenges. There is a template for them to follow which allows the risks to be collated at CSG level. This allows them to identify more appropriate mitigation actions and promote risk escalation if appropriate.

2.13 We note that there have been three key areas that have been developed within the Health Board to ensure that quality services are recognised. In September 2021 a presentation on 'The Perfect Ward' was provided to the QSEC. The presentation highlighted that ward accreditation was a development of a set of standards to enable areas for improvement to be identified and areas of excellence to be celebrated. The accreditation is suitable for primary and secondary care settings. The aim is for all areas to achieve a Bronze, Silver or Gold standard.

2.14 The standards require three core audits to be completed with a satisfactory finding for a period of six months before the ward can apply for accreditation. There is a verification process carried out for a further period before the Bronze standard can be awarded. Silver and Gold build on the standards achieved by adding more requirements that have to be maintained for a longer period.

2.15 We note that all of the audit findings can be verified independently, and by management. If the audit results show any levels lower than the minimum acceptable standard the accreditation will lapse.

2.16 A pilot scheme was launched using Tendable ward audit software which is used to control and manage a full programme of ward audits that can be configured for any ward and used to support and underpin the ward accreditation programme.

2.17 The Tendable software was well received and ward staff gave positive feedback on the software and audit process. They reported it allowed them to recognise that they were achieving good results across the three core audits and the process stimulated discussion on quality processes. The pilot ward achieved accreditation, which has been reported on the Health Board's website and has resulted in other wards wanting to join the scheme.

2.18 All Clinical Audits are now managed using the Audit Management and Tracking (AMaT) software, which promotes consistent audit standards and provides accessible management information on the audit results.

2.19 AMaT functionality is designed to support Clinical Audit and individual quality improvement schemes. The feedback received is that this tool is extremely beneficial in supporting quality improvement projects and promoting quality through consistent management of all Clinical Audits. It is also used to store and track recommendations and agreed actions from other inspections, e.g. HIW, from acceptance to completion.

2.20 We note that the ward accreditation, Tendable and AMaT activities are linked to the QSEF priorities. We consider that this is an important link in the overall 'Ward to Board' quality process and provides evidence of quality service being maintained in achievement of the Framework priorities.

2.21 Since October 2022 patient experience has been collected monitored and managed using the All-Wales Civica software. This software facilitates 'immediate' feedback using modern practices, e.g. text messaging, which has a response rate of nearly 20%. Patient and family responses are stored automatically on submission and can be analysed by the Patient Experience team to produce information and publicity materials to promote further feedback. The Patient Experience Team are able to make improvements and provide a better service from the feedback received.

2.22 The patient experience team have launched a patient survey using Civica; 'Tell us in 2'. It takes two minutes for patients and relatives to complete and the results are collated automatically. It is planned that the survey results will be fed back to the patients using system generated 'You said We did' posters.

2.23 The next planned steps are postcode collection to identify possible feedback trends based on patient location, and an animated feedback option to encourage and assist younger patients to provide their own feedback.

Conclusion:

2.24 Overall, we consider quality is a central element of the Board's planning process. It is included in the Health Board's IMTP and appropriate steps have been taken to enable the QSEF to become operational and effective. There are effective software tools to gather and analyse the patient experience (Civica) and support operational quality measurement and improvement (AMaT and Tendable) which are included within the QSEF.

Objective 2: The Quality, Safety and Experience Committee is kept informed of progress of implementing the Quality, Safety and Experience Framework (2021 – 2026) and any issues are highlighted for scrutiny

2.25 We note that the QSEC approved the QSEF in September 2021 and had updates on its implementation and effectiveness in February 2022 and March 2023. As the framework will take five years to be fully implemented, we consider this to be appropriate.

2.26 Progress in delivering the QSEF has clearly been evidenced through the work undertaken within this audit. We were informed by the Assistant Director of Quality and Patient Safety that progress on the Framework is to be reported to the Investment Group (IG) through a post approval review. This gives a high-level description of progress descriptions using three headings:

- What should have been completed by this point;
- What has actually been completed; and
- What remains outstanding and actions being taken to address identified delays.

2.27 The update gives details of the risks identified at the start of the implementation; any that have emerged during the initial implementation phase, and how they have been mitigated. The last section contains the 'planned next steps' for both patient experience, and patient quality.

Conclusion:

2.28 We are satisfied that delivery of the Framework priorities are progressing and the progress is being reported to the QSEC. We consider that there have been material improvements in quality and patient experience and the Board has linked the quality priorities in the framework with day to day activities at the operational level using the clinical audit and ward accreditation software that is now in place.

Appendix A: Opportunities for improvement and development

Finding 1: Establishment of the Organisational Learning Committee		**Residual Risk**
The QSEF was adopted by the Board in September 2021 and within the document it was agreed that an Organisational Learning Committee should be established as a sub-committee of the QSEC. As yet this Committee has not been formed. We do note that a new lead for Organisational Learning has recently been appointed and is researching and developing the specific role and priorities of the Committee.		Quality, Safety and Experience Framework is not being complied with
Opportunity 1		**Priority**
The Organisational Learning Committee should be established as soon as possible with appropriate terms of reference that detail: • definition(s) of organisational learning (short, medium, and long-term); • the role of the Committee and its aim and purpose; and • frequency and membership of meetings and quorate requirements etc.		**N/A - Advisory Review**
Management Response 1	**Target Date**	**Responsible Officer**
Work is underway to discuss the purpose and scope of this meeting with a number of corporate bodies within the UHB including planning. A draft term of reference will be presented to the October 2023 Quality Safety and Experience Committee in November 2023 with a view to convene the first meeting in Quarter 4 of the financial year.	March 2024	Assistant Director of Quality and Patient Safety

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Finding 2: Reviewing and updating the Clinical Effectiveness Committee and Clinical Safety Group TORs	**Residual Risk**
We reviewed the terms of reference (TOR) for the Clinical Effectiveness Committee (CEC) and the Clinical Safety Group (CSG) and both were out of date as detailed below: CEC • The Committee was approved on the 24th March 2021 and the TOR stated that the next review date was 6 months from approval date, but they have yet to be reviewed. • The TOR detail the membership of the Committee, but a number of these members are no longer employed by the Health Board. CSG • The Group was approved on the 16th September 2021 and the TOR stated that they will be reviewed on an annual basis but they have yet to be reviewed.	Quality, Safety and Experience Framework is not being complied with.
Opportunity 2	**Priority**
The terms of reference for the CEC and the CSG require review and updating.	**N/A - Advisory Review**

Management Response 2	**Target Date**	**Responsible Officer**
The terms of reference for the Clinical Effectiveness Committee have been updated and circulated for review and will be signed off at the meeting on the 29th September 2023. The terms of refence for the Clinical Safety Group will be reviewed and a draft will be presented for comment at the meeting on 10th November 2023 and signed off at the subsequent meeting in January 2024.	September 2023 January 2024	Assistant Director of Quality and Patient Safety

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.
	**Unsatisfactory 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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Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Report Title:	**Report on the Draft Annual Accounts of the Cardiff and Vale University Health Board's Fund Held on Trust 2022/23.**			Agenda Item no.	TBC
Meeting:	**Audit and Assurance Committee**	Public	X	Meeting Date:	07.11.23
		Private			
Status *(please tick one only):*	Assurance	**x**	Approval	Information	
Lead Executive:	**Executive Director of Finance**				
Report Author (Title):	**Deputy Director of Finance**				

Main Report
Background and current situation:

Cardiff and Vale Health Charity ("the Health Charity") is the official charity and working/trading name of Cardiff and Vale University Health Board General Purposes Charitable Fund, Charity Registration number 1056544.

Cardiff and Vale University Health Board holds Charitable Funds as sole corporate trustee and the board members of the Health Board are jointly responsible for the management of those charitable funds. The management of Charitable Funds is a delegated responsibility from the Board of Trustee to the Charitable Funds Committee.

The Finance Department of Cardiff and Vale University Health Board provides financial administration for the Health Charity. The day to day administration of funds and operational management of the Health Charity is undertaken by a team of staff based at Woodland House. The Draft Annual Accounts are provided to the Audit and Assurance Committee for endorsement on an annual basis.

The draft accounts cover the activities of the Health Charity for the period 1st April 2022 – 31st March 2023. As the Draft Annual Accounts are currently being audited by Audit Wales, they are, still subject to change.

The Final Audited Accounts, ISA260 report and Letter of Representation will be taken to the Board of Trustee at its January 2024 meeting for formal approval.

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

The Audit and Assurance Committee is asked to receive and consider for endorsement the Health Charity Draft Accounts 2022/23 and the draft response provided to the audit enquiries to those charged with governance and management.

These documents are included as follows:

- Cardiff and Vale Charity Draft Annual Accounts;
- The response given to the audit enquiries to those charged with governance and management;

Assurance can be provided on the accuracy of the Draft Annual Accounts and associated documents by:

- The response given to the audit enquiries to those charged with governance and management.

- On completion of the audit of the financial statements, further assurance will be given on the annual accounts by the work that will be completed by Audit Wales in determining whether the Health Charity's Annual Report and Accounts give a true and fair view.

The Draft Annual Accounts of the Charity has been prepared in accordance with recommended practice. These will be subject for external review by Audit Wales. Should any misstatements or errors be identified during the course of the audit these will be noted in the ISA 260 audit report.

The key points to note are:

- Donations and legacies increased by £0.420m in 2022/23 to £1.699m.
- The Health Charity investments saw losses of £0.325m in 2022/23.
- The value of the Health Charity increased by £1.271m in 2022/23 to £10.259m. This is mainly attributable to the revaluation of Rookwood Hospital by the Valuation Office Agency.

Recommendation

The Audit and Assurance Committee is asked to:

- REVIEW Draft Annual Accounts;
- NOTE the reported financial performance contained within the Draft Annual Account**s**;
- NOTE the response of the audit enquiries to management an those charged with governance:
- Subject to any further amendments SUPPORT and ENDORSE the Draft Annual Accounts.

n

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	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	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	X

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term	X	Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
n/a
Safety: Yes/No
n/a
Financial: Yes/No
n/a
Workforce: Yes/No
n/a
Legal: Yes/No
n/a
Reputational: Yes/No
n/a
Socio Economic: Yes/No
n/a
Equality and Health: Yes/No
n/a
Decarbonisation: Yes/No
n/a

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

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CARDIFF & VALE HEALTH CHARITY

Annual Report 2022-2023

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

Cardiff & Vale HealthCharity
Elusenlechyd Caerdydd a'r Fro

CONTENTS

INTRODUCTION

Welcome to the Cardiff & Vale Health Charity Annual Report for 2022 - 2023

This year has seen a period of refocusing and reflection in the Health Charity to ensure that charitable fund donations are used where needed most. We have engaged with services across the Health Board and Third Sector organisations to support a wide variety of patient, staff, volunteer, and community led environmental based projects and improvements, plus research, training, and development.

KEY HIGHLIGHTS OF 2022 - 2023

- The Health Charity continued to align its focus to Cardiff and Vale University Health Board's Shaping Our Future Healthcare and Wellbeing programmes, via its funding of a variety of projects. Successful grants received have supported a wide range of healthcare, research and development, and sustainability projects across the Health Board. Further details of these can be found in this report
- Several of our key Appeals, i.e. PROP and The Breast Centre Appeal held their annual fundraising events for the first-time post-pandemic, which were generously supported by donors, fundraisers and sponsors
- Staff members and their families and friends represented the Health Charity at a number of events, including the Cardiff Half Marathon and London Marathon, and we are very grateful for their amazing support
- The Arts for Health and Wellbeing programme had a very busy and successful year. Details of the wide range of projects and activities it has funded and supported in 2022/23 can be found in the Arts for Health and Wellbeing Annual report

We would like to thank all of the fundraisers and donors who have contributed so generously, and Health Board colleagues who have worked diligently to find new ways to fundraise and raise awareness of the Health Charity over the past twelve months.

The Health Charity will continue to focus on supporting patients, colleagues, volunteers, and communities of Cardiff and Vale University Health Board to live fulfilling and healthy lives.

If you would like to get involved in fundraising or volunteering to support Cardiff & Vale Health Charity, details about how to do so are at the end of this report.

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Thank You

Charles Janczewski
Chair of the Health Charity Trustees

Akmal Hanuk
Chair of the Charitable Funds Committee

FUNDRAISING features

HOW WE RAISED FUNDS

As the Health Charity's visibility and engagement continues to grow, we have been amazed at the incredible fundraising which has taken place locally, nationally, and even internationally throughout 2022/23. Here are a few examples of our fantastic fundraisers who have supported a variety of services, some of these generously doing so in memory of loved ones who had received healthcare from Cardiff and Vale University Health Board.

Tom Millis and Will Evans raised over £31,800 with multiple events to support the All Wales Cystic Fibrosis Unit at University Hospital Llandough in memory of their cousin Charli who underwent a double lung transplant in 2015 but sadly passed away after a courageous battle in 2017. Events included the Richard Burton 10K route which they ran continuously for 24 hours.

Employees of Hafod, a housing support and care provider based in South Wales, have raised over £4,000 for Cardiff & Vale Health Charity, specifically for the Bone Marrow Transplant Unit at Cardiff and Vale University Health Board.

The Bone Marrow Transplant Unit serves patients with haematological diseases in Mid and South Wales, covering roughly three quarters of the Welsh population.

The Unit was nominated to be Hafod's charity partner by an employee whose son received a life-saving bone marrow transplant as part of his treatment for acute myeloid leukaemia.

WE RECEIVED GENEROUS DONATIONS OF £1.276M FROM OUR SUPPORTERS AND FUNDRAISERS

Andrea Drury arranged an aqua fitness fundraising event in sunny Australia, in memory of the late Toby Carrington, to support Cardiology services at Cardiff and Vale University Health Board and raised over £1,880!

Back in 2019 we celebrated the success of Irene Hicks and team for raising just over £100,000 for our Breast Centre Appeal.

Fast forward three years, and even during a global pandemic, this wonderful team were not to be outdone. Amazingly, in August this year, they reached their fundraising goal of £200,000, donated to the Breast Centre Appeal since they started supporting us in 2014.

THE HEALTH CHARITY'S TOTAL INCOME FOR 2022/23 WAS £2.203M FROM DONATIONS, LEGACIES, INVESTMENT INCOME, AND OTHER TRADING ACTIVITIES

The Health Charity is extremely grateful to all volunteers and donors who have continued to support and fundraise in so many amazing ways during this past year

Supported by
Gifts in Wills
Cefnogir gan
Rhodd mewn Ewyllys

The Health Charity is very grateful to the regular donations it receives from donors who leave a gift in their Will to Cardiff and Vale University Health Board, in recognition of the healthcare received by themselves or their loved ones.

These generous donations support inpatient and community services across Cardiff and the Vale of Glamorgan in a wide variety of ways.

LEGACY DONATIONS RECEIVED DURING 2022/23 TOTALLED

£0.423M

The Staff Lottery continues to successfully support a wide variety of patient and staff related funding applications, and the Health Charity is grateful to its existing and new members for their support.

£0.283M

FROM THE CARDIFF AND VALE STAFF LOTTERY, THE HEALTH CHARITY GENERATED

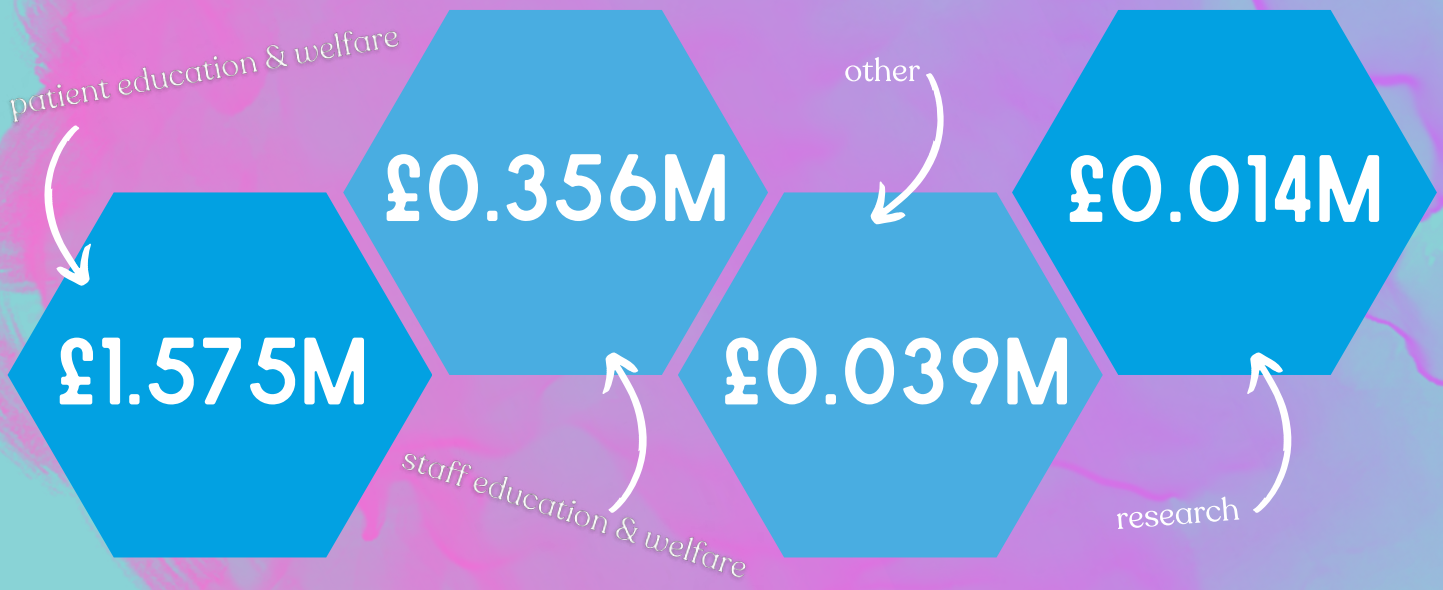
DONATIONS *distributed*

HOW WE SPENT CHARITABLE FUNDS

Healthcare services in Cardiff and the Vale of Glamorgan are funded by the NHS. At Cardiff & Vale Health Charity we work alongside colleagues to identify ways to provide additional support that will enhance the services we provide.

Working in alignment with Cardiff and Vale University Health Board Shaping our Future Wellbeing, and Wellbeing of Future Generations, helps shape the current and future work of the Health Charity. We will continue to review the needs of the Health Board as the framework of healthcare services is reviewed and developed to meet the needs of the community of Cardiff and the Vale of Glamorgan.

These are just some of the ways the Health Charity used your generous donations to support services across Cardiff and Vale University Health Board.



STAFF HEALTH & WELLBEING

The overwhelming support of the public and high profile individuals in response to the pressure on the NHS during the COVID-19 pandemic saw Health Boards and Trusts focusing even more on ways to support the health and wellbeing of its staff. The Health Charity was pleased to assist Cardiff and Vale University Health Board in a number of ways by utilising the generous donation of £500,000 from Mr and Mrs Gareth Bale to benefit the University Hospital of Wales, in accordance with their request, and the general purpose 'Make It Better Fund' to support applications from inpatient and community services across Cardiff and the Vale of Glamorgan.

One of these included using charitable funds to make environmental improvements in patient services and staff rest areas.

Donations Distributed

Colleagues from Daytime Services Call Centre, Barry Leisure Centre were provided with a new garden bench through funding from the Staff Lottery Bids Panel which allows them to spend more time outdoors during their breaks, improving their workplace environment.

For their Wellbeing Summer Project, the Penarth District Nursing Team received a new seating area for staff to relax and reflect during their lunchbreaks. By transforming an area of their workspace into a colourful and tranquil environment, it has allowed colleagues to unwind during their breaks as well as having a space to process difficult situations and events they come across during their day.

Comfortable chairs, a sofa, and coffee table were purchased.

The Occupational Health Department were delighted to receive funding from the 'Make It Better Fund' to provide a brighter and more welcoming environment to its Employee Wellbeing Services at Denbigh House. The waiting room refurbishment, using wall art and the purchase of new furniture, has made a huge difference to colleagues both working in the department and for visiting staff members.

Donations Distributed

The Camerados Public Living Room ('The Hive') at University Hospital of Wales officially opened in July 2022. Supported by Cardiff & Vale Health Charity, the area was equipped with comfortable furniture, books, and games to help foster mental wellbeing and encourage colleagues to talk and reach out for support.

The Health Charity continues to develop its partnership working with national organisations and in the local community.

An example of this was demonstrated in staff from a local Starbucks outlet visited the Health Charity Team at Woodland House to donate a selection of reusable cups, totes, and bamboo sets to be used to support staff wellbeing initiatives.

In partnership with NHS Charities Together, Starbucks launched a campaign to support the NHS, raising in excess of £100,000 from the sale of their colour changing cups. It also offered free food and drinks when the pandemic was at its peak.

Cardiff & Vale Health Charity is extremely grateful to NHS Charities Together for its continued support via its successful grant awards plus partnership companies for their generous donations.

In an attempt to help staff 'beat the heat' of the hot summer of 2022, funding from the Staff Lottery Fund supported the provision of free ice creams to as many colleagues as possible at University Hospital of Wales and University Hospital Llandough, as well as ice pops given out to staff at Barry and St Davids' Hospitals.

PATIENT SERVICES

A generous donation from Nathaniel Cars (official partners of Cardiff & Vale Health Charity) supported the launch of new and improved areas of the Paediatric Emergency Unit at the University Hospital of Wales

The Health Charity is very grateful to Nathaniel's for its continued support via its donations, fundraising, and the provision of a hybrid vehicle, which supports the Health Charity with fundraising events and distribution of practical donations across hospital sites.

Donations Distributed

A project to improve the environment of the Antenatal Clinic at University Hospital Llandough, which includes the Rainbow Clinic, was supported from charitable funds. Some of this was raised by staff who walked 15 miles from University Hospital Llandough in a heart shape, as well as a generous donation from Cwmtawe 7's who hosted a golf day.

The Health Charity has supported the Welsh Transplant Team in recent years to celebrate organ donation and encourage patients to lead healthy lifestyles. In 2022, the Charitable Funds Committee approved new funding to support the Wales Transplant Team with their participation in the British Transplant Games over the next five years.

The Transplant Games provides opportunities for Cardiff and Vale University Health Board transplant patients to stay active and take part in sport, which in turn supports their health and wellbeing by motivating the team to stay active.

THIRD SECTOR PROJECTS

The Health Charity has been delighted to continue its support of a wide variety of third sector projects across Cardiff and the Vale of Glamorgan during 2022/23, and is very grateful to its partner organisations for their involvement, support, and dedication to these projects which includes:

THIRD SECTOR GRANT SCHEME 2022/23

Working in partnership with Glamorgan Voluntary Services (GVS) and Cardiff Third Sector Council (C3CS), the Health Charity helped fund community based third sector projects across Cardiff and the Vale of Glamorgan, including:

INNOVATE TRUST

NYAS CYMRU

GVS GARDENING PROJECT

VALE PEOPLE FIRST

BREATHE CREATE

MOSS ROSE COTTAGE

VALE PLUS

THE MENTOR RING

OUR HEALTH MEADOW

The continued development of Our Health Meadow at University Hospital Llandough has been warmly welcomed and engaged with by inpatient clinical and rehabilitation services, and the local community.

The Health Charity is delighted to be part of this ground breaking initiative within healthcare services, supporting the delivery of non-clinical, therapy-based services in alignment with the Health Board's 10 year Shaping our Future Wellbeing Strategy.

Successful bids for grants income from NHS Charities Together, the National Lottery Heritage Fund, the Active Inclusion Fund, and the generous fundraising and donations of local supporters of Our Health Meadow have contributed to the ongoing success of this project.

In July 2022, Our Health Meadow became the first project in Wales to receive a 'Building with Nature Full Award'. The Building with Nature Standards provide planners and developers with evidence-based, how-to guidance on delivering high quality green infrastructure. The Standard out nature at the heart of development in a way that is good for people and for wildlife.

CEO of Cardiff and Vale University Health Board, Suzanne Rankin, Head of Cardiff & Vale Health Charity and Arts Programme, Simone Joslyn, Minister for the Economy of Wales, Vaughn Gething MS, and our Down to Earth partners met in Our Health Meadow in July to celebrate the success of receiving the award.

In August, the Health Charity hosted an outdoor cinema event at Our Health Meadow. Despite the soaring temperatures of the heatwave, many came along to enjoy the three free films on offer throughout the day.

The Health Charity would like to say a huge thank you to Down to Earth, patients, staff, and community members who have been involved in the various projects at Our Health Meadow this past year, supporting the development of this unique green space on the hospital site at Llandough

Donations Distributed

HORATIO'S GARDEN

Cardiff & Vale Health Charity joined Health Board colleagues to celebrate the official opening of Horatio's Garden in the Spinal Injury and Neuro Rehabilitation Centre at University Hospital Llandough on 2nd July.

Horatio's Garden is an award-winning National Charity building specialist garden environments to enhance physical and psychological wellbeing or spinal injury patients, and this garden is a first for patients and Health Boards in Wales and is considered an exemplar in its field.

A joint funded project with Cardiff and Vale University Health Board generously providing the land, and Cardiff & Vale Health Charity making a significant contribution of charitable funds to the initial development and continued site maintenance.

STRATEGY *shake up*

OUR STRATEGY - MOVING FORWARD

In 2023, following a period of reflection and lessons learned through the pandemic, Cardiff and Vale University Health Board will set out its ambition to tackle healthcare inequalities that exist within our communities, enable people to keep well, and deliver outstanding services to those who need them, when they need them.

Cardiff & Vale Health Charity will continue to work alongside colleagues in the Health Board to support this need, and will hold a review of the current Health Charity Strategy 2020 -2025, to continue to align with the changing needs of healthcare services in Cardiff and the Vale of Glamorgan.

The strategic aims of the Health Charity continue to be focused on:

- Going above and beyond NHS services for the benefits of patients, staff and communities
- Support the health, wellbeing and welfare of our population through positive engagement to care and keep them well
- To work with fund holders to ensure that donated funds are spent, and to attract funds to benefit our local communities
- Creating the best possible environment for sustainable healthcare, including making the best use of technology

Further information on the Cardiff & Vale Health Charity Strategy 2020 - 2025 can be found here.

Cardiff & Vale HealthCharity
Elusenlechyd
Caerdydd a'r Fro

Cardiff & Vale Health Charity manages over 300 funds which help with research, treatment and patient care across Cardiff and Vale University Health Board. Your donations provide equipment, improve environments and support internal and external projects that are over and above what mainstream NHS funding can provide. The Health Charity works solely to facilitate this on your behalf.

The Health Charity supports donors and fundraisers by working closely with staff to ensure that every penny you donate is spent where it's needed most. It funds projects that improve services for patients, and helps staff both practically and emotionally so they can continue the incredible work that they do.

Thank You

FOR YOUR SUPPORT AND GENEROSITY DURING 2022/23

You can find out more about Cardiff & Vale Health Charity and ways to support Cardiff and Vale University Health Board through donations, fundraising, or volunteering by visiting our website.

WWW.HEALTHCHARITY.WALES

@HealthCharity @cardiffandvalehealthcharity @Health_Charity @cavhc.nhs

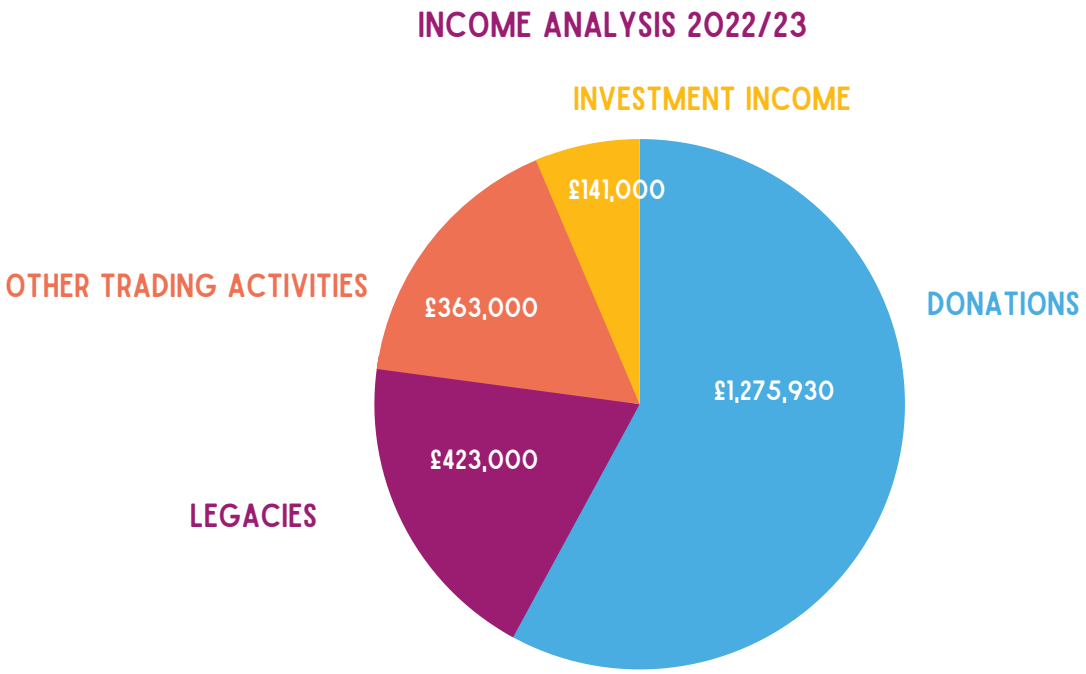
ANNUAL accounts

FINANCIAL ACHIEVEMENTS AND PERFORMANCE

INCOME SUMMARY

Incoming resources for the year 2022-23 totalled £2.203m which represents an increase of £0.443m from the previous financial year.

The Charity's income was generated from donations, legacies, investment income, and other trading activities.



Donations (58% - £1.276m)
The Charity is very grateful to have received donations of £1.276m to help us achieve our goals and objectives.

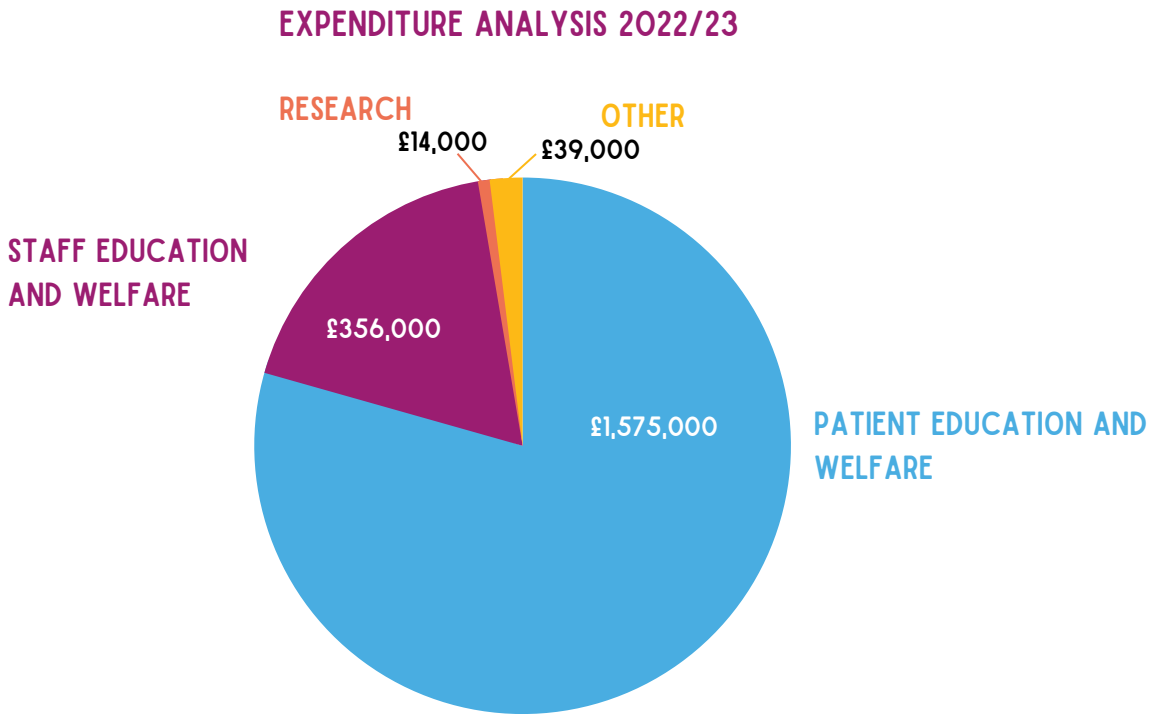
Legacies (19% - £0.423m)
The Charity received £0.423m in legacies. We are extremely grateful to those individuals who remembered our wards and departments in their will.

Other Trading Activities (17% - £0.363m)
The Charity generated £0.283, from the Cardiff and Vale Staff Lottery and a further £0.080m from other trading activities.

Investment Income (6% - £0.141m)
Dividends and interest from the Charity's Investment Portfolio was £0.141m.

EXPENDITURE ANALYSIS 2022/23

In 2022/23 expenditure on charitable activities was £1.984m. This included patient education and welfare, staff education and welfare, research and other items.



Investments and performance

During 2022/23 the Charity had market value losses of £0.325m.

Overall financial position

The overall value of the Charity as at 31st March 2023 has increased from an opening balance of £8.988m to £10.259m. This movement of £1.271m is represented by net expenditure of £0.236m, investment loss of £0.325m and asset revaluation of £1.832m.

CARDIFF & VALE HEALTH CHARITY ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2023

FOREWORD

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

STATUTORY BACKGROUND

The Cardiff and Vale University Local Health Board is the corporate trustee of the charity under paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990.

The Trustees have been appointed unders11 of the NHS and Community Care Act 1990.

MAIN PURPOSE OF THE FUNDS HELD ON TRUST

The main purpose of the charity is to apply income for any charitable purposes relating to the National Health Service wholly or mainly for the services provided by the Cardiff and Vale University Local Health Board.

STRUCTURE, GOVERNANCE AND MANAGEMENT

THE CHARITY

The Health Charity was created on 3rd June 1996 by Declaration of Trust and following reorganisations of health services, was amended by Supplementary Deed on 12th July 2001 and 2nd December 2010. Cardiff and Vale University Local Health Board (UHB) is the Corporate Trustee for the Health Charity. The UHB delegates responsibility for the management of the funds to the Charitable Funds Committee. The aim of the Corporate Trustee (Trustee) is to raise and use charitable funds to provide the maximum benefit to the patients of Cardiff and Vale UHB and associated local health services in Cardiff and the Vale of Glamorgan, by supplementing and not substituting government funding of the core services of the NHS.

REGISTRATION

The Charitable Funds held by the Cardiff and Vale NHS Trust transferred to the Cardiff and Vale UHB by virtue of Statutory Instrument 2009 No. 1558 The National Health Service Trusts (Transfer of Staff, Property, Rights and Liabilities) (Wales) order 2009. The supplemental deed dated 2nd December 2019 formally changed the name of the Health Charity to Cardiff and Vale University Local Health Board General Purpose Charity - Registered Charity number 1056544. The Health Charity has a number of constituent charities and these are listed below:

- Catherine Jenkins
- Education and Training General Charity
- Rookwood Hospital Charity
- Rookwood Hospital General Charity
- Research and Development General Charity
- Staff and Patient Welfare and General Charity
- Training Research and Education Fund
- UHW General Charity

The registration also encompasses Cardiff and Vale University Health Board (Expendable Funds) Common Investment Fund. This combines the funds of the Health Charity into one pool for investment purposes.

CONSTITUTION

Cardiff and Vale University Local Health Board holds charitable funds as sole corporate trustee and the board members of the Health Board are jointly responsible for the management of those charitable funds. The membership of the board was as follows at the time the annual report was approved.

OFFICER MEMBERS

Suzanne Rankin	Chief Executive
Ruth Walker	Executive Nurse Director until 31/05/2022
Jason Roberts	Executive Interim Nurse Director effective 23/02/2022
Caroline Bird	Interim Chief Operating Officer until 24/07/2022
Paul Bostock	Chief Operating Officer effective 22/08/2022
Abigail Harris	Executive Director of Strategic Planning
Catherine Phillips	Executive Director of Finance
Rachel Gidman	Executive Director of People & Culture
Dr Fiona Jenkins	Executive Director of Therapies and Health Science and also Interim Executive Director of Therapies and Health Science at Cwm Taf University Health Board. This is a dual role.
Fiona Kinghorn	Executive Director of Public Health
Professor Meriel Jenney	Executive Medical Director

OTHER DIRECTORS

James Quance	Interim Director of Corporate Governance effective 18/01/2023
Nicola Foreman	Director of Corporate Governance until 3/02/2023
David Thomas	Director of Digital and Health Intelligence

INDEPENDENT MEMBERS

Charles Janczewski	Chair
Ceri Phillips	Vice Chair
Michael Imperato	Independent Member - Legal
John Union	Independent Member - Finance
David Edwards	Independent Member - Information Communication & Technology
Professor Gary Baxter	Independent Member - University until 31/12/2022
Sara Moseley	Independent Member - Third (Voluntary Sector)
Councillor Susan Elsmore	Independent Member - Local Authority
Akmal Hanuk	Independent Member - Local Community
Rhian Thomas	Independent Member - Capital Estates
Mike Jones	Independent Member - Trade Union
Keith Harding	Independent Member - University effective 01/01/2023

ASSOCIATE MEMBERS

Sam Austin	Chair, stakeholder reference group
Lance Carver	Associate Member - Local Authority

CHARITABLE FUNDS COMMITTEE

The Committee is empowered with the responsibility to:

- ★ Control, manage and monitor the use of the funds resources for the public benefit, having regard for the guidance issued by the Charity Commission
- ★ Agree Governance arrangements for standards and monitoring
- ★ Review strategy to maximise benefits to the Health Charity
- ★ Determine the Health Charity's investment strategy
- ★ Agree expenditure plans
- ★ Determine fundraising objectives and strategy

The members of the committee who served during 2022/23 are listed below:

Akmal Hanuk	Committee Chair - Independent Member - Community
Mike Jones	Vice Chair of the Committee - Independent Member - Trade Union
Ruth Walker	Executive Nursing Director
Catherine Phillips	Executive Director of Finance
Rachel Gidman	Executive Director of People and Culture
Fiona Jenkins	Executive Director of Therapies and Health Science
Nicola Foreman	Director of Corporate Governance until 3/02/2023
James Quance	Interim Director of Governance effective 18/01/2023
Susan Elsmore	Independent Member - Local Authority
Sara Moseley	Independent Member - Third Sector
John Union	Independent Member - Finance

CHARITABLE FUNDS

Our Charity is made up of more than 300 different funds, each with a specific purpose whether for research, training or for a specific area of a hospital or department. All money received is allocated to these funds. The general purpose fund is used where the donor wishes the Charity to allocate money to support projects and activities most in need of support across the whole of the UHB. Each fund is managed by a specialist fund holder - generally a specialist in the particular field relevant to the fund. The Charity is responsible for providing guidance, financial information and advice to fund holders.

We manage three types of funds:

Unrestricted funds - these are general funds and are those funds that may be spent at the discretion of the Trustees to enhance the services across the UHB.

Restricted funds - these can only be spent in accordance with the restrictions imposed when the funds were donated, granted or raised by the Charity.

Endowment funds - where capital funds are made available to our Charity and the Trustees are legally required to invest or retain them. Where a permanent endowment exists, Trustees have no automatic power to spend the capital. If the fund is an expendable endowment, trustees have the power to convert capital to income.

The day to day administration of funds is undertaken by:

Charitable Fund Department, Cardiff and Vale University Health Board
2nd Floor, Woodland House,
Cardiff, CF14 4HH

INVESTMENT RISK MANAGEMENT

The Investment Management Company screen the investments prior to purchase for compliance with the ethical policy. In addition existing holdings are screened on a regular basis to ensure continued compliance. If the fund were to purchase a position in a holding which did not comply and was identified as part of the post purchase process, the investment would be subsequently sold.

The portfolio does not have investments in companies whose principal manufacturing activities are tobacco, alcohol, armaments and pornography/adult entertainment related. This includes common investment funds (and similar products) that incorporate these in their portfolio.

RESERVES POLICY

The strategy of the Corporate Trustee is to apply charitable funds within a reasonable time of receipt, ideally within one to two years, unless there are specific requirements attached to income. Historically, the level of expenditure has been generally approximated to the level of income, with greater than required reserves held to manage any fluctuations.

The current reserves policy states that the Charity should hold the following reserves:

- A separate fixed asset investment reserve, based on 10% of the value fixed asset investments (circa £550,000)
- A minimum of £500,000 to ensure that there is sufficient funds for on-going commitments

From a process point of view there is no individual fund that holds all the reserves, however the current level of reserves is considered more than adequate for current needs. Going forward the Charity will review the reserves policy to reflect any changes to the Charity's financial position.

INVESTMENT CONTRACT RISK

Cardiff & Vale Health Charity's Investment Managers are Rathbone Investment Management, which commenced on the 1st June 2021 for a period of three years with an option to extend for a further two years.

The Charity seeks to maximise the total return on funds while adopting a conservative policy on risk and flexible structure in respect of Asset Class Distribution. The portfolio is structured to enable a range of investments in order to yield a competitive rate of return. The investment director has delegated authority to purchase and sell investments as market opportunities arise. The Investment Managers formally attend and report to the Charitable funds Committee twice a year.

FINANCIAL CONTROL RISK

A financial control procedure, expenditure guideline, governance framework and strategy have been developed to ensure that there are sufficient management controls in place to:

- ★ Ensure that spending is in accordance with objects and priorities agreed by the Charitable Funds Committee
- ★ Ensure the criteria for spending charitable monies are fully met
- ★ Ensure that accounting records are maintained
- ★ Ensure devolved decision making is within specific parameters

Internal Audit also undertakes annual reviews to evaluate the adequacy of procedures and controls, to ensure compliance and to provide reasonable assurance over:

- ★ Achievement of management objectives for the systems
- ★ Economic and efficient use of resources
- ★ Compliance with policies and procedures
- ★ Safeguarding of assets

The Internal Audit reports are presented to both the Charitable Funds Committee and the Audit Committee, and this is a key measure in mitigating control risk.

ADVISORS

BANKERS

Government Banking Service
Southern House
7th Floor
Wellesley Grove
Croydon
CF9 1WW

INVESTMENT MANAGERS

Rathbone Brothers Plc
8 Finsbury Circus
London
EC2M 7A2

EXTERNAL AUDITORS

Auditor General for Wales
24 Cathedral Road
Cardiff
CF11 9LJ

INTERNAL AUDITORS

NWSSP Internal Audit Department
1st Floor, Woodland House
Cardiff
CF14 4HH

VAT ADVISORS

Ernst & Young LLP
The Paragon
Counterslip
Bristol
BS1 6BX

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD CHARITIES ACCOUNTS 2022/23

STATEMENT OF FINANCIAL ACTIVITIES FOR THE YEAR ENDED 31ST MARCH 2023

	Note	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	Total 2022-23 £000
Incoming resources from generated funds:					
Donations and Legacies	4	577	1,122	0	**1,699**
Other trading activities	5	0	363	0	**363**
Investments Income	6	92	48	1	**141**
Total incoming resources		669	1,533	1	2,203
Expenditure on :					
Raising funds	7	365	90	0	**455**
Charitable activities	8	845	1,115	24	**1,984**
Total expenditure		1,210	1,205	24	**2,439**
Net gains / (losses) on investments	14	**(323)**	**0**	**(2)**	**(325)**
Net income / (expenditure)		**(864)**	**328**	**(25)**	**(561)**
Transfer between funds		**(4)**	**4**	**0**	**0**
Net movement in funds		**(868)**	**332**	**(25)**	**(561)**
Gains / (losses) on revaluation of fixed assets	13	0	0	1,832	1,832
Reconciliation of Funds		**(868)**	**332**	**1,807**	**1,271**
Total Funds brought forward as at 1 April 2022 (Restated)	20	**4,340**	**2,127**	**2,521**	**8,988**
Total Funds carried forward as at 31 March 2023		3,472	2,459	4,328	10,259

The notes on page 34 to 50 form part of these accounts

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD CHARITIES ACCOUNTS 2022/23

STATEMENT OF FINANCIAL ACTIVITIES FOR THE YEAR ENDED 31ST MARCH 2023

Cardiff and Vale University Local Health Board Charities Accounts 2021/22

Statement of Financial Activities for the year ended 31st March 2022

	Note	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	Total 2021-22 £000
Incoming resources from generated funds:					
Donations and Legacies	4	425	854	0	1,279
Other trading activities	5	21	286	0	307
Investments Income	6	123	50	1	174
Total incoming resources		569	1,190	1	1,760
Expenditure on :					
Raising funds	7	371	85	0	456
Charitable activities	8	1,082	874	25	1,981
Total expenditure		1,453	959	25	2,437
Net gains / (losses) on investments	14	448	0	3	451
Net income / (expenditure)		(436)	231	(21)	(226)
Transfer between funds		5	(5)	0	0
Net movement in funds		(431)	226	(21)	(226)
Gains / (losses) on revaluation of fixed assets	13	0	0	67	67
Reconciliation of Funds		(431)	226	46	(159)
Total Funds brought forward as at 1 April 2021 (Restated)	20	4,755	1,914	2,478	9,147
Total Funds carried forward as at 31 March 2022 (Restated)		4,340	2,127	2,521	8,988

Cardiff and Vale University Local Health Board Charities Accounts 2022/23

Statement of Cash Flows for the year ending 31 March 2023

	Note	Total Funds 2022-23 £000	Total Funds 2021-22 £000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities	18	(486)	(731)
Cash flows from investing activities:			
Dividend, interest and rents from investments	6	141	174
Movement in Investment Cash	14	69	(11)
Proceeds from the sale of investments		3,611	1,923
Purchase of investments	14	(2,982)	(1,662)
Net cash provided by (used in) investing activities		839	424
Change in cash and cash equivalents in the reporting period		353	(307)
Cash and cash equivalents at the beginning of the reporting period	16	207	514
Cash and cash equivalents at the end of the reporting period	16	560	207

The notes on page 34 to 50 form part of these accounts

Cardiff and Vale University Local Health Board Charities Accounts 2022/23

Balance Sheet as at 31 March 2023

	Note	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total 31 March 2023 £000	Total 31 March 2022 (Restated) £000
Fixed assets:						
Tangible Assets	13	0	0	4,288	4,288	2,479
Investments	14	3,602	1,908	36	5,546	6,569
Total fixed assets		3,602	1,908	4,324	9,834	9,048
Current assets:						
Debtors	15	47	467	0	514	145
Cash and cash equivalents	16	326	230	4	560	207
Total current assets		373	697	4	1,074	352
Liabilities:						
Creditors: Amounts falling due within one ye	17	503	146	0	649	412
Net current assets / (liabilities)		(130)	551	4	425	(60)
Total net assets/ (liabilities)		3,472	2,459	4,328	10,259	8,988
The funds of the charity:						
Endowment Funds	20	0	0	40	40	42
Revaluation Reserve	20	0	0	4,288	4,288	2,479
Restricted income funds	20	0	2,459	0	2,459	2,127
Unrestricted income funds	20	3,472	0	0	3,472	4,340
Total funds		3,472	2,459	4,328	10,259	8,988
		0	0	0	0	

Director of Finance

Mrs Catherine Phillips

Date.....

Saunders,Nathan
06/11/2023 11:21:06

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

a) Basis of Preparation

The financial statements have been prepared under the historic cost convention, with the exception of tangible fixed assets and investments which have been included at a valuation.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

The accounts (financial statements) have been prepared to give a "true and fair" view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a "true and fair" view. This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern. In future years, the key risks to the Charity are a fall in income from donations or a fall in investment income but the Trustees have arrangements in place to mitigate those risks (see the Investment Risk Management and Reserves Policy sections of the annual report for more information).

The Charity meets the definition of a public benefit entity under FRS.

b) Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as:

- A restricted fund or
- An endowment fund

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose.

Endowment funds arise when the donor has expressly provided that the gift is to be invested and only the income of the fund may be spent. These funds are sub analysed between those where the trustees have the discretion to spend the capital (expendable) and those where there is no discretion to expend the capital (permanent endowment).

Those funds which are neither endowment nor restricted income fund, are unrestricted income funds which are sub analysed between designated (earmarked) funds where the trustees have set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors and unrestricted funds which are at the trustees' discretion, including the general fund which represents the charity's reserves.

c) Incoming resources

All incoming resources are recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet.

d) Income resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable.

Receipt is probable when:

- ★ Confirmation has been received from the representatives of the estate(s) that probate has been granted
- ★ The executors have established that there are sufficient assets in the estate to pay the legacy and
- ★ All conditions attached to the legacy have been fulfilled or are within the Charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated then the legacy is shown as a contingent asset until all of the conditions for income generation are met.

e) Income resources from endowment funds

The incoming resources received from the invested endowment fund are wholly restricted.

f) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably. Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

A constructive obligation arises when:

- We have communicated our intention to award a grant to a recipient who then has a reasonable expectation that they will receive a grant
- We have made a public announcement about a commitment which is specific enough for the recipient to have a reasonable expectation that they will receive a grant
- There is an established pattern of practice which indicates to the recipient that we will honour our commitment.

The Trustees have control over the amount and timing of grant payments and consequently where approval has been given by the trustees and any of the above criteria have been met then a liability is recognised. Grants are not usually awarded with conditions attached. However, when they are then those conditions have to be met before the liability is recognised.

Where an intention has not been communicated, then no expenditure is recognised but an appropriate designation is made in the appropriate fund. If a grant has been offered but there is uncertainty as to whether it will be accepted or whether conditions will be met then no liability is recognised but a contingent liability is disclosed.

g) Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include staff costs, costs of administration, internal and external audit costs. Support costs are apportioned on an average fund balance basis.

h) Fundraising costs

The costs of generating funds are those costs attributable to generating income for the charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the charity's objects. The costs of generating funds represent fundraising costs together with investment management fees. Fundraising costs include expenses for fundraising activities and a fee paid to a related party, the Health Board, under a fundraising agreement. The fee is used to pay the salaries and overhead costs of the Health Board's fundraising office.

i) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 8.

j) Debtors

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount.

k) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due. Cash equivalents are short term, highly liquid investments, usually in 90 day notice interest bearing savings accounts.

l) Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt. Amounts which are owed in more than a year are shown as long-term creditors.

m) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening carrying value (purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening carrying value (or purchase date if later).

n) Fixed assets

Investments are stated at market value at balance sheet date. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year. Tangible fixed assets are valued at current cost as follows:

i) The land and buildings in respect of Rookwood Hospital was revalued as at 1st April 2022, and the revaluation reflected the restriction to hospital use only. Where appropriate between valuations an appropriate index, supplied from the Welsh Government, is applied to revalue the asset.

ii) Assets in the course of construction are valued at current cost.

iii) Capitalisation threshold is £5,000.

iv) Movements in revaluation are recorded in the revaluation reserve on the balance sheet.

Professional valuations are carried out by the District Valuer Service every five years, which (as the commercial arm of the Valuation Office Agency) is part of HMRC. The valuations are carried out in accordance with Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Welsh Government and HM Treasury. Movements in revaluations are recognised in the Revaluation Reserve.

Depreciation

i) Depreciation is charged on each main class of tangible asset as follows: land and assets in the course of construction are not depreciated. Buildings, installations and fittings are depreciated on their revalued amount over the assessed remaining life of the asset as advised by the professional valuers;

ii) Impairments, where incurred in the year, are separately identified in note 13 and charged to the funds of the charity where caused by price fluctuations and to the Statement of Financial Activities for the year when the impairment was recognised.

iii) The estimated remaining life of the assets are split between engineering (15 years) and structure (45 years).

Donated assets are capitalised at their valuation on full replacement cost basis on receipt and are revalued and depreciated as described above.

2. PRIOR YEAR RESTATEMENT

To correctly state the classification of the Charity's unrestricted funds as at 31st March 2022, the following disclosures have been restated.

Statement of Financial Activities 2021/22	**£k**
Unrestricted funds brought forward increased by	16
Restricted funds brought forward decreased by	13
Endowment funds brought forward decreased by	3

Balance sheet 31st March 2022 restated	
Unrestricted funds brought forward increased by	16
Restricted funds brought forward decreased by	13
Endowment funds brought forward decreased by	3

3. RELATED PARTY TRANSACTIONS

Cardiff and Vale University Local Health Board is the Corporate Trustee of the Charity. During the year, other than noted below, there are no other material related party transactions involving the Corporate Trustee, board members or senior key management staff.

Board Members (and other senior staff) take decisions both on Charity and Exchequer matters but endeavour to keep the interests of each discrete and do not benefit personally from such decisions. Declarations of personal interest have been made and are available to be inspected by the public.

The Local Health Board has close links with Cardiff University which includes the sharing of staff as well as sharing accommodation on the University Hospital of Wales site.

The table below relates to the related party financial transactions for financial year 2022/23

Related Party	Income related party 2022/23 £000	Expenditure related party 2022/23 £000	Amounts owed to related party 2022/23 £000	Amounts due from related party 2022/23 £000
Cardiff Council	97	9	0	97
Welsh Government	0	0	0	0
University of South Wales	0	4	0	1
Swansea University	0	3	0	0
Cardiff Metropolitan University	0	2	0	0
Cardiff and Vale Health Board	23	1,084	352	23
Cardiff University	0	25	1	0

The table below includes the names of the individual board members and the relationship with the related party

Board Member	Related Party Relationship
Gary Baxter	Professor of Pharmacology of Cardiff University. British Heart Foundation research work
Ceri Phillips	Emeritus Professor, Swansea University; Honorary Professor, Cardiff University Independent Member, WHSSC
Charles Janczewski	Swansea University - Chair of Governance Board for Health & Wellbeing Academy
Susan Elsmore	Cabinet Member for Social Care, Health & Wellbeing Cardiff Council/Deputy Health & Social Care Spokesperson WLGA/Spokesperson for Migration WLGA & Chair Wales Strategic Migration Partnership/Member C&V Regional Partnership Board & Chair Ageing Well Partnership

Detailed below are the comparative figures for Financial Year 2021/22

Related Party	Income related party 2022/23 £000	Expenditure related party 2022/23 £000	Amounts owed to related party 2022/23 £000	Amounts due from related party 2022/23 £000
Cardiff Council	0	23	8	0
Welsh Government	0	0	0	0
University of South Wales	0	8	0	2
Cardiff and Vale Health Board	0	876	209	23
Cardiff University	0	24	0	0

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD CHARITIES ACCOUNTS 2022/23

4. INCOME FROM DONATIONS AND LEGACIES

	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total 2022-23 £000	Total 2020-21 £000
Donations	313	963	**0**	**1,276**	**1,145**
Legacies	**264**	**159**	**0**	423	**134**
	577	**1,122**	**0**	**1,699**	**1,279**

5. OTHER TRADING ACTIVITIES

	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total 2022-23 £000	Total 2021-22 £000
Staff lottery	**0**	283	**0**	283	**278**
Other trading	0	80	0	**80**	**29**
	0	**363**	**0**	**363**	**307**

6. GROSS INVESTMENT INCOME

6.Gross investment income	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total 2022-23 £000	Total 2021-22 £000
Fixed asset equity and similar investments.	**92**	**48**	**1**	**141**	**174**
Short Term Investments	**0**	**0**	**0**	**0**	**0**
Deposits and cash on deposit					
	92	**48**	**1**	141	**174**

7. ANALYSIS OF EXPENDITURE ON RAISING FUNDS

7. Analysis of expenditure on raising funds	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total 2022-23 £000	Total 2021-22 £000
Fundraising office	347	0	0	347	356
Fundraising events	0	80	0	80	79
Investment management fees	18	10	0	28	21
	365	**90**	**0**	**455**	**456**

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD CHARITIES ACCOUNTS 2022/23

8. ANALYSIS OF CHARITABLE ACTIVITY

	Activities taken £000	Support costs £000	Total 2022-23 £000	Total 2021-22 £000
Patient education and welfare	1,461	114	1,575	1,560
Staff education and welfare	330	26	356	344
Research	13	1	14	19
Other	4	12	16	34
Depreciation	23	0	23	24
	1,831	153	1,984	1,981

9. GRANTS

During 2022/23 £0.033m was approved by the Charitable Funds Committee.
During 2021/22 £0.033m was approved by the Charitable Funds Committee.

The table below provides the details of the grant payments.

Organisation	2022-23 £000	2021-22 £000
GLAMORGAN VOLUNTARY SERVICES	33	33
Total	**33**	**33**

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD CHARITIES ACCOUNTS 2022/23

10. ALLOCATION OF SUPPORT COSTS

	Raising funds £000	Charitable activities £000	Total 2022-23 £000	Total 2021-22 £000
Governance	**0**	**0**	**0**	**0**
Audit Wales	**0**	**40**	**40**	**20**
Internal Audit	**0**	**20**	**20**	**9**
Investment Management Fees	**28**	**0**	**28**	**21**
Total governance	**28**	**60**	88	**50**
Finance and administration	**0**	**95**	95	**94**
	28	**155**	183	**144**

The finance and administration is to a related party (Cardiff and Vale University Health Board) and this related to staff costs.

	Unrestricted funds £000	Restricted Income funds £000	Endowment funds £000	Total Funds 2022-23 £000
Raising funds	18	10	0	**28**
Charitable activities	102	52	1	**155**
	120	**62**	**1**	**183**

11. TRUSTEES' REMUNERATION, BENEFITS AND EXPENSES

The Charity does not make any payments for remuneration not to reimburse expenses to the charity trustees for their work undertaken as Trustee.

12. AUDITOR'S REMUNERATION

The external auditor's remuneration for 2022/2023 is £23,785 however there were additional audit fees of £16,686 relating to 2020/2021 included within 2022/2023 figures (2020/2021 £20.683 original). The fees relate to statutory annual report and accounts only.

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD CHARITIES ACCOUNTS 2022/23

13. TANGIBLE FIXED ASSETS

	Freehold Land and Buildings 2022-23 £000	Freehold Land and Buildings 2021/22 £000	
Cost or valuation			
Opening Balance	2,584	2,517	
Additions	0	0	
Revaluations	1,816	67	
Indexation	(89)		
Disposals	0	0	
Impairments	0	0	
Closing Balance	4,311	2,584	
Accumulated depreciation			
Opening Balance	105	81	
Disposals	0	0	
Revaluations	(105)	0	
Impairments	0	0	
Charge for year	23	24	
Closing Balance	23	105	
Opening NBV	2,479	2,436	
Closing NBV	4,288	2,479	1,809

Rookwood Hospital is the only Tangible Fixed Asset recognised in "Freehold Land and Buildings"

The LHBs Land and Buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

The LHB is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arm's length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

As part of the revaluation as at 1st of April the value of the LHB Estate increased by £1.809m of which: upward revaluations set against reserves were £1.971m, downward revaluations set against reserves were (£0.050m) and reversals of the accumulated depreciation of (£0.105m).

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD CHARITIES ACCOUNTS 2022/23

14. FIXED ASSET INVESTMENTS

Movement in fixed assets investments

	Investments Listed on Stock Exchange £000	Cash Held in Investment Portfolio £000	Total 2022-23 £000	Total 2021-22 £000
Market value brought forward	5,904	665	6,569	6,368
Add: additions to investments at cost	2,982	0	2,982	1,662
Less disposals at carrying value	(3,739)	0	(3,739)	(1,861)
Add any gain / (loss) on revaluation	0	(197)	(197)	389
Movement of cash held as part of the investment portfolio	0	(69)	(69)	11
Market value as at 31st March 2022	5,147	399	5,546	6,569

The loss on revaluation relates to the unrealised gain, however the overall loss of £325,000 (2021-22 £0.451m gain) as shown in the Statement of Financial Activities is calculated by also adjusting for realised gains of £0.127 (2021-20 £62,000). The movement of cash held as part of the investment portfolio includes a withdrawal of £700,000 from the investment portfolio.

As at 31st March 2023 the following investment was the largest percentage weighting (4.74%). Treasury 7/8% Green Gilt 31/07/2033

The Charity's investments are handled by investment advisors appointed by the Charity using the appropriate Health Board purchasing contract process. The Charity operates an investment policy that provides for a high degree of diversification of holdings within investment asset classes. A large proportion of investments are made with companies listed on a UK stock exchange or incorporated in the UK. The majority of expenditure is financed from donations and legacies and there are no borrowings, therefore the Charity is not exposed to significant liquidity risk. The Investment Management Company attends the Charitable Funds Committee twice a year to discuss all aspects of investment performance and the factors influencing the performance. The asset class allocation is an integral part of the discussion as this is intrinsically linked to minimising risk within the portfolio.

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD CHARITIES ACCOUNTS 2022/23

15. ANALYSIS OF CURRENT DEBTORS

Debtors under 1 year	Total 31 March 2023 £000	Total 31 March 2022 £000
Other debtors	133	2
Long-term prepayments	18	24
Short-term prepayments (one year)	52	23
Accrued income	311	96
Total debtors	514	145

16. CASH AT BANK AND IN HAND

	31 March 2023 £000	31 March 2022 £000
Cash at bank	560	207
	560	207

17. ANALYSIS OF LIABILITIES

	Total 31 March 2023 £000	Total 31 March 2022 £000
Creditors under 1 year		
Other creditors	624	389
Accruals	25	23
Total creditors	649	412

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD CHARITIES ACCOUNTS 2022/23

18. RECONCILIATION OF NET INCOME/EXPENDITURE TO NET CASH FLOW FROM OPERATING ACTIVITIES

	Total 2022-23 £000	Total 2021-22 £000
Net income / (expenditure) (per Statement of Financial Activities)	(561)	(226)
Adjustment for:		
Depreciation charges	23	24
(Gains) / losses on investments	325	(451)
Dividends, interest and rents from investments	(141)	(174)
(Increase) / decrease in debtors	(369)	(15)
Increase / (decrease) in creditors	237	111
Net cash provided by (used in) operating activities	(486)	(731)

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD CHARITIES ACCOUNTS 2022/23

19. ROLE OF VOLUNTEERS

Cardiff & Vale Health Charity continue to be extremely grateful to all the volunteers who support fundraising with so much energy, passion and skill. The Charity could not achieve all their objectives without the on-going commitment of the volunteers to make such a difference to patients, their families and colleagues.

The Charity has begun working more closely with the Health Board volunteers to develop and support more specific Charity Champion roles, including supporting our runners at organised events and supervising the charity collection tins. In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD CHARITIES ACCOUNTS 2022/23

20. ANALYSIS OF FUNDS

a) Analysis of endowment funds

	Balance 1 April 2,022 (Restated) £000	Income £000	Expenditure £000	Transfers £000	Gains and losses £000	Balance 31 March 2023 £000
Catherine Jenkins	42	1	(1)	0	(2)	40
	42	1	(1)	0	(2)	40

b) Analysis of restricted material fund movements

		Balance 1 April 2,022 (Restated) £000	Income £000	Expenditure £000	Transfers £000	Gains and losses £000	Balance 31 March 2023 £000
9447	Cystic Fibrosis Better Life Appeal Fund	376	25	(57)	0	0	344
9479	Phillips Legacy - Asthma Research	209	5	(6)	0	0	208
9149	Breastcare Unit - General Purpose	175	108	(84)	0	0	199
9478	May Legacy - Asthma Research	137	3	(8)	0	0	132
9582	Murphy Legacy (Morfa Day Unit - General Purpose)	79	2	(6)	0	0	75
9639	Childrens Telemetry Appeal (General Purpose)	95	2	(3)	0	0	94
9678	Staff Lottery	143	286	(322)	4	0	111
9726	Food Sense Wales	142	382	(269)	0	0	255
9725	ULHB Arts Programme	122	13	(122)	0	0	13
	Other	649	707	(328)	0	0	1,028
		2,127	1,533	(1,205)	4	0	2,459

c) Analysis of unrestricted and material designated fund movements

		Balance 1 April 2,022 (Restated) £000	Income £000	Expenditure £000	Transfers £000	Gains and losses £000	Balance 31 March 2023 £000
	Unrestricted Funds						
9809	Unrestricted Non Delegated	428	0	(603)	0	(323)	(498)
		428	0	(603)	0	(323)	(498)
	Designated Funds						
9649	Bale Covid Donation	263	6	(72)	0	0	197
9644	Hughes Legacy (Cardiology)	292	6	(34)	0	0	264
9600	UHW Nurses	302	48	(13)	0	0	337
9524	Leukaemia & Lymphona	137	8	(4)	0	0	141
9153	Geriatric Research (UHW)	127	2	(59)	0	0	70
9494	Biggs Legacy Cardiac Research	103	3	(3)	0	0	103
9659	Morgan Legacy Cardiac Research	102	2	(5)	0	0	99
9541	Cardiac Services General.	8	181	(3)	0	0	186
	Other	2,578	413	(414)	(4)	0	2,573
		3,912	669	(607)	(4)	0	3,970
	Total	4,340	669	(1,210)	(4)	(323)	3,472

d) Revaluation reserve

	Balance 1 April 2,022 £000	Income £000	Expenditure (Depreciation) £000	Transfers £000	Gains and losses £000	Balance 31 March 2023 £000
Rookwood	2,479	0	(23)	0	1,832	4,288
	2,479	0	(23)	0	1,832	4,288

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD CHARITIES ACCOUNTS 2022/23

ADDITIONAL NOTES

21. COMMITMENTS

	2022/23
	£000
The funds have the following commitments:	
Charitable projects	299
Total	**299**
Name of commitment	**£000**
Neurological Gardens Maintenance Cost(BT 20/07/013) (10 years)	94
Staff Recognition Awards (CFC 18/052) (4 Years)	5
Disposal of Rookwood (CTM 19/06/009) (1-4Years)	155
UHB Transport Solutions (CT/19/03/007) (1-3 years)	32
Forget Me Not Chorus (CFC 22/03/010) (1 Year)	5
Welsh Transplant Team (CFC 21/12/011) (1-5 years)	8
	299

	2021/22
	£000
The funds have the following commitments:	
Charitable projects	**620**
Total	**620**
Name of commitment	**£000**
Third Sector Grant Scheme (CFC 22/06/012) 1 year	**36**
Neurological Gardens (BT 20/07/013) (1-3 Years)	**192**
Neurological Gardens Maintenance Cost(BT 20/07/013) (1-3 Years)	**94**
Staff Recognition Awards (CFC 18/052) (4 Years)	**20**
Disposal of Rookwood (CTM 19/06/009) (1-4Years)	**155**
UHB Transport Solutions (CT/19/03/007) (1-3 years)	**70**
Forget Me Not Chorus (CFC 22/03/010) (1 Year)	**13**
Welsh Transplant Team (CFC 21/12/011) (1-5 years)	**40**
	620

22. DONATED ASSETS

During the year the Charity purchased assets to the value of £0.092m (2021/22 £0.061m). These are included in the Charity's Statement of Financial Activities and are classified as Donated Assets in the LHB Financial Statements.

23. POST BALANCE SHEET EVENTS

The financial statements are required to reflect the conditions applying at the end of the financial year. Therefore no adjustments are made for any changes in fair value of investments between 31 March 2023 and the date the financial statements are approved. The fair value of the investments held by the Charity at 31st March 2023 has changed in the intervening period as follows:

	31 March 2023 £000	xx January 2024 £000
Investment	5,546	

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD CHARITIES ACCOUNTS 2022/23

As Financial Trustee of the funds held on trust I am responsible for:

- ★ the maintenance of financial records appropriate to the activities of the fund (s).
- ★ the establishment and monitoring of a system of internal control.
- ★ the establishment of arrangements for the prevention of fraud and corruption.
- ★ the preparation of annual financial statements which give a true and fair view of the funds held on trust and the results of their operations.

..... 2024 ..... On behalf of Financial Trustee

Archwilio Cymru
Audit Wales

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Catherine Phillips
Director of Finance
Cardiff and Vale
University Health Board
Maes-Y-Coed Rd
Cardiff
CF14 4HH

Dear Catherine,

Charity Account: audit enquiries to management and those charged with governance

The Auditor General's Statement of Responsibilities sets out that he is responsible for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. It also sets out the respective responsibilities of auditors, management and those charged with governance.

This letter and the enclosed tables formally seek the documented consideration and understanding on a number of governance areas, which impact on our audit of the Health Board's Charity's financial statements.

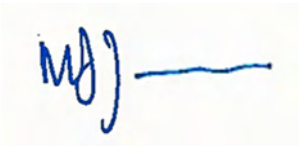
There is a section for management; a section for 'those charged with governance' (the Trustee Members); and a section with background information.

The responses will inform our understanding of the Charity and its business processes; and support our work in providing an audit opinion on your 2022-23 financial statements.

The completed tables should be formally considered and communicated to us, on behalf of both management and those charged with governance, by 20 October 2023.

I have copied this letter to Rob Mahoney, Helen Lawrence, and Aaron Fowler.

Yours sincerely,



Mark Jones
Audit Manager

Saunders.Nathan
06/11/2023 11:21:06

Enquiries of management

General enquiries (including financial reporting) of management	
Question	**Response**
1. Are there significant matters and/or events that have occurred since April 2022 that could influence our audit approach or the Charity's financial statements?	No
2. What are your general views on the Charity's risk assessment process relating to financial reporting?	The assessed risk that the financial statements are materially misstated due to fraud is extremely low.
3. Are you aware of significant transactions that are outside the normal trading activities of the Charity's business?	No

General enquiries (including financial reporting) of management	
Question	**Response**
4. Are you aware of any transactions, events or changes in circumstances that would cause impairments of non-the Charity's non-current assets?	No
5. Are you aware of any transactions, events and conditions (or changes in these) that may give rise to recognition or disclosure of significant accounting estimates that require significant judgement?	No
6. Does the Charity have any new estimates in respect of the 2022-23 year of account?	No
7. Have there been any issues that may impact the preparation of the 2022-23 financial statements?	No issues have arisen in relation to the preparation of the 22-23.

General enquiries (including financial reporting) of management	
Question	**Response**
8. Do you have knowledge of events or conditions beyond the period of the going concern assessment that may cast significant doubt on the Charity's ability to continue as a going concern?	There are no events or conditions which have arisen that may cast significant doubt on the Charities ability to continue as a going concern.
9. Are there any issues around the use of service organisations or common functions, including uncorrected misstatements from service organisations? This would include the NHS Wales Shared Services Partnership.	No
10. Please provide information on the status of any disclosed contingencies from the prior year.	N/A

Enquiries of management - in relation to fraud	
Question	**Response**
11. What is management's assessment of the risk that the financial statements may be materially misstated due to fraud? What is the nature, extent and frequency of management's assessment?	The assessed risk that the financial statements are materially misstated due to fraud is extremely low. Management are not aware of any fraud or potential fraud that would materially impact on the financial statements. This assessment is made on the basis of robust and comprehensive counter fraud and internal audit services. All potential fraud cases are rigorously investigated and pursued by the Health Board's counter fraud service. Internal Audit also regularly undertake a review of charitable funds and the main financial systems from which the financial statements are prepared, during which no concerns were raised in relation to fraud.
12. Do you have knowledge of any actual, suspected or alleged fraud affecting the Charity?	No

Enquiries of management - in relation to fraud	
Question	**Response**
13. What is management's process for identifying and responding to the risks of fraud in the Charity, including any specific risks of fraud that management has identified or that have been brought to its attention?	The Health Board charity has a year-end accounts closure process which includes a management review which aims to mitigate against the risks of any financial misstatements. The Health Board's internal auditors also annually review the core fundamental financial systems upon which the financial statements are based. The risks round fraud are mitigated by a robust and well-resourced counter fraud programme. All senior staff in the Finance Department must be professionally qualified accountants whose professional institutes have strong code of conducts and professional ethics. Any deliberate breach would be thoroughly investigated and have the appropriate professional and employment sanctions applied.

Enquiries of management - in relation to fraud	
Question	**Response**
14. What classes of transactions, account balances and disclosures, within the financial statements, have you identified as most at risk of fraud?	The assessed risk that the financial statements are materially misstated due to fraud is extremely low. All classes of transactions, account balances and disclosures, within the financial statements have been considered and robust processes put in place.
15. Are you aware of any whistleblowing or complaints by potential whistleblowers? If so, what has been the Charity's response?	No
16. What is management's communication to those charged with governance (the Trustee Members) regarding their processes for identifying and responding to risks of fraud?	Assurances are gained via the Charitable Funds Committee and other appropriate Board Committees where these issues are discussed.
17. What is management's communication to employees regarding their views on business practices and ethical behaviour?	All staff have access to the Standards of Behaviours Framework Policy via the Intra and Internet plus this is included upon recruitment and at induction. Consultant Medical and Dental Staff are reminded of the need to declare

Enquiries of management - in relation to fraud	
Question	**Response**
	interests etc, when completing their job plans. Board members/ are made aware of the policy on recruitment and are also prompted to complete a declaration on an annual basis. This requires them to confirm that they have read and understood the policy. ‘Declarations of Interest’ is also a standing item on the agenda of all Board and Committee meetings. In addition, the Standards of Behaviours Framework policy has been circulated across the Health Board via Internet, Intranet and Email communications. These communications have highlighted the need to comply with the policy at key times of the year, including Christmas, during key sporting events and at the start of the new financial year. This has been done to make sure that expectations of ethical governance and standards of conduct and behaviour are

Enquiries of management - in relation to fraud	
Question	**Response**
	being communicated to all professional staff and not only to Medical and Dental staff.
18. For the Charity's service organisations, have you reported any fraud or potential fraud to any affected parties?	No

Enquiries of management – in relation to laws and regulations	
Question	**Response**
19. What are the policies and procedures in place to identify applicable legal and regulatory requirements to ensure compliance?	Assurances are gained via the Charitable Funds Committee where these issues are discussed. The Charity has also issued detailed guidance as to what expenditure is appropriate to be funded from the charity and this has been subject to legal review.

Enquiries of management – in relation to laws and regulations	
Question	**Response**
20. Are you aware of any instances of non-compliance with laws or regulations? Has the Charity received any notice of any such known of possible instances of non-compliance?	Since its launch in 2005, the lottery has been required to register with the local authority as a Small Society Lottery. The Health Charity was advised during 2023 that as the annual income into the lottery had increased to and exceeded the threshold of £250,000 per annum, it could no longer be registered as a small society lottery but required a license from the UK Gambling Commission to run the lottery, without which it would be in breach of gambling licensing legislation. Cardiff Council have granted in the interim period a small society lottery registration whilst an application is made for a gaming license. The timeline for a gaming licence to be approved is approx. 16 weeks This matter has been shared and discussed in the Private Board of Trustees meeting held on 5 October 2023.
21. Have there been any examinations or inquiries performed by licensing, tax, or other authorities/regulators?	None

Enquiries of management – in relation to laws and regulations	
Question	**Response**
22. Has there been any significant communications with regulators?	There have been no significant communications with regulators during 22/23. However, a new application is in process with the Gambling Commission in relation to the Staff Lottery.
23. For the Charity's service organisations, have you reported any non-compliance with laws and regulations?	No

Enquiries of management in relation to related parties	
Question	**Response**
24. Have there been any changes to related parties from the prior year? If so, what is the identity of the related parties and the nature of those relationships?	None
25. What transactions have been entered into with related parties during the period? What is the purpose of these transactions?	The charity holds close links with C&V UHB including sharing of staff and accommodation, other related party transactions did take place but these were minimal. All transactions were carried out under the normal operations of the Health charity and listed in detail within the related party note.
26. What controls are in place to identify, account for and disclose related parties?	Staff are required to make declarations in accordance with the Standards of Behaviour Framework Policy, incorporating Gifts, Hospitality and Sponsorship. All Board members / Trustees are asked to make a declaration on an annual basis, which is then recorded and published in the Declarations of Board Members' Interests.

	Where a Board Member's interests change during the year, they have a personal responsibility to declare this and inform the Board Secretary.
27. What controls are in place to authorise and approve significant transactions and arrangements: • with related parties; and • outside the normal course of business?	All transactions with related parties and outside the normal course of business are reviewed based on the above-mentioned controls.

Enquiries of those charged with governance

Enquiries of those charged with governance	
Question	**Response**
28. Do you have any knowledge of actual, suspected, or alleged fraud affecting the entity?	No
29. What is your assessment of the risk of fraud within the entity, including those risks that are specific to the Charity's business sector?	The assessed risk that the financial statements are materially misstated due to fraud is extremely low. Management are not aware of any fraud or potential fraud that would materially impact on the financial statements. This assessment is made on the basis of robust and comprehensive counter fraud and internal audit services. All potential fraud cases are rigorously investigated and pursued by the Health Board's counter fraud service.

Enquiries of those charged with governance	
Question	**Response**
	Internal Audit undertake a regular review of charitable funds and the main financial systems from which the financial statements are prepared.
30. How do you exercise oversight of: • Management's processes for identifying and responding to the risk of fraud in the Charity; and • The controls to manage these risks?	The Health Board charity has a year-end accounts closure process which includes a management review which aims to mitigate against the risks of any financial misstatements. The Health Board's internal auditors also annually review the core fundamental financial systems upon which the financial statements are based. The risks round fraud are mitigated by a robust and well-resourced counter fraud programme. All senior staff in the Finance Department must be professionally qualified accountants whose professional institutes have strong code of conducts and professional ethics.

Enquiries of those charged with governance	
Question	**Response**
	Any deliberate breach would be thoroughly investigated and have the appropriate professional and employment sanctions applied.
31. Are you aware of any non-compliance with laws and regulations that may be expected to have a fundamental effect on the operations of the Charity?	An operating licence application is currently in process with the Gambling Commission to allow the staff lottery to operate in excess of £250k income. This will not impact the 22/23 accounts due to the issue of the temporary Small Society lottery licence. If the operating licence >£250 is not approved then the staff lottery income would need to be restricted in 24/25. There are currently no known factors which would prevent this from being granted.

Enquiries of those charged with governance	
Question	**Response**
32. Are you aware of any instances of non-compliance with relevant laws and regulations?	As above (point 31).
33. What is the process for identifying and responding to the risks of fraud?	The Health Board charity has a year-end accounts closure process which includes a management review which aims to mitigate against the risks of any financial misstatements. The Health Board's internal auditors also annually review the core fundamental financial systems upon which the financial statements are based. The risks round fraud are mitigated by a robust and well-resourced counter fraud programme. All senior staff in the Finance Department must be professionally qualified accountants whose professional institutes have strong code of conducts and professional ethics.

Enquiries of those charged with governance	
Question	**Response**
	Any deliberate breach would be thoroughly investigated and have the appropriate professional and employment sanctions applied.
34. Are there any matters which those charged with governance consider require particular attention during the audit?	No
35. Are there any other matters which those charged with governance consider may influence the audit of the financial statements?	No
36. Are those charged with governance aware of any significant communications with regulators?	No

Enquiries of those charged with governance	
Question	**Response**
37. What arrangements are in place to oversee the effectiveness of internal control?	Internal Audit undertake a regular review of charitable funds and the main financial systems from which the financial statements are prepared.

Background information

Matters in relation to fraud

International Standard for Auditing (UK) and Ireland) 240 covers auditors' responsibilities relating to fraud in an audit of financial statements.

The primary responsibility to prevent and detect fraud rests with both management, and 'those charged with governance', being the Trustee Members. Management, with the Trustee Members, should ensure there is a strong emphasis on fraud prevention and deterrence and create a culture of honest and ethical behaviour, reinforced by active oversight by the Members.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error. We are required to maintain professional scepticism throughout the audit, considering the potential for management override of controls.

What are we required to do?

As part of our risk assessment procedures, we are required to consider the risks of material misstatement due to fraud. This includes understanding the arrangements management has put in place in respect of fraud risks. The ISA views fraud as either:

- the intentional misappropriation of assets; or
- the intentional manipulation or misstatement of the financial statements.

We also need to understand how the Members exercise oversight of management's processes. We are also required to make enquiries of both management and the Members as to their knowledge of any actual, suspected, or alleged fraud and for identifying and responding to the risks of fraud and the internal controls established to mitigate them.

Matters in relation to laws and regulations

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the impact of laws and regulations in an audit of financial statements.

Management, with the oversight of those charged with governance, (the Trustee Members), is responsible for ensuring that the Fund's operations are conducted in accordance with laws and regulations, including compliance with those that determine the reported amounts and disclosures in the financial statements.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error, taking into account the appropriate legal and regulatory framework. The ISA distinguishes two different categories of laws and regulations:

- laws and regulations that have a direct effect on determining material amounts and disclosures in the financial statements; and
- other laws and regulations where compliance may be fundamental to the continuance of operations, or to avoid material penalties.

What are we required to do?

As part of our risk assessment procedures, we are required to make inquiries of management and the Members as to whether the Fund is in compliance with relevant laws and regulations. Where we become aware of information of non-compliance or suspected non-compliance, we need to gain an understanding of the non-compliance and the possible effect on the financial statements.

Matters in relation to related parties

International Standard for Auditing (UK and Ireland) 550 covers auditors' responsibilities relating to related party relationships and transactions.

The nature of related party relationships and transactions may, in some circumstances, give rise to higher risks of material misstatement of the financial statements than transactions with unrelated parties.

Because related parties are not independent of each other, many financial reporting frameworks establish specific accounting and disclosure requirements for related party relationships, transactions, and balances to enable users of the financial statements to understand their nature and actual or potential effects on the financial statements. An understanding of the Charity's related party relationships and transactions is relevant to the auditor's evaluation of whether one or more fraud risk factors are present as required by ISA (UK and Ireland) 240, because fraud may be more easily committed through related parties.

What are we required to do?

As part of our risk assessment procedures, we are required to perform audit procedures to identify, assess and respond to the risks of material misstatement arising from the Charity's failure to appropriately account for or disclose related party relationships, transactions or balances in accordance with the requirements of the framework.