

# Audit and Assurance Committee Meeting

Tue 05 July 2022, 09:00 - 12:30

## Agenda

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### 1. Welcome and Introductions

*John Union*

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### 2. Apologies for Absence

*John Union*

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### 3. Declarations of Interest

*John Union*

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### 4. Minutes of the Committee meetings held on 12 May 2022 and 14 June 2022

*John Union*

-  04 Draft Public Audit Minutes -12.5.22 IV MD NF. JU.pdf (7 pages)
  -  04 Draft Special Public Audit Minutes - June MD.NF. JU.pdf (11 pages)
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### 5. Action log following meetings held on 14 June 2022

*John Union*

-  05 Draft Public Action Log - June MD.pdf (3 pages)
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### 6. Any other urgent business: To agree any additional items of urgent business that may need to be considered during the meeting



*John Union*

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### 7. Items for Review and Assurance

#### 7.1. Internal Audit Progress Report

*Ian Virgil*

-  7.1 Internal Audit Progress Report Cover.pdf (3 pages)
-  7.1a Internal Audit Progress Report.pdf (18 pages)

#### 7.2. Temporary Staffing Department (Nurse Bank) Internal Audit Report Update

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*Rachel Gidman / Jonathan Pritchard*

- 📄 7.2 Temporary Staffing Department (Nurse Bank) Internal Audit Report.pdf (2 pages)
- 📄 7.2a Nurse Bank Updated Report Cover.pdf (2 pages)
- 📄 7.2b Nurse Bank\_Final Internal Audit Report (Inc. Mgt. Responses).pdf (20 pages)

### **7.3. IT Service Management Update (Verbal)**

*David Thomas*

### **7.4. Audit Wales Update**

*Wales Audit*

Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response

- 📄 7.4 Audit Wales - Review of Quality Governance Arrangements - C&VUHB (Final).pdf (30 pages)
- 📄 7.4(a) Review of Quality Governance Arrangements - CVUHB Management Response 27.06.2022 - FINAL.pdf (17 pages)

### **7.5. Ultrasound Clinical Governance Position**

*Fiona Jenkins / Paul Rogers*

- 📄 7.5 USCGG - Exec Summary.pdf (3 pages)
- 📄 7.5a US Clinical Governance-USCGG-ToRs.pdf (13 pages)
- 📄 7.5b Ultrasound Governance (CDT CB).pdf (16 pages)

### **7.6. Declarations of Interest, Gifts and Hospitality Report**

*Nicola Foreman*

- 📄 7.6 Declarations of Interest Gifts and Hospitality Tracking Report July 2022.pdf (4 pages)
- 📄 7.6 - Declarations of Interest Apr 20 to Present.pdf (4 pages)

### **7.7. Internal Audit Tracking Report**

*Nicola Foreman*

- 📄 7.7 - Internal Audit Tracking Report July 2022.pdf (4 pages)
- 📄 7.7(a) Appendix 1 - Internal Audit Tracker July 2022.pdf (14 pages)
- 📄 7.7b Appendix 2 - Internal Audit Summary Tables - July 2022.pdf (3 pages)

### **7.8. Audit Wales Tracking Report**

*Nicola Foreman*

- 📄 7.8 - Audit Wales Recommendation Tracker July 2022.pdf (3 pages)
- 📄 7.8b - Audit Wales Recommendation Tracker - Recommendation Table (July 2022).pdf (1 pages)
- 📄 7.8c - Audit Wales Tracker.pdf (4 pages)

### **7.9. Regulatory Tracking Report**

- 📄 7.9 Regulatory Compliance Tracking Report July 2022.pdf (5 pages)
- 📄 7.9(a) Regulatory Tracker - July 2022.pdf (2 pages)

### **7.10. Review Risk Management**

*Nicola Foreman*

- 📄 7.10 - Risk Management Review.pdf (3 pages)

### **7.11. Procurement Compliance Report - Single Tender Actions**

*Catherine Phillips*

- 📄 7.11 Procurement Compliance Report - Single Tender Actions.pdf (6 pages)

### **7.12. Counter Fraud Progress Report**

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*Catherine Phillips / Gareth Lavington*




-  7.12 Counter Fraud Progress Report Cover Paper.pdf (2 pages)
-  7.12a Counter Fraud Progress Report.pdf (12 pages)
-  7.12a(i) - Fraud Alert - Mandate Fraud.pdf (1 pages)
-  7.12a(ii) - Fraud Alert - Telephone Scam.pdf (1 pages)
-  7.12a(iii) - Fraud Alert - ESR Phishing Email.pdf (1 pages)
-  7.12a(iv) - Fraud Alert - Counter Fraud Newsletter.pdf (2 pages)

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## **8. Items for Approval / Ratification**

### **8.1. Draft Management of Policies, Procedures and Other Written Control Documents Policy**

*Nicola Foreman*

-  8.1 Controlled Documents Policy\_Report.pdf (2 pages)
-  8.1a UHB 001 POLICY ver 6\_draft\_TD.pdf (3 pages)
-  8.1b UHB 242 PROCEDURE v3\_draft\_AF.pdf (28 pages)

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## **9. Items for Information and Noting**


### **9.1. Internal Audit reports for information:**

*Ian Virgil*


#### **9.1.1. Recovery of services and Delivery of the Annual Plan 2021 – 2022 Final Report – Substantial Assurance**

-  9.1a Delivery of Annual Plan and Recovery.pdf (12 pages)

#### **9.1.2. Risk Management Final Internal Audit Report – Reasonable assurance**

-  9.1b Risk Management Report.pdf (13 pages)

#### **9.1.3. Performance Reporting (Data Quality) Final Report – Reasonable Assurance**

-  9.1c Performance Reporting (Data Quality).pdf (15 pages)

#### **9.1.4. ChemoCare IT System Final Report – Limited Assurance**

-  9.1d Chemo Care System Final Report.pdf (23 pages)

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## **10. Agenda for Private Audit and Assurance Committee**

*John Union*

- i. Counter Fraud Progress Report (Verbal)
- ii. Workforce and Organisational Development Compliance Report

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## **11. Any Other Business**

*John Union*

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## **12. Review and Final Closure**

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## **12.1. Items to be deferred to Board / Committee**

*John Union*

## **12.2. To note the date, time and venue of the next Committee meeting:**

Tuesday 6 September 2022 at 9am via MS Teams

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## **13. Declaration**

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].

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**Draft Minutes of the Public Audit & Assurance Meeting  
Held On 12 May 2022 at 09:00  
Via MS Teams**

<b>Chair:</b>		
John Union	JU	Independent Member for Finance
<b>Present:</b>		
Mike Jones	MJ	Independent Member for Trade Union
Ceri Phillips	CP	UHB Vice Chair
David Edwards	DE	Independent Member for ICT and Committee Vice Chair
<b>In Attendance:</b>		
Nicola Foreman	NF	Director of Corporate Governance
Catherine Phillips	CP	Executive Director of Finance
Ian Virgil	IV	Head of Internal Audit
Wendy Wright	WW	Deputy Head of Internal Audit
Sian Harries	SH	IM&T Audit Manager
Mark Jones	MJ	Audit Wales
Robert Mahoney	RM	Interim Deputy Director of Finance (Operational)
David Thomas	DT	Director of Digital & Health Intelligence
Gareth Lavington	GL	Lead Local Counter Fraud Specialist
Andrew Crook	AC	Head of People Assurance & Experience
<b>Secretariat</b>		
Sarah Mohamed	SM	Corporate Governance Officer
Nathan Saunders	NS	Senior Corporate Governance Officer
<b>Apologies:</b>		
Rachel Gidman	RG	Executive Director of People & Culture
Charles Janczewski	CJ	UHB Chair
Darren Griffiths	DG	Audit Wales

Item No	Agenda Item	Action
<b>AAC 12/05/001</b>	<b>Welcome &amp; Introduction</b>  The Committee Chair (CC) welcomed everyone to the meeting.	
<b>AAC 12/05/002</b>	<b>Apologies for Absence</b>  <b>The Committee resolved that:</b>  a) Apologies were noted.	
<b>AAC 12/05/003</b>	<b>Declarations of Interest</b>  <b>The Committee resolved that:</b>  a) No Declarations of Interest were noted.	
<b>AAC 12/05/004</b>	<b>Minutes of the meeting held on 5<sup>th</sup> April 2022</b>  <b>The Committee resolved that:</b>  a) The draft minutes of the meeting held on 5 <sup>th</sup> April 2022 were held as a true and accurate record of the meeting.	

<p><b>AAC 12/05/005</b></p>	<p><b>Action Log - following meeting held on 5<sup>th</sup> April 2022</b></p> <p>The Head of Internal Audit (HIA) commented that AAC 22/5/4/018 was still in progress and would be reported at a later committee meeting.</p> <p><b>The Committee resolved that:</b></p> <p>a) Subject to the above amendment, the Action Log was up to date.</p>	<p><b>Action log</b></p>
<p><b>AAC 12/05/006</b></p>	<p><b>Any other urgent business:</b> To agree any additional items of urgent business that may need to be considered during the meeting</p> <p><b>The Committee resolved that:</b></p> <p>a) No other urgent business was noted.</p>	
<p><b>Items for Review and Assurance</b></p>		
<p><b>AAC 12/05/007</b></p>	<p><b>Compliance with the Corporate Governance Code</b></p> <p>The Director of Corporate Governance (DCG) stated that it showed the Health Boards (HBs) compliance with the UK Corporate Governance Code.</p> <p>The DCG added that there were some areas where the HB did not need to comply due to the level and status of the corporate governance, however, where the HB did not feel that they were compliant they would need to explain this.</p> <p>It was completed annually as a self-assessment and fed into the annual report through the annual governance statement.</p> <p><b>The Committee resolved that:</b></p> <p>a) The assessment of compliance against the UK Code of Corporate Governance for April 2021-March 2022 was noted.</p> <p>b) The self-assessment of compliance against the UK Code of Corporate Governance for inclusion in the Accountability Report for 2021-2022 was approved.</p>	
<p><b>AAC 12/05/008</b></p>	<p><b>Board and Committee Effectiveness Surveys 2021-22</b></p> <p>The DCG stated that it was a requirement of the standing orders to undertake an effectiveness review of all the committees of the Board.</p> <p>It was completed through a monkey survey and it was noted that a different tool may be used next year.</p>	

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	<p>The individual results of the committees and the Board were included. An action plan which provided areas that required improvement was also included.</p> <p>It was noted that this year the survey was broadened to committee members and also attendees to increase response rates.</p> <p>The DCG added that the HB would be looking at its strategic objectives and aligning those with the strategic objectives of the committees of the Board. Therefore, the structure of the committees could change over the next 12 months.</p> <p><b>The Committee resolved that:</b></p> <ol style="list-style-type: none"> <li>a) The results of the Annual Board Effectiveness Survey 2021-2022, and the action plan for 2021-2022, to be progressed via Board Development sessions were noted.</li> <li>b) The completed actions within the Board Committee Effectiveness Action plan 2020-2021 were noted.</li> <li>c) The results of the Annual RATS Committee Effectiveness Survey 2021-2022, and the action plan for 2021-2022 attached as Appendix 1, to be progressed via Board Development sessions were noted.</li> </ol>	
<p><b>AAC 12/05/009</b></p>	<p><b>Counter Fraud Progress Report (Verbal)</b></p> <p>The Lead Local Counter Fraud Specialist (LLCFS) advised the Committee on the following:</p> <ul style="list-style-type: none"> <li>• Most of the activity taken place had been in relation to building the infrastructure that was required.</li> <li>• This included creating infrastructure for awareness, education and reporting routes.</li> </ul> <p><b>The Committee resolved that:</b></p> <ol style="list-style-type: none"> <li>a) The Counter Fraud Progress Report Verbal Update was noted.</li> </ol>	
<p><b>AAC 12/05/010</b></p>	<p><b>Internal Audit Progress Report</b></p> <p>The HIA presented the Internal Audit Progress Report (the Report) and highlighted the following –</p> <ul style="list-style-type: none"> <li>• There were two limited assurance reports. One was with the Executive Director of People and Culture and the other was with the Director of Digital &amp; Health Intelligence.</li> <li>• Section 2 highlighted that 4 audits were planned to be delivered for this committee. Two were at the draft stage. Outcomes of those reports would feed into the Head of Internal Audits opinion. Details of the report would be brought to the July committee meeting.</li> </ul>	<p><b>IV</b></p>

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- Section 3 highlighted that 8 reports had been finalised. Four received substantial assurance, two received reasonable assurance and two received limited assurance.
- Summaries were included in section 6 of the report.
- Section 4 highlighted the delivery of the 2021/22 plan. 24 final audits have been delivered. A further 2 were in draft and 5 were in progress.

It was noted that a piece of work to validate actions recorded as complete within the tracker had started. They were waiting on responses from management to confirm the position. The outcome would feed into the Head of Internal Audit opinion at the June meeting but the outcome would go to the July meeting.

The CC queried how the sample was decided.

The HIA responded that Internal Audit looked at all the actions recorded as complete and took a sample from those which were a high and medium priority.

It was noted that section 6 detailed the executive summaries of the 8 final reports. The full reports were under section 9 of the papers. The first four reports were substantial assurance.

The HIA presented the Development of Genomics Partnership Wales report and highlighted the following:

- A reasonable assurance was given - This reflects that there were robust project teams operating and appropriate engagement with stakeholders and users.
- The key matters arising related to:  
A need for improved contractual management arrangements at all stages of the project; and  
Weaknesses in the approvals process in relation to the accelerated approach.

An action plan had been agreed to allow management to address the issues.

The Deputy Head of Internal Audit (DHIA) presented the Nurse Rostering: Children's Hospital for Wales report and highlighted the following;

- It was completed in readiness to allow transition across to the new HB rostering system.
- Reasonable assurance was provided.
- The health roster project team had confirmed that the new system would address issues identified and gave a demonstration of controls.
- Management had accepted the recommendation and the HB would be one of the earlier adopters of the new roster system.

The DHIA presented the Nurse Bank report and highlighted the following:

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- A number of issues were encountered.
- Management agreed with the findings.
- High priority issues were identified. Most which related to the structure of the temporary staffing department and how they could best support the nurse bank and how the HB could make the best use of agencies to support them.
- The health roster would also have an impact on the temporary staffing department.

The Head of People Assurance and Experience (HPAE) stated that the service was inherited from corporate nursing. The plan was to work through all the action points and come back with a detailed report to ensure the bank works to full effect.

Mark Jones (MJ) from Audit Wales commented that Audit Wales did not always take assurance from Internal Audit however, they would need to speak to the HIA to understand the report in relation to auditing the accounts.

The CC queried how this would be reported back to the committee.

MJ responded that unless there was a material issue, it could be picked up in their meeting on 14<sup>th</sup> June.

The IM&T Audit Manager presented the NIS Directive and highlighted the following:

- They had reviewed the implementation of the network and information system directive. It was a core piece of legislation related to cyber security with the intention to increase the levels of security and resilience to key systems.
- The review found that an appropriate plan was in place to complete the cyber assessment.
- Concluded limited assurance.
- Management immediately dealt with the high priority recommendation.

The Independent Member for ICT (IMI) queried the audit process. The IMI stated he was concerned of the high priority recommendation where a section had been missed in the final assessment which carried through to the audit report and now the meeting.

The HIA responded that initial findings were discussed with management. However, the reports needed to reflect the situation at the time of completing the audit.

The Director of Digital & Health Intelligence (DDHI) highlighted the following:

**EDPC**

	<ul style="list-style-type: none"> <li>• Action 1 had been taken on board and accepted the 600 questions posed by the cyber resilience unit. Need to have a mechanism to maintain it.</li> <li>• There was an oversight on one of the questions. This had been completed.</li> <li>• They were now actively recruiting a dedicated cyber team.</li> <li>• The risk register had been updated and reflected the NIS situation.</li> <li>• A detailed response on NIS and the cyber element would be discussed in the private part of the Digital committee meeting in June.</li> </ul> <p>The HIA stated that the meeting papers included the advisory work on the mental health arrangements which came to the last audit meeting. It did not include the management responses. It was noted that the responses were included under section 9.1.</p> <p>The DCG stated that she wanted to make sure the tracker included the advisory report recommendations and noted that it had also gone to the Mental Health committee.</p> <p><b>The Committee resolved that:</b></p> <p>a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports were considered.</p>	
<b>Items for Approval / Ratification</b>		
<p><b>AAC 12/05/011</b></p>	<p><b>Counter Fraud Annual Plan</b></p> <p>The LLCFS presented the Counter Fraud Annual Plan and highlighted the following:</p> <ul style="list-style-type: none"> <li>• Proposed work for 2022/23.</li> <li>• It looked slightly different from previous years. This was due to changes in the NHS counter fraud authorities' standards. They were mandatory from next year onwards.</li> <li>• 12 requirements needed to be worked to.</li> <li>• It measured 3 levels of compliance – green, red and amber.</li> <li>• The HB should be able to achieve green ratings in the upcoming year.</li> <li>• The annual plan is expected to be flexible and broad.</li> </ul> <p><b>The Committee resolved that:</b></p> <p>a) The Counter Fraud Annual Plan 2022 – 2023 was discussed and approved.</p>	
<p><b>AAC 12/05/012</b></p>	<p><b>The Counter Fraud Annual Report 2021/22</b></p> <p>It was noted that the main part of the report formed the summary of compliance.</p>	

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	<p>The HB was listed as green in all areas but improvements needed to be made in fraud awareness, education and reporting routes.</p> <p>The Executive Director of Finance (EDF) stated it was a progress report and it had been reviewed by the team.</p> <p><b>The Committee resolved that:</b></p> <p>a) The report as an accurate assessment of the work undertaken during the year and a measure of compliance with the standards set out by the NHS CFA was discussed and approved.</p>	
<b>Items for Information and Noting</b>		
<b>AAC 12/05/013</b>	<ul style="list-style-type: none"> <li>i) COVID-19 Vaccination Programme - Phase 3 delivery Final Report (Substantial Assurance)</li> <li>ii) Health &amp; Safety Final Report (Substantial Assurance)</li> <li>iii) Wellbeing Hub at Maelfa Final Report (Reasonable Assurance)</li> <li>iv) Development of Genomics Partnership Wales Final Report (Reasonable Assurance)</li> <li>v) Network and Information Systems (NIS) Directive Final Report (Limited Assurance)</li> <li>vi) Welsh Risk Pool Claims (Substantial Assurance)</li> <li>vii) Nurse Rostering: Children's Hospital for Wales, Children and Women's CB (Reasonable Assurance)</li> <li>viii) Nurse Bank (Limited Assurance). Otherwise Approved.</li> <li>ix) Delivery of Mental Health Services – Advisory Report</li> </ul>	
	<p><b>Any Other Business</b></p> <p>No other business was discussed.</p>	
<b>Review and Final Closure</b>		
<b>AAC 12/05/014</b>	<p><b>Items to be deferred to Board / Committee</b></p> <p>Nothing further was added.</p>	
	<p><b>Date &amp; time of next Meeting</b></p> <p>To note date, time and venue of the next Committee meeting:</p> <p><b>Tuesday 14th June 2022 (Special Meeting) at 9am</b></p>	

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**Draft Minutes of the Special Audit and Assurance Committee Public Meeting  
Held on Tuesday 14th June 2022 at 9.30am  
Via MS Teams**

<b>Chair:</b>		
John Union	JU	Independent Member for Finance
<b>Present:</b>		
Mike Jones	MJ	Independent Member for Trade Union
Ceri Phillips	CP	UHB Vice Chair
David Edwards	DE	Independent Member for ICT and Committee Vice Chair
<b>In Attendance:</b>		
Nicola Foreman	NF	Director of Corporate Governance
Catherine Phillips	CP	Executive Director of Finance
Ian Virgil	IV	Head of Internal Audit
Wendy Wright	WW	Deputy Head of Internal Audit
Mark Jones	MJ	Audit Wales
Marcia Donovan	MD	Head of Corporate Governance
Robert Mahoney	RM	Interim Deputy Director of Finance
Rachel Pressley	RP	Workforce Governance Manager
Helen Lawrence	HL	Head of Financial Accounts and Services
Timothy Davies	TD	Head of Corporate Business
<b>Observers:</b>		
Natalie Painter	NP	Audit Wales Graduate Trainee
<b>Secretariat</b>		
Sarah Mohamed	SM	Corporate Governance Officer
<b>Apologies:</b>		
Rachel Gidman	RG	Executive Director of People & Culture
Suzanne Rankin	SR	Chief Executive Officer
Meriel Jenney	MJ	Executive Medical Director
Charles Janczewski	CJ	UHB Chair

Item No	Agenda Item	Action
<b>AAC 14/6/22 001</b>	<b>Welcome &amp; Introduction</b>  The Committee Chair (CC) welcomed everyone to the meeting.	
<b>AAC 14/6/22 002</b>	<b>Apologies for Absence</b>  <b>The Committee resolved that:</b>  a) Apologies were noted.	
<b>AAC 14/6/22 003</b>	<b>Declarations of Interest</b>  <b>The Committee resolved that:</b>	

	a) No Declarations of Interest were noted.	
<b>AAC 14/6/22 004</b>	<p><b>Any other urgent business</b></p> <p>The CC thanked the Finance and Corporate Governance teams for getting the papers ready in time for the meeting.</p>	
	<b>Items for Approval / Ratification</b>	
<b>AAC 14/6/22 005</b>	<p><b>Report of the Losses and Special Payment Panel</b></p> <p>The Interim Deputy Director of Finance (IDDF) presented the Report of the Losses and Special Payment Panel paper and advised the Committee on the following:</p> <ul style="list-style-type: none"> <li>• The Losses and Special Payments Panel last met on 10th May 2022 to consider the 6-month period from 1st October 2021 to 31st March 2022.</li> <li>• The report informed the Audit and Assurance Committee of the items considered at this meeting and the recommendations made for formal Audit and Assurance Committee approval.</li> <li>• The minutes of the 10th May Panel were previously discussed in the Private session of the Audit Committee on held earlier on 14 June 2022.</li> <li>• The figures have been approved by the Losses and Special Payment Panel and have now been incorporated into the Annual Accounts.</li> </ul> <p><b>The Committee resolved that:</b></p> <p>a) The write offs outlined in the Key Issues Section of the report were approved.</p>	
<b>AAC 14/6/22 006</b>	<p><b>Introduction to Annual Report and Accounts 2021-22</b></p> <p>The Head of Financial Accounts and Services (HFAS) presented the Introduction to the Annual Report and Accounts 2021-22 and advised the Committee on the following:</p> <ul style="list-style-type: none"> <li>• The report set out the key changes identified between the draft and final version of the draft Annual Report.</li> <li>• In accordance with the agreed deadlines, the 2021/22 Draft Annual Accounts, Draft Performance Report and Draft Accountability Report were completed and forwarded to the Welsh Government and Audit Wales.</li> </ul>	

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- With regards to its role in providing advice to the Board, the Audit and Assurance Committee, in accordance with its Terms of Reference, had responsibility to specifically comment upon the accounting policies, the Accounts, the Annual Report of the organisation and the Letter of Representation. The Audit and Assurance Committee also has a key role in reviewing the ISA 260 report from Audit Wales.
- The Annual Report contains the Annual Accounts and the Remuneration Report which were the key financial statements.
- The Draft Performance Report, Draft Accountability Report, Draft Annual Accounts and associated documents were reviewed in detail by the Audit and Assurance Committee at its workshop held on 12th May 2022.
- Assurance on the accuracy of the Annual Report and Accounts could be taken by:
  - The programme of work and review that the Audit and Assurance Committee had undertaken throughout 2021/22 and the process it followed to verify and sign off the Annual Report and Accounts.
  - The work completed by Audit Wales and presented to the Audit and Assurance Committee in their ISA 260 Report;
  - The response given to the Audit Enquiries to those Charged with Governance and Management and the Letter of Representation that would be sent to Audit Wales.
  - Assurance could also be taken from the programme of work undertaken by the Audit and Assurance Committee, the work completed by Audit Wales, the response given to the Audit Enquiries with those Charged with Governance and the Letter of Representation sent to Audit Wales.
  - Assurance could also be taken from the work carried out by Internal Audit, Counter Fraud and the opinion issued by the Head of Internal Audit.
- This year attention was drawn to the ISA260 Report regarding the regularity opinion qualification. The financial statements included a provision (and corresponding expenditure) of £2.193 million. That related to the Health Board's estimated liability arising from a Ministerial Direction in 2019. The Direction instructed payments to be made to Clinical staff, if claimed,

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to restore the value of their pension benefits packages.

- For NHS Clinicians who opted to claim the financial offer to settle their annual allowance tax charges arising from their 2019-20 NHS pension savings, their NHS employers would meet the impact of those personal tax-charges on their pension when they retire.
- Claims that were submitted by the deadline of 31 March 2022 were accounted for as expenditure within the 2021-22 Financial Statements. That expenditure was irregular and material by its nature.
- An unqualified Audit opinion was given on the 2021-22 Financial Statements, with the exception of the above-mentioned regularity opinion.

#### Changes to the Draft Annual Report and Accounts

- Audit Wales had reviewed the Draft Performance Report and Draft Accountability Report and provided feedback on a number of minor narrative changes which were incorporated within the Annual Report.
- The Accountability Report had also been amended to include the Head of Internal Audit Opinion where reasonable assurance had been provided.
- There were small number of changes made to the Draft Accounts. Those however, did not impact on the reported financial performance of the Health Board and the £232,000 surplus remained against the revenue resource limit. Those amendments were mentioned on pages 2 and 3 of the Committee papers and include:
  - £17.685m PFI disclosure had been added to PFI note 25.2. That referenced note 11 and the capital value included within the PFI scheme. It was a disclosure adjustment because the PFI was correctly included within the body of the draft accounts.
  - Within note 18 there was a £9.48m reclassification of capital creditors that was previously misclassified within the revenue creditors.
  - Within note 22 the capital commitment disclosure was reduced. It was purely a disclosure adjustment and capital adjustment expenditure occurred was correctly reflected within the drafts account.

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- Within note 3.3 it was identified that the depreciation charges were understated by £349,000. As depreciation was funded by Welsh Government (WG), the revenue resource limit was reviewed and increased by £349,000 in line with the increased expenditure. The revenue resource performance had been updated to reflect that. As a result of the increased expenditure allocated by WG there were no changes to the bottom line.
- Staff note 9.6.1 showed that disclosure amendments were made adjusting the pay banding for the Chief Executive Officer and the highest paid Director. Salaries were correctly included in the accounts and note 9 was amended to be consistent with the Remuneration Report.
- Two amendments were made to note 30. Welsh Wound Centre amounts owed to related party were increased by £2k. Cardiff Council expenditure to related party was decreased by £3.412m. They were correctly included in the accounts but not the disclosure notes.
- In comparison to previous audits, the adjustments were small.
- The following adjustments were made to the Remuneration Report. Firstly, the pay bands for three senior officers were amended to a different pay band.
- A column had been added to the remuneration table to disclose the full-year-equivalent salaries of the senior officers.

The CC queried how many Health Boards would have had the same qualification.

The HFAS replied that it would have been consistent across all the Health Boards. Clinicians who had applied for the payment would have had the comparable regularity qualification.

Mark Jones (MJ) responded it was all Welsh Health Bodies except 3 (Health Education and Improvement Wales (HEIW), Welsh Ambulance Service Trust (WAST) and Digital Health and Care Wales). They either did not have senior Clinicians or did not put in any claims.

The HFAS stated the changes made to the Draft Accounts and Remuneration Report were set out in Appendix 4 of the ISA 260 Report.

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### Uncorrected misstatements

There was only one non-trivial uncorrected misstatement which related to land and building assets. The District Valuer (DV) had issued its indexation reports on an all-Wales basis, and supplied its 2021-22 report in August 2021. It stated that building asset values should be updated by 5% for 2021-22. However that was further updated in March 2022 by the DV to 7%.

It was noted that following Welsh Government discussions and in-line with other Welsh Health Boards that increased indexation had not been amended for in the accounts.

If the Health Board had applied the 7% indexation instead of 5%, it would result in:

- an increase of £10.280 million in the value of land and buildings in respect of indexation, as at 31 March 2022;
- an increase in depreciation of £331,000 for 2021-22;
- a reversal of past impairments of £8.184 million for 2021-22; and.
- an increase in the revaluation reserve of £2.096 million, as at 31 March 2022.

The CC queried if there would be opportunity to catch up at the end of the current financial year.

The HFAS responded that they would be accurately revalued during this financial year.

The Executive Director of Finance (EDF) stated that the volatility of indexation and resource allocation was not previously discussed by the Audit Committee. It had a material impact on the accounts and the Committee should be aware of that in the account preparation. If there were material errors, then materiality was substantially used by the non-adjustment that the Committee was not aware of.

### Overview of financial performance 2021-22

- The National Health Service Finance Act 2014 placed two financial duties on the Health Board:

- A duty under Section 175 (1) to ensure that its expenditure did not exceed the aggregate of the funding allocated to it over a period of 3 years.
- A duty under Section 175 (2A) to prepare and obtain approval from the Welsh Ministers for a plan which achieved the first duty above (ie Section 175(1)), while also improving the health of the people for whom the Health Board was responsible and improving the healthcare provided to them.

It was noted that the Health Board had an approved Integrated Medium-Term Plan (IMTP) covering the years 2019-20 to 2021-22. The Health Board had therefore achieved its financial duty under Section 175 (2A). The approved IMTP was to achieve a year-end balanced out-turn position in each year of the plan. The financial performance for the year, as contained in the accounts was a year-end surplus of £0.232m for 2021/22.

The Health Board had a surplus of £0.058m in 2019/20 and a surplus of £0.090m in 2020/21. That meant that over the three-year period the aggregated surplus was £0.380m.

Thus, the Health Board had met its financial duty against its Revenue Resource Limit, both under Section 175 (1) and Section 175 (2A), over the three-year period 2019/20 to 2021/22.

#### Performance against its Capital Resource Limit

It was noted that the Health Board had effectively managed its considerable Capital programme during the year and the accounts had shown a small surplus of £0.041m against its Capital Resource Limit of £70.989m.

It was noted that the Health Board had a surplus of £0.089m in 2019/20 and a surplus of £0.104m in 2020/21 against its Capital Resource Limit. That meant that over the three-year period the aggregated surplus was £0.234m. Thus, the Health Board had met its financial duty to break-even against its Capital Resource Limit over the three years 2019/20 to 2021/22.

The CC stated it was good to meet the in-year revenue especially during the pandemic. The CC thanked all the teams involved.

The CC said that the Committee would return to consider the proposed recommendations set out in the report once all of the agenda items have been presented to the Committee.

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<p><b>AAC 14/6/22 007</b></p>	<p><b>The Head of Internal Audit Opinion and Annual Report for 2021-22</b></p> <p>Ian Virgil (IV) presented the Head of Internal Audit Opinion and Annual Report for 2021-22 and highlighted the following:</p> <ul style="list-style-type: none"> <li>• The majority of the final document was the same as the draft presented in the Audit Workshop in May.</li> <li>• The HIA Opinion for 21/22 was that ‘The Board could take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively’.</li> <li>• It was a positive Opinion overall and consistent with the draft report.</li> <li>• 29 audits were completed within 2021-22. That included 7 Substantial Assurance, 12 Reasonable Assurance, 7 Limited Assurance and 3 advisory or non-opinion.</li> <li>• The only difference from the draft document was that they had anticipated 32 audits but 3 were still “work in progress” and had not been included in the Opinion. However, those would be included in this year’s audits.</li> </ul> <p>The Independent Member for ICT (IMI) queried the data analytics and system development audit. It is was an area that the Health Board could improve. It would be interesting to look at the report.</p> <p>IV responded that he would forward the documents to the IMI.</p> <p>The CC stated that the 3 of the limited assurance reports were in the IT area and the Director of Digital Health Intelligence had given assurance to the Committee.</p> <p>The CC thanked Internal Audit for all their work.</p> <p><b>The Committee resolved that:</b></p> <ol style="list-style-type: none"> <li>a) the Head of Internal Audit Opinion and Annual Report for 2021/22 was recommended to the Board to agree and endorse.</li> </ol>	<p>IV</p>

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<p><b>AAC 14/6/22 008</b></p>	<p><b>Audit Wales ISA 260 Report</b></p> <p>Mark Jones (MJ) presented the Audit Wales ISA 260 Report and highlighted the following:</p> <ul style="list-style-type: none"> <li>• The Audit Wales Report discharged responsibility before the accounts were considered for approval and signed.</li> <li>• Unqualified audit opinion was given except for regularity opinion and that related to scheme pay and tax issues.</li> <li>• There was accrued expenditure in the accounts.</li> <li>• Corrections that were done were low in number in comparison to previous years.</li> </ul> <p>A follow up report would go to the September Audit meeting.</p> <p>MJ thanked the Finance team and all those involved for their help in completing this.</p> <p><b>The Committee resolved that:</b></p> <p>a) The Audit Wales ISA 260 Report was noted.</p>	<p>AW</p>
<p><b>AAC 14/6/22 009</b></p>	<p>To receive and consider the following for 2020-21:</p> <p>a) The Letter of Representation included within the ISA 260 report (see item 7.4)</p> <p>The EDF stated that it was a standard document. It was the Health Board's letter back to the Auditor General.</p> <p>An indexation was inserted into the letter. It detailed that the Health Board had chosen not to amend the misstatements. It reflected that it was the Health Board's choice not to amend the accounts.</p> <p>b) The response to the Audit Enquiries to those charged with Governance and Management</p> <p>It was noted that this was a standard process by Audit Wales. It was presented to the Committee for completeness.</p> <p>The CC stated that he received and signed it prior to the Audit Workshop.</p>	

- c) The CVUHB Annual Report 2021-2022 including the Annual Accountability Report, Performance report and the Financial Statements

The Director of Corporate Governance (DCG) stated that the draft Performance Report had been approved by Audit Wales and WG with only minor changes. The changes to the Remuneration Report were also mentioned by the HFAS.

MJ stated that the audit was open until the accounts were certified by WG. On Friday morning the EDF would have to state that she would still sign the accounts.

The DCG stated that there would be an abridged version for the AGM that would pick up on the more interesting points.

The Committee returned to the recommendations set out in the report for agenda item 7.2 above.

**The Committee resolved that:**

- a) The reported financial performance contained within the Annual Report and Accounts and that the Health Board had met its statutory financial duties in respect of revenue and capital expenditure, were noted.
- b) The changes made to the Draft Annual Report and Accounts were noted.
- c) The ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation, the response to the Audit Enquiries to those charged with Governance and Management, and the Annual Report and Accounts, were reviewed.
- d) The ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation and the response to the Audit Enquiries to those charged with Governance and management were recommended to the Board to agree and endorse.
- e) The Annual Report and Accounts for 2021/22 were recommended to the Board for approval.

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<b>AAC 14/6/22 010</b>	<b>Any Other Business</b>  No other business was discussed.	
<b>AAC 14/6/22 011</b>	<b>Items to be deferred to Board / Committee</b>  No other items were deferred to Boards or Committees.	
	<b>Date &amp; time of next Meeting</b>  Tuesday 5 <sup>th</sup> July 2022 at 9am via MS Teams	

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Public Action Log  
Following Audit & Assurance Committee Meeting  
12<sup>th</sup> May 2022  
(For the Meeting 5th July 2022)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
<b>Completed Actions</b>					
AAC 22/2/8/023	Meeting with Audit Wales	Independent Members to meet with Audit Wales virtually.	Nicola Foreman	5/7/2022	<b>Complete</b>  Meeting between the Committee IMs and Audit Wales scheduled to take place on 5 July 2022.
AAC 22/5/4/007	IT Service Management Report	David Thomas to provide an update on the IT service Management Report actions.	David Thomas	5/7/2022	<b>Complete</b>  On July agenda – item 7.5
AAC 12/05/005 AAC 22/5/4/ 018	Internal Audit Tracking Report	Internal Audit to give further assurance to the Committee on the accuracy of the information on the tracker.	Internal Audit	5/7/2022	<b>Complete</b>  On July agenda (7.1)
AAC 12/05/010	Nurse Bank	Update to be provided on the nurse bank once actions from Internal Audits report have been put into place.	Rachel Gidman	5/7/2022	<b>Complete</b>  On July agenda - item 7.2
AAC 12/05/010	Internal Audit Progress Report	4 Audits will be delivered to the Committee.	Internal Audit	5/7/2022	<b>Complete</b>  On July agenda- item – 9.1
AAC 12/05/010	Internal Audit Tracking Report	A piece of work to validate actions recorded as complete within the Tracker had started.	Internal Audit	5/7/2022	<b>Complete</b>  Please refer to action AAC 22/5/4/ 018

AAC 12/05/010	Auditing the accounts	Audit Wales would speak to HIA to understand the nurse bank report in relation to auditing the accounts.	Internal Audit Audit Wales	13/5/2022	<b>Complete</b>  Discussion took place on 13 May 2022
AAC 12/05/010	Cyber update	A detailed response on NIS and the cyber element would be discussed in the private part of the Digital Committee meeting in June.	David Thomas	7/6/2022	<b>Complete</b>  It was discussed at DHIC meeting in June
<b>Actions in Progress</b>					
AAC 22/2/8/009	Audit Wales Report: Taking Care of the Carers' – Management Response	Nicola Foreman to agree timescales with Rachel Gidman and Claire Whiles regarding when to take the recommendations off the Tracker.	Nicola Foreman	30/09/2022	<b>In progress</b>  These will be removed at the end of September after a final check with the EDPC
AAC 22/5/4/013	Procurement Audit Influenceable Spend Report	Procurement will complete a deep dive analysis on the potential opportunities to increase procurement influence within non-pay expenditure and return to the Audit Committee in September 2022 with a further update.	Claire Salisbury/Catherine Phillips	6/9/2022	<b>In progress</b>  Update to be provided at the September meeting.
AAC 22/5/4/013	Procurement Audit Influenceable Spend Report	The Procurement team could look at whether the Primary Care spend could be influenced.	Claire Salisbury	6/9/2022	<b>In progress</b>  Update to be provided at the September meeting.
<b>Actions referred to Board / Committees</b>					
AAC 22/5/4/010	Review System of Assurance	A high-level assurance map to be provided to Board.	Nicola Foreman	28/7/2022	<b>In progress</b>  To be shared at the Board meeting in July 2022 (added to Board Forward Plan).

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**CARING FOR PEOPLE  
KEEPING PEOPLE WELL**



**GIG  
CYMRU  
NHS  
WALES**

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

Report Title:	<b>Internal Audit Progress Report</b>			Agenda Item no.	7.1
Meeting:	Audit & Assurance Committee	Public	X	Meeting Date:	05/07/22
		Private			
Status <i>(please tick one only):</i>	Assurance	X	Approval	X	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 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.

The 2022/23 plan was formally approved by the Audit Committee at its April 22 meeting.

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

Appendix A of the progress report sets out the Internal Audit plan as agreed by the committee, including 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 four audit reports from the 2021/22 plan have been finalised since the May 22 meeting of the Committee:

- Recovery of services and Delivery of the Annual Plan 2021 – 2022 (Substantial Assurance)
- Risk Management (Reasonable Assurance)
- Performance Reporting (Data Quality) (Reasonable Assurance)
- Chemocare IT System (Limited Assurance)

Although these reports were not finalised in time for submission to the May Committee, the outcomes were included within the Head of Internal Audit Opinion and Annual Report for 2021/22.

The progress report also includes details of proposed amendments to the planned timings for a number of audits from the 2022/23 plan.

### Recommendation:

The Audit & Assurance Committee are requested to:

- **Consider** the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports.
- **Approve** the proposed adjustments to the planned timings for the identified 2022/23 audits.

**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	
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**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

Financial: Yes/No

Workforce: Yes/No

Legal: Yes/No

Reputational: Yes/No

Socio Economic: Yes/No

Equality and Health: Yes/No

Decarbonisation: Yes/No

**Approval/Scrutiny Route:**

Committee/Group/Exec      Date:

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# Cardiff and Vale University Health Board

## Internal Audit Progress Report

### Audit & Assurance Committee July 2022

NWSSP Audit and Assurance Services



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WALES

Partneriaeth  
Cydwasaethau  
Cydwasaethau Archwilio a Sicrwydd  
Shared Services  
Partnership  
Audit and Assurance Services



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Appendix A      Assignment Status Schedule

Appendix B      Assurance on Recommendation Tracker

Appendix C      Assurance Ratings

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## 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 2022/23 Internal Audit plan.

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




The plan for 2022/23 was agreed by the Audit & Assurance Committee in April 2022 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

## 2. Outcomes from Completed Audit Reviews

A number of audit reports from the 2021/22 plan were not finalised in time for submission to the Audit Committee in May 22, although the outcomes were included within the Head of Internal Audit Opinion and Annual Report for 2021/22.

All but one of the audits have now been finalised, as detailed in the table below. The Executive Summaries from the final reports are provided in Section six. The full reports are included separately within the Audit Committee agenda for information.

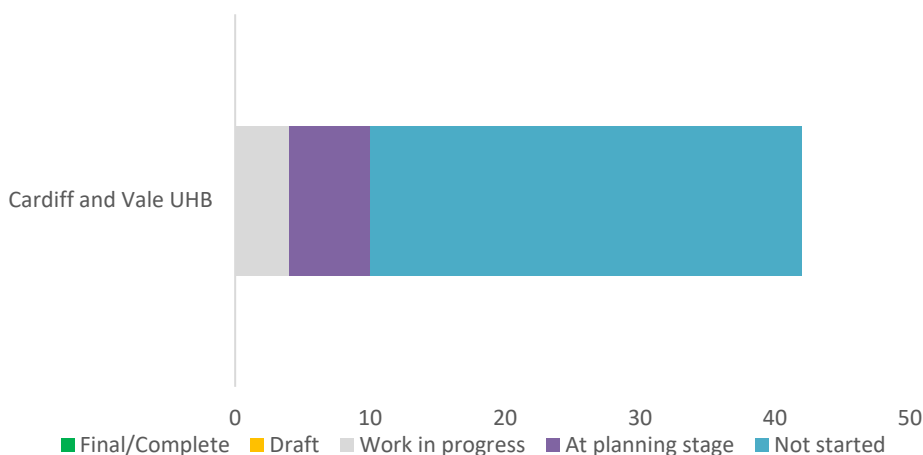
The Audit of Waste Management is still to be finalised and will be reported to the September meeting of the Committee.

FINALISED AUDIT REPORTS (2021/22 Opinion)	ASSURANCE RATING	
Recovery of services and Delivery of the Annual Plan 2021 - 2022	Substantial	
Risk Management	Reasonable	
Performance Reporting (Data Quality)		
Chemocare IT System	Limited	

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### 3. Delivery of the 2022/23 Internal Audit Plan

There are a total of 41 reviews included within the 2022/23 Internal Audit Plan, and overall progress at this early stage of the year is summarised below.



From the illustration above it can be seen that there are four audits that are currently work in progress with a further six 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 2021/22 plan that had not been sufficiently progressed to be included within the Head of Internal Audit Opinion for 2021/22. The outcomes from these audits will feed into the 2022/23 Opinion.

### 4. Changes to the 2022/23 Plan

The plan that was agreed by the Committee in April 22 included details of the proposed quarters in which each of the identified audits would be undertaken.

Following a more detailed review of the availability of Internal Audit resources and discussions with relevant lead contacts, adjustments have since been proposed to the planned timings for the following audits:

- Medical & Dental Staff Bank – Move from Q1 to Q2
- Reporting of Covid Deaths – Move from Q3 to Q2
- Financial Plan / Reporting – Move from Q2 to Q3
- Performance Reporting – Move from Q3 to Q4

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## 5. Assurance on Recommendation Tracking

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

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

Appendix B provides detail of the entries from the Tracker that we attempted to validate implementation.

Our audit sample focused on the recommendations reported to the Audit Committee through 2021/22 as complete. From a total of 56 recommendations reported as complete, we selected a third (18) to form our sample across the following split of committees; April 2021 (5), July 2021 (2), September 2021 (5), November 2021 (2), and February 2022 (4).

The overall outcome of the 18 recommendations sampled can be summarised as follows:

- The majority were verified as complete (11);
- An Internal Audit follow up noted partially complete recommendations, but these had been superseded by further recommendations made through the follow up (2);
- We were unable to validate a small number of recommendations due to the absence of evidence presented by management, which remains outstanding (3); and
- In the instance of one audit, there had been a change in staff which impacted the ability to provide evidence, although assurance was offered of a forward look in nature (2).

The exercise has highlighted that the Audit Committee can be reasonably assured that the progress information detailed within the Tracker for 2021/22 is accurate, although further efforts are required to obtain complete assurance from management.

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## 6. Final Report Summaries

### 6.1 Recovery of services and Delivery of the Annual Plan 2021 - 2022

#### Purpose

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to 'Recovery of Services and Delivery of the Annual Plan 2021/22'.

#### Overview

We have issued an overall rating of substantial assurance on this area and are also able to provide substantial assurance for each of the individual objectives, as detailed within the Assurance Summary table.

Our report makes two low priority recommendations, which are forward looking given the review focused on 2021/22 arrangements. The recommendations can be taken forward to 2022/23 and relate to:

- The transparency of reprofiling recovery funding; and
- The timeliness of information contained within the Board Assurance Framework.

#### Report Classification

Substantial



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

**Low impact** on residual risk exposure.

#### Assurance summary<sup>1</sup>

Assurance objectives	Assurance
1 Appropriate governance arrangements have been established which provide effective oversight	Substantial
2 Deliverables outlined within the Addendum to the 2021/22 Annual Plan are regularly monitored	Substantial
3 The Board Assurance Framework adequately highlights the risk of delivery of the Annual Plan 2021/22	Substantial

<sup>1</sup>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

#### Key Matters Arising

There are no key matters arising to report on this occasion.

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## 6.2 Risk Management

### Purpose

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

### Overview



We have issued reasonable assurance on this area.

For three of the five objectives reviewed we have offered reasonable assurance, largely due to the continued efforts required by Clinical Boards and Corporate Departments to enhance their risk registers, as highlighted in the key matter arising below.

We also note that the tools available to management are lacking, in that risk registers are currently held in spreadsheets, which limits the visibility of risks and the ability to profile and aggregate risks across the Health Board. We make no recommendation in this area given an all-Wales solution is being developed but highlight the position, and the impact on the assurance we can offer against Objective 3.

Our report makes two further low priority recommendations, which are best practice in nature to support the Health Board's risk maturity.

### Report Classification

Reasonable	Some matters require management attention in control design or compliance.	Trend
		 2020/21
<b>Low to moderate impact</b> on residual risk exposure until resolved.		

### Assurance summary<sup>1</sup>

Assurance objectives	Assurance
1 Up to date Risk Management Strategy and Procedures.	Substantial
2 Risks are managed effectively at Clinical Board/Corporate Department level.	Reasonable
3 Risks are profiled and aggregated where possible.	Reasonable
4 Risks are consistently captured, scored and mitigated (where applicable).	Reasonable
5 Progress with internal audit recommendations from 2020/21 Risk Management audit.	Substantial

<sup>1</sup>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

### Key Matter Arising

	Assurance Objective	Control Design or Operation	Recommendation Priority	
2	Enhancements required to Clinical Board and Corporate Department Risk Registers	2 & 4	Operation	Medium

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## 6.3 Performance Reporting (Data Quality)

### Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to Performance Reporting (Data Quality).

The review specifically focused on the 'Integrated Performance Report' and the processes in place for its production and reporting.

### Overview

We have issued reasonable assurance on this area.

We have made two medium priority recommendations which require management attention, both fall within objective two of this review and focus on the robustness of systems and processes to capture and validate the data within the Integrated Performance Report, specifically the Balanced Scorecard.

Whilst we found no fundamental data quality issues within our sample, we did note the absence of data completely for one indicator. The recommendations proposed, once implemented would enhance the clarity and completeness of the report.

Other low priority recommendations are within the detail of the report.

### Report Classification

Reasonable



Some matters require management attention in control design or compliance.

**Low to moderate** impact on residual risk exposure until resolved.

### Assurance summary<sup>1</sup>

Assurance objectives	Assurance
1 Appropriate governance arrangements for effective reporting of the Integrated Performance Report	Substantial
2 Robustness of systems and processes to capture and validate the data required to produce the Integrated Performance Report	Reasonable
3 Timely compilation of the Integrated Performance Report	Substantial

<sup>1</sup>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

### Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
2	Data accuracy and completeness of the Balanced Scorecard	2	Operation	Medium
4	Further enhancements to develop the Balanced Scorecard	2	Operation	Medium

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## 6.4 ChemoCare IT System

### Purpose

To provide assurance that data held within the Chemocare IT System is accurate, secure from unauthorised access and loss, and that the system is used fully.

### Overview

There is a framework for control over the Chemocare system and there were areas of good practice. However, the controls have not been fully enacted. The significant matters which require management attention include:

- Out of date versions of Windows server and SQL Server database in use.
- Generic accounts exist with system administrator privileges.
- Lack of formal supplier's performance monitoring mechanism.
- Weaknesses within the Business Continuity Plan and Hosting and Backup arrangements.
- Weaknesses in password policy and current configuration settings.
- No automatic alerts configured to notify in the event of interface failures.

Additional recommendations are also made which can be found within the detail of the report.

### Report Classification

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



### Assurance summary<sup>1</sup>

Assurance objectives	Assurance
1 Governance Process	Reasonable
2 Database Control	None
3 Input Controls	Substantial
4 Application Access	Limited
5 Outputs and Interfaces	Reasonable
6 Audit Log	Substantial
7 Continuity	Limited

<sup>1</sup>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

### Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Performance Monitoring Mechanism.	1	Design	Medium
2	Database Security	2	Operation	High
4	User Management	4	Operation	Medium
5	Password Controls	4	Operation	Medium
6	Interface Failure Alerts	5	Design	Medium
7	Hosting and Backup Agreements	7	Operation	Medium
8	Business Continuity	7	Operation	Medium

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## ASSIGNMENT STATUS SCHEDULE

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
<b>2021/22 Plan</b>							
Capital Systems Management		Finance			Work In Progress		September
Management of Staff Sickness Absence		People & Culture			Work In Progress		September
Post Contract Audit of DHH Costs		Finance			Work In Progress		September
<b>2022/23 Plan</b>							
Assurance Mapping	05	Corporate Governance	Q1		Planning		November
Staff Wellbeing – Culture & Values	07	People & Culture	Q1		Planning		November
5 Steps to Safer Surgery (Follow-up)	18	Medical	Q1		Planning		September
Uptake of National IT Systems	20	Digital & Health Intelligence	Q1		Work in Progress		September
CD&T CB – Ultrasound Governance (Follow-up)	26	Therapies & Health Science	Q1		Work in Progress		September
IMTP Development Process	37	Strategic Planning	Q1		Work in Progress		September
Medical & Dental Staff Bank	06	People & Culture	<del>Q1</del>	Q2	Planning		September

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Reporting of Covid Deaths	11	Nursing	<del>Q3</del>	Q2	Planning		November
Clinical Audit (Follow-up)	17	Medical Director	Q2		Planning		November
Estates Assurance – Decarbonisation (Deferred from 21/22)	15	Finance	Q2				November
IT Strategy	21	Digital & Health Intelligence	Q2				November
Medical Equipment & Devices (Deferred from 21/22)	25	Therapies & Health Science	Q2		Work in Progress		November
Application of Local Choices Framework	28	Chief Executive / COO	Q2				November
Mental Health CB – Administration Services	29	Chief Operating Officer	Q2				November
Specialist Services CB – Community Patient Appliances	33	Chief Operating Officer	Q2				February
CD&T CB – Medical Records Tracking	34	Chief Operating Officer	Q2				November
QS&E Governance (Deferred from 21/22 plan)	03	Nursing / Medical	Q3				February
Implementation of People & Culture Plan	09	People & Culture	Q3				February
Nurse Staffing Levels Act	10	Nursing	Q3				April
Financial Plan / Reporting (Deferred from 21/22)	12	Finance	<del>Q2</del>	Q3			February

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Charitable Funds	13	Finance	Q3				February
Medical Staff Additional Sessions	16	Medical	Q3				February
New IT Service Desk Tool	22	Digital & Health Intelligence	Q3				February
PCIC CB – GMS Access (Deferred from 21/22 plan)	30	Chief Operating Officer	Q3				February
Medicine CB – QS&E Governance Framework (Deferred from 21/22 plan)	31	Chief Operating Officer	Q3				February
Surgery CB – Consultant Job Plans	32	Chief Operating Officer	Q4				April
Strategic Programmes / Recovery & Redesign Governance Arrangements	36	Strategic Planning	Q3				February
Commissioning – IPFR Process	38	Strategic Planning	Q3				April
Regional Planning Arrangements	39	Strategic Planning	Q3				February
Risk Management	01	Corporate Governance	Q4				April
Core Financial Systems	02	Finance	Q4				February
Management of Health Board Policies	04	Corporate governance	Q4				May
Inclusion & Equality Team	08	People & Culture	Q4				April

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Capital Systems	14	Finance	Q4				April
Performance Reporting	19	Digital & Health Intelligence	<del>Q3</del>	Q4			April
Data Warehouse	23	Digital & Health Intelligence	Q4				April
Recovery of Services	27	Chief Operating Officer	Q3				May
Women & Children's CB – Management of Locum Junior Doctors	35	Chief Operating Officer	Q4				April
Cyber Security	24	Digital & Health Intelligence	TBC				April
Shaping Our Future Hospitals Programme	40	Strategic Planning	Q1-4		Ongoing		n/a
Development of Integrated Audit Plans	41	Strategic Planning	Q1-4		Ongoing		n/a

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## ASSURANCE ON RECOMMENDATION TRACKER

Audit Information			Validation process	
Audit Title	Recommendation	Rating	Internal Audit validation result	Basis of validation
Internal Audit Follow Up (1) Consultant Job Planning (CVU 1920-41)  Final Report Issued: 07/01/20  Audit Rating: Limited Assurance	1. Annual Job Plans	High	Complete	Internal Audit Follow Up (2) Consultant Job Planning (CVU 2021-37)  Final Report issued: 29/04/21  Audit Rating: Reasonable Assurance
	2. Job Planning Documentation	High	Complete	
Data Quality Performance Reporting - Single Cancer Pathway (CVU 2021-10)  Final Report Issued: 27/05/21  Audit Rating: Reasonable Assurance	2. Operational Procedures	Medium	<b>Validation incomplete</b> A meeting was held with the Interim Lead Cancer Services Manager who confirmed the change in procedures and processes, however the supporting evidence remains outstanding.	Evidence requested from the Interim Lead Cancer Services Manager to confirm completion.
	4. Accuracy and validation of SCP data	Medium		
Mental Health Outpatient Clinic Cancellations (CVU 2021-31)  Final Report issued: 13/01/21  Audit Rating: Limited Assurance	1. Written procedures	High	Complete and supplementary follow up recommendation made - Low Priority	Internal Audit Follow Up Cancellation of Outpatient Clinics: Mental Health Clinical Board (CVU 2122-29)  Final Report issued: 16/08/21  Audit Rating: Reasonable Assurance
	2. Lack of evidence to support cancellations	Medium	Partially Complete but superseded by supplementary follow up recommendation - Medium Priority	
	3. Authorisation of clinic cancellations	Medium	Partially Complete but superseded by supplementary follow up recommendation - Medium Priority	






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Audit Information			Validation process	
Audit Title	Recommendation	Rating	Internal Audit validation result	Basis of validation
	4. PARIS is used inconsistently between Mental Health Directorates	Medium	Complete	
	5. Monitoring of Outpatient Clinic Cancellations	High	Complete - Supplementary Medium Priority Recommendation made	
Claims Reimbursement (CVU 2021-04) Final Report issued: 19/03/21 Audit Rating: Substantial Assurance	1. Central Repository for Claims Reimbursement Documentation	Medium	Complete	Internal Audit of Welsh Risk Pool Claims (CVU 2122-04) Final Report issued: 28/04/22 Audit Rating: Substantial Assurance
Core Financial Systems (CVU 2021-13) Final Report issued: 23/03/21 Audit Rating: Reasonable Assurance	2. Asset Verification Review	High	<b>Validation incomplete</b> Evidence remains outstanding	Evidence requested from Head of Financial Accounts and Services, and Head of Financial Services to confirm completion
	3. Bank reconciliation	Medium	Complete - Evidence received from Head of Financial Services	
Environmental Sustainability Report (CVU 1920-44) Final Report issued: 16/08/19 Audit Rating: Reasonable Assurance	1. Accuracy Check & Sign Off	Medium	Whilst information was provided to support completion of the recommendations, the narrative was forward looking, given a change in staff since the initial audit.	Evidence requested from the Trust Energy Advisor to confirm completion.
	2. Guidance Document	Medium		
Integrated Health Pathways (CVU 2021-20) Final Report issued: 25/02/21 Audit Rating: Reasonable Assurance	5. User Feedback on Health Pathways	Medium	Complete	Evidence requested from the Primary Community and Intermediate Care Clinical Board, which the Assistant Director of Operations – Planning & Delivery provided.
	6. Performance Metrics and Reporting	Medium	Complete	

Audit Information			Validation process	
Audit Title	Recommendation	Rating	Internal Audit validation result	Basis of validation
Risk Management (CVU 2021-03) Final Report issued: 24/03/21	2. Aggregation and visibility of risk across the Health Board	Medium	Complete – although a risk was highlighted in the 2021/22 audit.	Risk Management (CVU 2122-01) Final Report issued: 9/06/22
Audit Rating: Reasonable Assurance	4. Risk Management Maturity	Medium	Complete	Audit Rating: Reasonable Assurance

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## Assurance Ratings

	<p><b>Substantial assurance</b></p>	<p>Few matters require attention and are compliance or advisory in nature.  <b>Low impact</b> on residual risk exposure.</p>
	<p><b>Reasonable assurance</b></p>	<p>Some matters require management attention in control design or compliance.  <b>Low to moderate impact</b> on residual risk exposure until resolved.</p>
	<p><b>Limited assurance</b></p>	<p>More significant matters require management attention.  <b>Moderate impact</b> on residual risk exposure until resolved.</p>
	<p><b>No assurance</b></p>	<p>Action is required to address the whole control framework in this area.  <b>High impact</b> on residual risk exposure until resolved.</p>
	<p><b>Assurance not applicable</b></p>	<p>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.</p>

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Report Title:	Temporary Staffing Department (Nurse Bank) Internal Audit Report			Agenda Item no.	7.2
Meeting:	Audit Committee	Public	X	Meeting Date:	5 July 2022
		Private			
Status <i>(please tick one only):</i>	Assurance	<input checked="" type="checkbox"/>	Approval		Information
Lead Executive:	Executive Director of People and Culture				
Report Author (Title):	Assistant Director of People Resourcing				

## Main Report

### Background and current situation:

This report is to provide assurance to the Audit Committee in respect of the Audit of the Temporary Staffing Department (TSD) where issues of 'limited assurance' were reported.

The People and Culture department commenced their accountability and management of the TSD in October 2021. An internal Audit was subsequently requested to identify any issues that needed to be addressed. An Audit report was received on 10 May 2022. The report highlighted 2 objectives which had only 'limited' assurance and 3 recommendations which were rated as 'high' priority which are as follows:

1. Inadequate structure within the TSD (Design)
2. Lack of resilience of the TSD (operation)
3. Range of agency usage (operation)

In response to the Audit, the Assistant Director of People Resourcing and the Senior Nurse developed an action plan to address all recommendations within the report including those that were rated as a 'medium' priority.

A number of the actions have already been implemented and the remainder will be undertaken within the timescales indicated with the audit report.

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

One of the key issues within the report was the lack of resilience in processing invoices if the Senior Nurse was absent. Two other members of staff have been trained to ensure this process continues however, as the function has now moved to self-billing, this will not be an issue for the department moving forward.

As the new Allocate Health rostering system is phased in over the UHB, some of the functions of the department will become more automated and the roles of the staff working within the team will change to focus more on expanding the numbers working on the bank and also increasing the range of professions being supplied. The roll-out of Allocate should be completed by March 2023.

### Recommendation:

The Board/Committee are requested to:

- Note the contents of this 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: Yes/No

The department has improved its resilience by reviewing and documenting all processes to ensure that if a member of the team is absent, there are clear processes in place for someone else to undertake. Staff are also in the process of being trained on different processes and job rotation is being tested.

Safety: No

Financial: No

Workforce: Yes

Changes to the structure were recommended within the report to include appointing a deputy to the senior nurse. This can be done within the existing workforce and will be cost neutral.

Legal: No

Reputational: No

Socio Economic: No

Equality and Health: No

Decarbonisation: No

**Approval/Scrutiny Route:**

Committee/Group/Exec	Date:

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Report Title:	<b>Nurse Bank Internal Audit Report - Update</b>			Agenda Item no.	7.2				
Meeting:	Audit & Assurance Committee	Public	X	Meeting Date:	05/07/22				
		Private							
Status <i>(please tick one only):</i>	Assurance	X	Approval	Information	X				
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Head of Internal Audit								
<b>Main Report</b>									
Background and current situation:									
The Final Limited Assurance Internal Audit Report on the Nurse Bank (Temporary Staffing Department) was presented to the Audit Committee in May 2022 but did not include any management actions.									
The management actions have since been provided and agreed, and are included within the updated final report which is presented to the Committee for information and assurance.									
<b>Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:</b>									
The agreed management actions are included within Appendix A of the updated final Nurse Bank (Temporary Staffing Department) report.									
<b>Recommendation:</b>									
The Audit & Assurance Committee are requested to:									
<ul style="list-style-type: none"> <li>• <b>Consider and note</b> the management actions within the updated final report.</li> </ul>									
<b>Link to Strategic Objectives of Shaping our Future Wellbeing:</b>									
<i>Please tick as relevant</i>									
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance							
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn			x				
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology			x				
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us			x				
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives							
<b>Five Ways of Working (Sustainable Development Principles) considered</b>									
<i>Please tick as relevant</i>									
Prevention		Long term	x	Integration	x	Collaboration	x	Involvement	
<b>Impact Assessment:</b>									
<i>Please state yes or no for each category. If yes please provide further details.</i>									
Risk: Yes/No									
Safety: Yes/No									

Financial: Yes/No	
Workforce: Yes/No	
Legal: Yes/No	
Reputational: Yes/No	
Socio Economic: Yes/No	
Equality and Health: Yes/No	
Decarbonisation: Yes/No	
<b>Approval/Scrutiny Route:</b>	
Committee/Group/Exec	Date:

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# Nurse Bank (Temporary Staffing Department)

## Final Internal Audit Report

May 2022

Cardiff & Vale University Health Board

NWSSP Audit and Assurance Services



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Cardiff and Vale  
University Health Board



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Review reference:	CVU-2122-13
Report status:	Final Report
Fieldwork commencement:	26 January 2022
Fieldwork completion:	23 March 2022
Debrief meeting:	6 April 2022
Draft report issued:	12 April 2022
Management agreement received	25 April 2022
Final report issued:	28 April 2022 (without management responses) 26 May 2022 (with management responses)
Auditors:	Lucy Jugessur, Internal Audit Manager Wendy Wright-Davies, Deputy Head of Internal Audit
Executive sign-off:	Rachel Gidman, Executive Director of People and Culture
Distribution:	Jonathan Pritchard, Assistant Director of Workforce Resourcing Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce
Committee:	Audit & Assurance Committee



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

### Acknowledgement

NHS Wales Audit 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 & 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 and Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

## Executive Summary

### Purpose

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

### Overview

We have issued limited assurance on this area.

We have made a number of high and medium priority recommendations which require management attention that relate to the structure and operation of the Temporary Staffing Department, which holds the Nurse Bank.

There is a lack of resilience within the current structure, which is impacting the recruitment to the Nurse Bank, payment to agencies, and a general lack of engagement with service users, whether that be ward management or bank staff themselves.

## Report Classification

Limited



More significant matters require management attention.

**Moderate impact** on residual risk exposure until resolved.

## Assurance summary<sup>1</sup>

Assurance objectives	Assurance
1 Policy, procedures and guidance.	Reasonable
2 Structure and operation of the Temporary Staffing Department.	Limited
3 Verification and authorisation of bank and agency shifts.	Limited
4 Accurate and timely reports on bank usage and costs.	Reasonable

<sup>1</sup>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1 Lack of Temporary Staffing Guidance	1	Design	Medium
2 Inadequate structure within the Temporary Staffing Department	2	Design	High
3 Resilience of the Temporary Staffing Department	2 & 3	Operation	High
4 Roles and responsibilities for Bank recruitment	2	Operation	Medium
5 Lack of engagement with service users	2 & 4	Operation	Medium
6 Operational management of the Temporary Staffing Department	2	Operation	Medium
7 Range of agency usage	3	Operation	High
8 Ward verification of agency shifts	3	Operation	Medium

## 1. Introduction

- 1.1 The review of the Nurse Bank (Temporary Staffing Department) was completed in line with the 2021/22 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').
- 1.2 The Health Board are reliant on the use of bank and agency staff to fill vacant shifts on hospital wards. Staff that are registered on the Bank, through the Health Board's Temporary Staffing Department can find available shifts through the Health Board's website<sup>1</sup>, Facebook page or by telephoning the Temporary Staffing team.
- 1.3 The Temporary Staffing Department has experienced some organisational changes through 2021, previously within the remit of the Executive Nurse Director, Workforce Resourcing took over responsibility in September 2021, within the Executive Director of People and Culture's portfolio.
- 1.4 The Board Assurance Framework (BAF) refers to Workforce as a key risk, noting that across the UK and in Wales there are increasing workforce challenges for healthcare professionals. In the context of the Nurse Bank, the BAF refers to the impact of the new Nurse E-Rostering System, to be rolled out in 2022/23, with improved Bank Application (App) functionality.<sup>2</sup>
- 1.5 The Board's Strategy and Delivery sub-committee routinely receives the People Dashboard of Workforce Key Performance Indicators report, which includes the trend of 'Whole Time Equivalent Permanent, Fixed-Term and Bank Staff in post numbers'. The Dashboard presented to the sub-committee on 16 November 2021 noted, "Nurse Bank usage remains fairly static, roughly equivalent to 400 WTE per month".<sup>3</sup>
- 1.6 The Executive Director of People and Culture is the lead for this review.

### Audit Risks

- 1.7 The potential risks considered in this review were as follows:
  - Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment of bank and agency staff;
  - The allocation and completion of bank shifts does not meet the priorities of the Clinical Boards;
  - Financial loss due to unnecessary usage or incorrect payment of bank and agency staff; and
  - Issues relating to bank and agency are not identified or addressed.

<sup>1</sup> <https://www.cardiffandvalenursebank.co.uk/en/calendar>

<sup>2</sup> <https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/2022-03-31-public-board-papers-v14-pdf/>

<sup>3</sup> <https://cavuhb.nhs.wales/files/board-and-committees/strategy-and-delivery-committee-2021-22/2021-11-16-audit-final-papers-v4-pdf/>

### Limitations to scope

- 1.8 At the time of audit fieldwork, given the pressures within the Health Board, our audit testing was limited to procedures, processes and documentation held by the Nurse Bank and did not extend to information held by the Clinical Boards.

## 2. Detailed Audit Findings

### Objective 1: Health Board policy, procedures and guidance are in place to efficiently direct the use of bank and agency staff, which is appropriate and up to date.

- 2.1 The Health Board's Rostering Procedure for Nurses and Midwives (UHB 339 v2) highlights an objective to, "Improve the utilisation of existing staff and reduce bank and agency spend by giving Ward Sisters/Charge Nurses/Departmental Managers, Lead/Senior Nurses and Midwives clear visibility of staff contracted hours."<sup>4</sup> The procedure clarifies the circumstances where bank and temporary staffing can be utilised and the expectations placed on wards to communicate changes with the Temporary Staffing Department.
- 2.2 We are aware that the Health Board has commenced rolling out a new e-rostering system, HealthRoster (Allocate) to facilitate the rostering process, which will include bank and agency shifts. The revised arrangements will impact Health Board procedures and guidance in this area. Guidance to support the new system will include recording bank shift availability and self-booking of available bank shifts, which is a change in process, giving greater autonomy to bank staff.
- 2.3 We reviewed current procedures and guidance in place within the Nurse Bank, a Temporary Staffing Authorisation Flowchart (dated August 2018) details the process to follow for completion of rotas, which includes requesting bank or agency cover. The flowchart was sent to each Director of Nursing for the Clinical Boards for review and approval. However, whilst helpful, it was unclear from review of the document who owns and approved the flowchart. (*Matter Arising 1 – Medium Priority*)
- 2.4 At the time of the audit, the Nurse Bank recruitment guidance had been updated from a narrative description into a series of flowcharts, which were more succinct and easier to follow, which include:
- Temporary Staffing Students;
  - Temporary Staffing Health Care Support Workers (HCSW) / Registered General Nurses / Registered Mental Health Nurse; and
  - Temporary Staffing Fast Track.

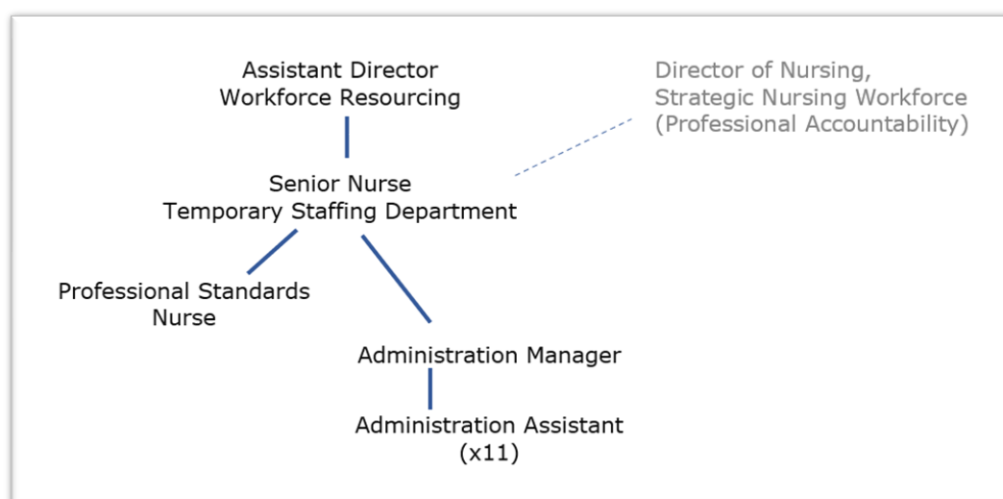
<sup>4</sup> <https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/workforce-and-od-policies/r-workforce-and-od/rostering-procedure-for-nurses-and-midwives-final-v2-pdf/>

2.5 We found no other process documents in place within the Temporary Staffing Department to cover areas such as, engaging with agencies or reviewing and actioning agency reports. *(Matter Arising 1 – Medium Priority)*

Conclusion 1: Whilst we found some procedural guidance in place to support the Temporary Staffing Department, there are gaps in the available guidance. Further guidance would enhance the resilience of the team. The control of guidance could also be improved, to clarify document approval. (Reasonable Assurance)

**Objective 2: The Temporary Staffing Department is adequately structured and operating effectively to enable the robust and timely recruitment of bank and agency staff.**

2.6 At the time of our review, we found the structure of the Temporary Staffing Department to be as follows:



2.7 The Temporary Staffing Department’s establishment holds no vacancies, however, it was evident that staff within the department are not fully proficient with the different functions and processes, for example supporting recruitment and administering agency invoices. *(Matter Arising 2 – High Priority)*

2.8 We found the current structure of the Temporary Staffing Department to be inadequate and currently presents a resilience risk, where issues have materialised through 2021/22. *(Matter Arising 3 – High Priority)*

2.9 We were advised that the recruitment of Bank staff is currently being undertaken by several areas within Workforce, therefore we were unable to verify if the Temporary Staffing Department can operate effectively, to facilitate the timely recruitment to the Nurse Bank. *(Matter Arising 4 – Medium Priority)*

2.10 We questioned the effectiveness of the Nurse Bank through the lens of service users, particularly hospital wards. However, we found no engagement activities, such as surveys to validate user experience with the Bank, or for Ward Managers

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to confirm if the Bank has been effective in obtaining adequate bank or agency staff to cover vacant shifts. *(Matter Arising 5 – Medium Priority)*

- 2.11 We considered the operational arrangements for managing the Temporary Staffing Department. In the first instance we reviewed the staff member's personal files, but these were found to be incomplete. We also selected a sample of sickness records from ESR to ensure that the appropriate documentation had been completed, but again found instances where these were incomplete. *(Matter Arising 6 – Medium Priority)*

Conclusion 2: The Temporary Staffing Department structure is inadequate, which impacts the operational effectiveness of the Nurse Bank. Due to current arrangements, we could not verify the ability of the Department to support the robust and timely recruitment to the Nurse Bank. There also seems to be a lack of engagement with hospital wards to obtain user feedback, although we note the COVID-19 pandemic has impacted face-to-face contact on hospital wards. (Limited Assurance)

**Objective 3: All requests for bank and agency staff are supported by appropriate justification and authorisation, and all completed shifts are appropriately verified and authorised prior to payment at the correct rate.**

- 2.12 We ascertained the process for requesting bank and agency cover. We were informed that the Ward Manager is required to record a reason for a vacant shift on Rosterpro, which confirms requirement for cover. The Temporary Staffing Department are responsible for contacting Bank workers to establish whether they can undertake a shift and they also contact the agencies to request cover.
- 2.13 The process will soon change as the Health Board migrates to HealthRoster and Bank staff will be able to book themselves onto a bank shift. Furthermore, the agencies will also be able to book their staff onto vacant shifts once they are released to them.
- 2.14 It was identified that the Health Board only utilises 36 out of an approximate 140 agencies that are on the All Wales framework to deploy agency staff. We reviewed the Bank and Agency staff report for the week commencing 27 February 2022, which noted challenging fill rates, for example 49% in the Specialist Services Clinical Board. There may be greater opportunities to deploy further agency staff, with specialist skills, when all other viable options have been exhausted to support hospital wards under pressure. *(Matter Arising 7 – High Priority)*
- 2.15 The Health Board implemented self-billing on 1 March 2022, which is directed by the 'Nurse Agency Self Billing - Standard Operating Procedure'. The process involves the Health Board preparing the agency's invoice and forwarding a copy to the agency with payment. As part of this process there is a reliance on ward managers to verify that agency shifts have been worked. However, it was evident during the review that the process needs to further embed amongst ward management. *(Matter Arising 8 – Medium Priority)*

- 2.16 The Senior Nurse within the Temporary Staffing Department spends a considerable amount of time reviewing and resolving issues on a weekly 'Invoices on Hold' report. The report includes invoices without a purchase order number, or instances where a shift has not been verified and requires action to enable the agencies to receive payment for the agency nurses deployed. (*Matter Arising 3 – High Priority*)
- 2.17 We identified that invoices are on hold for several reasons, examples include, staff on the wards failing to verify that an agency employee has worked a shift, the agency have provided an incorrect purchase order number, or the copy of a timesheet is illegible. Only two staff within the Temporary Staffing Department, aside from the Senior Nurse have been trained on the process for reviewing and actioning the 'Invoices on Hold' report, but both were absent from work at the time of the audit. (*Matter Arising 3 – High Priority*)
- 2.18 We requested reports on Bank usage and verification of shifts but at the close of audit fieldwork these had not been provided.

Conclusion 3: Following ward management approval, the Temporary Staffing Department is notified of unfilled shifts requiring bank and agency cover, through the RosterPro system. This process will move to HealthRoster once the roll out of the new system progresses. Our testing has identified issues with the verification of agency shifts worked, which if undertaken in a more timely manner would provide greater efficiencies to hospital wards and also the Temporary Staffing Department. Due to a lack of information provided, we were unable to evidence usage and verification of Bank staff. (Limited Assurance)

**Objective 4: Accurate and timely reports on bank usage and costs are produced and distributed to appropriate staff and groups / committees within the Health Board. Reports are subject to effective scrutiny and actions are taken where required.**

- 2.19 The Temporary Staffing Department produces a daily report showing all filled and unfilled shifts for the current day and the following day. This report is sent to all Lead and Senior Nurses within the Clinical Boards. In addition, the Temporary Staffing Administration Manager produces a report twice weekly showing the number of booked shifts and unfilled shifts for the week ahead. Once the Health Board has migrated to HealthRoster the Senior Nurses will be able to self-serve these reports.
- 2.20 The RosterPro Support and Training Co-ordinator produces a weekly bank and agency report which reports the weekly fill rates at different levels within the Health Board including the agency fill rate.
- 2.21 Although there are reports generated and circulated on nurse fill rates within the Health Board, through the lens of the Temporary Staffing Department, we were unable to evidence that these reports are scrutinised. We were also unclear what

action has been taken in response to the reports. (*Matter Arising 5 – Medium Priority*)

- 2.22 As noted in paragraph 2.18 we requested a report on Bank usage and verification, but we did not receive this.
- 2.23 We reviewed the reporting arrangements into the Committee structure, and we noted that the Strategy and Delivery Committee routinely receive a Workforce Key Performance Indicators report, which incorporates a graph on the WTE Permanent, Fixed-Term and Bank Staff in Post Numbers.

Conclusion 4: There are a number of reports produced showing the filled and unfilled shifts within the Health Board, but we were unable to verify the level of engagement, scrutiny and action taken in response to the reports, given the limited feedback within the Temporary Staffing Department. We also requested reports on Bank staff and usage, but did not receive these, for example how many are employed via the Nurse Bank, and when was a shift last worked. This information was not readily available, which is fundamental management information. (Reasonable Assurance)

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## Appendix A: Management Action Plan

Matter Arising 1: Lack of Temporary Staffing Guidance (Design)		Impact
<p>We found procedural guidance within the Nurse Bank to be lacking, for instance there is no guidance in place to support key processes, such as engaging with agencies and managing the payment of agency invoices, through the 'Invoices on Hold' report.</p> <p>Where guidance is in place, there was a lack of clarity of approval and ownership, such as:</p> <ul style="list-style-type: none"> <li>• Temporary Staffing Authorisation Flowchart (dated August 2018); and</li> <li>• The recently introduced Nurse Bank Recruitment Flowcharts.</li> </ul> <p>We appreciate that given the imminent roll-out of HealthRoster through 2022/23, the systems and processes in the Nurse Bank will evolve and procedures and guidance will require updating.</p>		<p>Potential risk of:</p> <p>Procedures and guidance are not in place within the Bank to assist the Bank staff to manage the Nurse Bank adequately.</p>
Recommendation 1		Priority
<p>Management should review the Temporary Staffing Department's procedural guidance to support the Nurse Bank, to ensure the resilience of the team, and to provide clarity of processes.</p> <p>Consideration should be given to the impact of the roll-out of HealthRoster on existing processes.</p>		<b>Medium</b>
Agreed Management Action 1	Target Date	Responsible Officer
<ol style="list-style-type: none"> <li>1. Identify the full range of processes that will require guidance</li> <li>2. Develop or improve existing guidance (this will include flowcharts)</li> <li>3. Communicate all procedures within TSD team</li> <li>4. Place all processes/flow charts onto shared folder with hard copies compiled on a file.</li> </ol>	01/09/2022	Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce

<b>Matter Arising 2: Inadequate structure within the Temporary Staffing Department (Design)</b>	<b>Impact</b>
<p>We were provided with a structure chart for the Temporary Staffing Department (see paragraph 2.6), we note the establishment, which currently holds no vacancies. Following consideration of the department’s remit, we found the current structure to be lacking in terms of resilience and continuity for the following reasons:</p> <ul style="list-style-type: none"> <li>• The Senior Nurse who is responsible for managing the Nurse Bank does not have a deputy in place;</li> <li>• The Temporary Staffing Administration Manager is responsible for managing the administration staff within the Nurse Bank, but reports directly to the Senior Nurse, although we note the gap in pay bands.</li> <li>• In terms of pay bands, a further resource is placed between the two roles but does not act as a deputy or manage the Administration staff. They are responsible for professional standards and manage any complaints received about Bank and Agency staff.</li> <li>• Members of the team have not all been trained in the different operations within the Temporary Staffing Department. There are currently only two employees within the Department that undertake recruitment tasks for the Bank.</li> <li>• The Senior Nurse undertakes the review of the agency ‘Invoices on Hold’ report, rather than this being disseminated to the team.</li> </ul>	<p>Potential risk of: Issues relating to bank and agency are not identified or addressed</p>
<b>Recommendation 2</b>	<b>Priority</b>
<p>The Assistant Director of Workforce Resourcing is to review the current structure of the Temporary Staffing Department, giving consideration to the resilience issues highlighted in this review, to ensure the Nurse Bank is operating effectively.</p>	<p style="text-align: center;"><b>High</b></p>

Agreed Management Action 2	Target Date	Responsible Officer
<ol style="list-style-type: none"> <li>1. Structure to be reviewed to include a Deputy post to the manager from within the existing structure (cost neutral).</li> <li>2. Implement Deputy Role</li> <li>3. Undertake a general review of the structure to ensure the roles match the changing requirements of the service and that the staff undertake the duties appropriate to their banding.</li> </ol>	<p>01/09/2022</p> <p>01/01/2023</p> <p>Dec 2022 – Jan 2023</p>	<p>Sandra Coles, Senior Nurse, Temporary Staffing &amp; Strategic Nursing Workforce</p>

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Matter Arising 3: Resilience of the Temporary Staffing Department (Operation)		Impact
<p>The Senior Nurse within the Temporary Staffing Department spends a considerable amount of time resolving issues with agency invoices that are listed on the 'Invoices on Hold' report, as referred to in matter arising 2.</p> <p>A period of absence of the Senior Nurse highlighted that this creates a lack of resilience as the report was not actioned during the period, which stopped payment. As a result, on return of the Senior Nurse the 'Invoices on Hold' report, dated 27 January 2022, reported a total invoice value of £1,280,149.06, with 2,374 line items of data. A subsequent report, dated 9 March 2022, reported a reduced value of £806,706.33, across 1,584 line items of data.</p> <p>We note that from 1 March 2022 the team's role in actioning the report should reduce given the introduction of agency self-billing, where greater reliance is placed on the wards to verify shifts.</p>		<p>Potential risk of:</p> <p>Issues relating to bank and agency are not identified or addressed.</p>
Recommendation 3		Priority
<p>Management need to ensure that there is greater resilience within the Temporary Staffing Department, to ensure transactional functions do not come to a stop, due to the absence of one individual.</p>		<p><b>High</b></p>
Agreed Management Action 3	Target Date	Responsible Officer
<ol style="list-style-type: none"> <li>The implementation of Allocate/Health roster and change to incorporate self-billing will resolve the current issue of processing invoices.</li> <li>Provide training to all of the team members to enable them to rotate into each other's roles. This will enable the ability for them to cross-cover when absences arrive and enrich their own roles.</li> </ol>	<p>December 2022</p>	<p>Sandra Coles, Senior Nurse, Temporary Staffing &amp; Strategic Nursing Workforce</p>

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<b>Matter Arising 4: Roles and responsibilities for Bank recruitment (Operation)</b>		<b>Impact</b>
<p>There is a lack of clarity of roles and responsibilities over the recruitment of bank staff. Recruitment is currently being undertaken by several departments, as noted below. We were therefore unable to verify if the Temporary Staffing Department can effectively operate to facilitate the timely recruitment to the Nurse Bank:</p> <ul style="list-style-type: none"> <li>• The Nursing Hub is responsible for recruiting nurses and HCSWs to the Bank;</li> <li>• The Workforce team is also undertaking recruitment on behalf of the Bank; and</li> <li>• The Temporary Staffing Department are recruiting Students.</li> </ul> <p>It has been proposed going forward that the recruitment of bank nurses will return to the Temporary Staffing Department. The Assistant Director of Workforce Resourcing has produced a spreadsheet to assess the effectiveness of the recruitment process, including time taken to recruit, and the numbers being recruited. If the process is undertaken in a timely manner, recruitment of bank nurses and HCSWs will return to the Temporary Staffing Department.</p> <p>We acknowledge the impact the COVID-19 pandemic has had on recruitment arrangements and the need to onboard greater numbers of temporary staff at speed to support mass vaccination and testing centres.</p>	<p>Potential risk of:</p> <p>Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment of bank and agency staff</p>	
<b>Recommendation 4</b>		<b>Priority</b>
<p>The Health Board should draw on the experience from recruiting at pace during the COVID-19 pandemic, to reaffirm the most effective means of recruiting Bank staff, and where this is best placed.</p>		<b>Medium</b>
<b>Agreed Management Action 4</b>	<b>Target Date</b>	<b>Responsible Officer</b>
<ol style="list-style-type: none"> <li>1. Training has already been provided on Trac recruitment system to the team and recruitment of Registered Nurses has taken place.</li> <li>2. HCSW recruitment (much higher volume) will commence with the TSD from 1<sup>st</sup> June going forward.</li> <li>3. From this time all recruitment for the bank will be undertaken by the TSD.</li> </ol>	June 2022	Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce

<b>Matter Arising 5: Lack of engagement with service users (Operation)</b>		<b>Impact</b>
<p>We found that there is currently a lack of engagement with hospital wards to ascertain if the Nurse Bank is meeting the needs of service users and therefore operating effectively. Similarly, we found that no satisfaction surveys are being undertaken with Bank staff.</p> <p>We note that reports are circulated by the Temporary Staffing Department on nurse fill rates, but we were unclear on the level of engagement and action following dissemination.</p> <p>The administrative tasks currently undertaken by the Senior Nurse hamper the available time to engage with hospital wards and key nursing contacts within the Health Board.</p> <p>We note that the COVID-19 pandemic has reduced face to face contact amongst staff. Although in such instances, surveys are a useful mechanism to seek feedback, but we were unable to evidence any such alternative means of ascertaining effectiveness.</p>		<p>Potential risk of:</p> <p>Issues relating to the Nurse Bank are not identified or addressed.</p>
<b>Recommendation 5</b>		<b>Priority</b>
<p>The Temporary Staffing Department's approach to engagement with service users, including ward management and bank staff requires a review, to ensure the team are continually striving to meet the needs of the Health Board, informed by service users.</p> <p>Engagement mechanisms used should be varied beyond face-to-face, to ensure the maximum reach.</p>		<b>Medium</b>
<b>Agreed Management Action 5</b>	<b>Target Date</b>	<b>Responsible Officer</b>
<ol style="list-style-type: none"> <li>Develop an engagement plan for our key stakeholders which will include:- bank staff, ward managers</li> <li>Implement engagement plan.</li> </ol>	<p>January 2023</p> <p>February 2023</p>	<p>Sandra Coles, Senior Nurse, Temporary Staffing &amp; Strategic Nursing Workforce</p>

<b>Matter Arising 6: Operational management of the Temporary Staffing Department (Operation)</b>		<b>Impact</b>
<p>To ascertain the operational arrangements for managing the Temporary Staffing Department we requested all personal files. We selected a sample of staff who have had instances of sickness absence and we reconciled these to the relevant personal files and electronic records available, to establish if the relevant documentation had been completed correctly, in accordance with the Managing Attendance at Work Policy. We identified that:</p> <ul style="list-style-type: none"> <li>We were unable to locate a personal file for the Professional Standards Nurse and therefore we were unable to establish if return to work interviews and forms had been completed.</li> <li>For further members of the department we found two instances whereby Return to Work (RTW) forms were not completed. In addition, there was one instance of the RTW form being completed a month following the employees return to work.</li> </ul>		<p>Potential risk of:</p> <p>Personal files are not being retained appropriately for staff.</p> <p>Sickness is not being managed correctly.</p>
<b>Recommendation 6</b>		<b>Priority</b>
<p>The operational management of the Temporary Staffing Department requires improvement. A personal file for all members of the team should be held by the relevant manager and updated in a timely manner, which should reconcile to electronic records.</p>		<b>Medium</b>
<b>Agreed Management Action 6</b>	<b>Target Date</b>	<b>Responsible Officer</b>
<ol style="list-style-type: none"> <li>Personal files to be reviewed and updated to include all relevant staff information.</li> <li>Administration manager to receive appropriate training in sickness management and relevant management training</li> </ol>	<p>July 2022</p> <p>31/09/2022</p>	<p>Sandra Coles, Senior Nurse, Temporary Staffing &amp; Strategic Nursing Workforce</p>

<b>Matter Arising 7: Range of agency usage (Operation)</b>		<b>Impact</b>
<p>We were provided with the most recent report for Bank and Agency staff fill rates and the overall fill rate for the Health Board week commencing 27 February 2022 was 66%. We reviewed the Clinical Board fill rate report, and the fill rate was 99% within CD&amp;T whilst in Specialist Services the fill rate was 49%, with 412 requests being made and 200 shifts being filled. The low fill rate within Specialist Services is a result of the Clinical Board's requirement for specialist Nurses in Cardiac Services and Neurosciences.</p> <p>We were provided with the Agency 2021 Framework with all the agencies recorded, which amounted to just over 140 agencies, but currently the Temporary Staffing Department only request agency nurses from 36 agencies. More shifts could potentially be filled if the Department utilised a greater number of agencies, particularly those of a specialist nature.</p>		<p>Potential risk of:</p> <p>Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment of bank and agency staff.</p>
<b>Recommendation 7</b>		<b>Priority</b>
<p>The Temporary Staffing Department is to maximise all available agency options via framework agreements, to ensure a greater fill rate, to support the safer operation of wards.</p>		<b>High</b>
<b>Agreed Management Action 7</b>	<b>Target Date</b>	<b>Responsible Officer</b>
<p>Undertake a review of agencies currently not used who are on the Welsh Framework to identify if there are further agencies that could provide appropriate numbers of staff.</p>	31/03/2023	Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce

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Matter Arising 8: Ward verification of agency shifts (Operation)		Impact
<p>The Health Board implemented self-billing on 1 March 2022, which places a greater reliance on ward management to verify agency shifts worked.</p> <p>The 'Invoices on Hold' report dated 9 March 2022, included invoices on hold with an invoice date from 1 March 2022 onwards, which totalled £95,068.04.</p> <p>At the time of the audit, the Senior Nurse in the Temporary Staffing Department circulated an email to all Senior and Lead Nurses requesting them to remind Ward Managers of the need to verify the shifts for the agency to receive payment.</p>		<p>Potential risk of: Agencies are not being paid in a timely manner</p>
Recommendation 8		Priority
<p>The Temporary Staffing Department are to engage with and remind ward managers of the requirement to verify agency shifts worked, until agency self-billing becomes an embedded process within the wards, to ensure timely payment.</p>		<p><b>Medium</b></p>
Agreed Management Action 8	Target Date	Responsible Officer
<p>1. Present reports on the failure to verify shifts by clinical boards to Nurse Directors for them to ensure compliance within the areas they are accountable for.</p>	<p>June 2022 and then monthly until health roster is fully embedded</p>	<p>Sandra Coles, Senior Nurse, Temporary Staffing &amp; Strategic Nursing Workforce</p>

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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:

	<b>Substantial assurance</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable assurance</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited assurance</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>No assurance</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Assurance not applicable</b>	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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# Review of Quality Governance Arrangements – Cardiff and Vale University Health Board

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# Summary report

## About this report

- 1 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. A key purpose of these 'quality governance' arrangements is to help organisations and their staff both monitor and where necessary improve standards of care.
- 2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users.
- 3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.
- 4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the COVID-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.
- 5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at Cardiff and Vale University Health Board (the Health Board) carried out during 2021. To test the 'floor to board' perspective, we examined the arrangements for general surgical services.

## Key messages

- 6 Overall, we found that the **Health Board has agreed quality and safety priorities at all levels of the organisation. Corporate and operational structures for quality governance are reasonably effective. However, there are opportunities to strengthen aspects of culture and quality improvement. Further investment is required to enable the Health Board to fully roll-out and embed planned quality and safety improvements.**
- 7 The Health Board has agreed quality and safety priorities at all levels of the organisation. There are reasonable corporate and operational arrangements in place for monitoring risk. Arrangements for monitoring mortality and morbidity are developing. The Health Board has effective arrangements to monitor and track progress with complaints, where it consistently achieves performance targets and arrangements to capture patient experience are reasonably effective. The Health Board has a well-established values and behaviour framework which is embedded in workforce processes. There is collective responsibility for quality and safety amongst Executive Leadership. Corporate and operational structures and processes for quality and safety are reasonably effective and the Health Board is taking steps to strengthen these further. Agendas for corporate and operational quality and safety meetings provide a wide coverage of quality and safety issues for discussion and there is sufficient information for scrutiny and assurance at both a corporate and clinical board levels and the Health Board's use of quality data is maturing.
- 8 However, we found poor alignment between corporate and operational quality and safety priorities and monitoring and reporting on their delivery needs strengthening. There is scope to ensure the corporate Quality, Safety, and Experience Committee maintains greater oversight of risks overseen by other committees where there is a clear quality and safety impact. Arrangements for clinical audit require significant improvement. The Health Board also needs to ensure that staff feel able to raise concerns. Whilst the departure of key clinical executives from the organisation potentially poses risks to rolling-out and embedding the new Quality, Safety and Patient Experience Framework; additional resources have been allocated to enable the Health Board to achieve this. There are opportunities for the agenda of corporate Quality, Safety and Experience Committee meetings to be more dynamic to reflect new and emerging quality risks and issues. Reporting on the four harms<sup>1</sup> associated with COVID-19 requires strengthening. Furthermore, reporting requires development at directorate level for services commissioned by the Health Board.

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<sup>1</sup> The four harms are – (i) harm from COVID-19 itself; (ii) harm from overwhelmed NHS and social care system; (iii) harm from reduction in non-COVID-19 activity; and (iv) harm from wider societal actions / lockdown

## Recommendations

- 9 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management response to these recommendations is summarised in **Appendix 1**.

### Exhibit 1: recommendations

#### Recommendations

##### Quality and Safety Priorities

- R1 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.

##### Risk Management

- R2 There is scope to ensure the corporate Quality, Safety and Experience Committee maintains greater oversight of risks scrutinised by other committees where there is a clear quality and safety impact. There is scope to improve the quality of risk information recorded on operational risks registers and the escalation and de-escalation of risk to / from the Corporate Risk Register. The Health Board, therefore, should ensure:
- the corporate Quality, Safety and Experience Committee seeks assurance from other Health Board committees where their risks potentially impact on quality and safety; and
  - review and improve the quality of risk information recorded on operational risks registers and introduce an appropriate process for the escalation and de-escalation of risk to / from the Corporate Risk Register.

##### Clinical Audit

- R3 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:
- complete the work on its clinical audit strategy, policy, and plan. The plan should cover mandated national audits, corporate-wide, and local audits

## Recommendations

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.

## Values and Behaviours

R4 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.

## Personal Appraisal Development Reviews (PADRs)

R5 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.

## Resources to support quality governance

R6 Resources within both the Corporate Patient Experience and Concerns Teams have reduced over the last three years and the COVID-19 pandemic has had a significant impact on the Infection Prevention and Control Team's capacity. At an operational level, the Surgery Clinical Board and Surgical Services Directorate have designated leads for many key aspects of quality and safety. However, they do not have protected time to fulfil several of these roles. The Health Board, therefore, should ensure there is sufficient resource and capacity to support quality governance at both corporate and operational levels.

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## Recommendations

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### Monitoring and Reporting

R7 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 Experience Committee and Board.

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# Detailed report

## Organisational strategy for quality and patient safety

- 10 Our work considered the extent to which there are clearly defined priorities for quality and patient safety and effective mitigation of the risks to achieving them.
- 11 We found that **whilst the Health Board has agreed quality and safety priorities at all levels of the organisation, there is scope to ensure that operational priorities are better aligned to corporate priorities. Risks are managed appropriately at both a corporate and operational level, but opportunities exist to improve these arrangements further.**

### Quality and patient safety priorities

- 12 The Health Board's 10-year strategy, 'Shaping our Future Wellbeing', sets out its mission of "caring for people and keeping people well" and its vision that "a person's chance of leading a healthy lifestyle is the same wherever they live and whoever they are". To achieve its mission and vision, the Health Board has developed a strategy based on a "home first" approach which aims to avoid harm, waste, and variation; empower people; and deliver outcomes that matter to them. The Health Board's strategic objectives cover four key areas: population, service priorities, sustainability, and culture.
- 13 A key priority for the Health Board is to develop a patient safety and service quality culture to ensure quality improvement is a part of everyday practice. The 10-year strategy identifies several outcomes for the Health Board if it maintains a continued focus on patient safety, such as:
  - zero tolerance of never events and hospital acquired infections;
  - patient safety principles are embedded, owned, understood, and acted on by staff at all levels of the organisation; and
  - recognised as a leading UK organisation for its work on patient safety initiatives and the application of improvement methodology.
- 14 To achieve these outcomes, the Health Board's strategy identifies several key actions which include:
  - establishing governance processes that demonstrate learning from the depth and breadth of quality, safety, and patient experience sources; and
  - investment in an expert specialist patient safety team who can support and work alongside teams to respond rapidly when things go wrong, supporting patient's, families, and staff and to ensure that actions are taken to prevent harm in the future.
- 15 The Health Board's Annual Plan 2021-22 outlines its commitment to "focus on quality, safety, and patient experience across all settings where healthcare is provided as we [the Health Board] look to be one of the safest organisations in the NHS". To achieve this, the quality, safety, and patient experience element of the plan identifies eight quality priority themes:

- Quality, Safety and Experience Framework 2021-2026 (see **paragraph 17**);
  - Organisational safety culture;
  - Leadership and the prioritisation of quality, safety, and experience;
  - Patient experience and involvement in quality, safety, and experience;
  - Patient safety learning and communication;
  - Staff engagement and involvement in safety, quality, and experience,
  - Patient safety, quality and experience data and insight;
  - Professionalism of patient safety, quality, and experience.
- 16 The Health Board's headline activities and delivery timescales are designed to support the achievement of its quality priorities. However, there is no monitoring and reporting framework in place. As a result, we found limited assurance and scrutiny at the corporate Quality, Safety and Experience Committee (QSE Committee) on the key areas of delivery. This creates a risk that the Committee, and subsequently the Board, are not fully sighted on aspects where quality delivery aims are not being achieved or where there is limited progress. This was also a key finding in our 2021 Structured Assessment report<sup>2</sup>, which resulted in a recommendation being made for the Health Board to strengthen its arrangements for monitoring and reporting on overall delivery of the 2021-22 Annual Plan and subsequent plans.
- 17 Our work found that the Quality, Safety, and Improvement Framework 2017-20 remained in place beyond its 2020 expiry date whilst the Health Board completed work on its new Quality, Safety, and Patient Experience Framework for the period 2021 to 2026. The framework, which was presented to the corporate QSE Committee in September 2021 for approval, focusses on eight key themes:
- Safety culture,
  - Leadership and prioritisation,
  - Patient experience and involvement,
  - Patient safety, learning and communication,
  - Staff engagement and involvement,
  - Data and insight,
  - Professionalism and
  - Quality Governance.
- 18 The Health Board engaged stakeholders as part of the new framework development by seeking the views of clinical and non-clinical staff, patients and their families / carers, and other key external stakeholders and partners, such as the Community Health Council.
- 19 Both the Surgery Clinical Board and Surgical Services Directorate identify quality and patient safety priorities and monitor their progress. The Clinical Board and Directorate revised their priorities in response to the COVID-19 pandemic.

<sup>2</sup>[https://www.audit.wales/sites/default/files/publications/cardiff\\_vale\\_health\\_board\\_structured\\_assessment\\_2021\\_phase\\_two\\_english\\_1.pdf](https://www.audit.wales/sites/default/files/publications/cardiff_vale_health_board_structured_assessment_2021_phase_two_english_1.pdf)

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. **(Recommendation 1)**

## Risk management

- 20 The Health Board revised its risk management strategy, approach, and Board Assurance Framework (BAF) during 2021, and established a risk appetite for the safety, quality, and accessibility of care which it defines as 'open'<sup>3</sup> with the intention to move to 'seek'<sup>4</sup>.
- 21 One of the ten principal risks to the Health Board as set out in the BAF relates to patient safety, which has been assigned to the clinical Executive Directors as leads responsible for managing the risk and to the corporate QSE Committee to seek and provide assurance that the Health Board is managing the risk appropriately. The BAF clearly outlines the current controls and assurances alongside any gaps and actions to address them.
- 22 Our observation of the corporate QSE Committee in February 2022 indicated that a brief presentation, discussion, and scrutiny took place on the BAF as well as the patient safety risk assigned to the committee.
- 23 There is scope to ensure the corporate QSE Committee maintains greater oversight of risks assigned to other committees where there is a clear quality and safety impact. For example, workforce risks are a consistent theme in the Surgery Clinical Board assurance report, the Corporate Risk Register (CRR), and the BAF. Whilst the strategic workforce risk is appropriately assigned to Executive Director of People and Culture as lead and to the Strategy and Delivery Committee for assurance purposes, the Health Board should consider how the corporate QSE Committee oversees and gains assurance on the wider workforce risks from a quality and safety perspective. **(Recommendation 2)**
- 24 The Health Board's CRR provides an overview of the key operational risks from the divisions and corporate directorates. Each risk is linked to a sub-committee of the Board for assurance purposes with any risks scoring 20 and above escalated onto the BAF as a principal risk to the Health Board. The CRR identifies several risks in relation to quality and safety.
- 25 At an operational level, the Health Board's Surgery Clinical Board and Surgical Services Directorate maintain and actively manage risk registers. They clearly articulate quality and safety risks at this level which are scored appropriately and

<sup>3</sup> Definition of 'open' risk appetite - "despite short term inherent risks it recognises potential for long term gain. The Health Board often challenges current clinical practices and pursues innovative treatment and care solutions. Confident in its risk control the Health Board allows non-critical decisions to be devolved to a low operational level."

<sup>4</sup> Definition of 'seek' risk appetite - "despite short term inherent risks it seeks potential for long term gain. The Health Board will routinely challenge current clinical practices and pursue innovative treatment and care solutions".

have appropriate controls. However, whilst the Clinical Board risk register identifies risk owners, the Surgical Services risk register does not. Risk also features on the agenda for both the Surgery Clinical Board and Surgical Services Quality, Safety, and Experience Committee meetings. Whilst operational processes for managing risk are reasonably effective, our discussions with staff found that risk management arrangements are developing. There is scope to improve the quality of risk information recorded on operational risks registers and the process of escalation and de-escalation of risks to / from the CRR to maintain the quality of the BAF and ensure the Board is appropriately sighted of key risks facing the organisation. We understand that the Health Board is currently addressing these issues.

## Organisational culture and quality improvement

- 26 NHS organisations should be focused on continually improving the quality of care and using finite resources to achieve better outcomes and experiences for patients and service users. Our work considered the extent to which the Health Board is promoting a quality and patient-safety-focused culture, including improving compliance with statutory and mandatory training, participating in quality improvement processes that are integral with wider governance structures, listening and acting upon feedback from staff and patients, and learning lessons.
- 27 We found that **the Health Board has a dedicated Quality Improvement Team, but the COVID-19 pandemic has impacted on the support it provides to the Health Board. Arrangements for monitoring mortality and morbidity are developing, but arrangements for clinical audit require significant improvement. There is a well-established values and behaviours framework, but more work is required to develop an open and supportive culture to enable staff to raise concerns. The Health Board has effective arrangements to monitor and track progress with complaints, and consistently achieves performance targets. There are reasonable arrangements to capture patient experience, but more work is required to improve Board and Committee oversight of patient stories.**

### Quality improvement

- 28 The Health Board's Quality Improvement (QI) Team consists of 2.6 Whole Time Equivalent (WTE) staff (4 headcount). The capacity of the team has recently increased through the reconfiguration of a previous role and securing 12 months' non-recurring funding for 1 WTE post.
- 29 Prior to the COVID-19 pandemic, the QI team delivered the Leading Improvement in Patient Safety (LIPS) Programme on a bi-annual basis to both clinical and non-clinical staff. However, the pandemic is limiting usual training activity. The Health Board's intention is to reinstate and refresh the programme during April and September 2022. However, the programme is under review as part of a wider review of the quality improvement process across the Health Board. The Health

Board was also able to secure a Health Foundation research grant for its Cardiff and Vale Quality Improvement (CAVQI) programme which aims to support departments across the organisation with data analysis and improvement. The Health Board has completed an evaluation of the programme which identified several positive outcomes, including the development of a dashboard to analyse incident report data in real-time. The Health Board intends to introduce the programme across the organisation.

- 30 The Health Board supports the Improving Quality Together Learning Programme; however, it did not provide data to demonstrate the proportion of staff that have completed the various levels of training.

## Clinical audit

- 31 Clinical audit is an important way of providing assurance about the quality and safety of services. At the time of our review, the Health Board was developing a Clinical Audit Strategy and Policy, but there has been a delay in progress due to staffing challenges (long-term sickness) and awaiting confirmation from the Health Board on investment plans for clinical audit.
- 32 The Health Board categorises clinical audits into three tiers:
- Tier 1 – Mandatory national clinical audit;
  - Tier 2 – All other national audits and local clinical audits undertaken to address the patient safety and quality agenda; and
  - Tier 3 – Local clinical audit for any other reason including revalidation and continual professional development (CPD) purposes.
- 33 The Health Board approved its clinical audit plan for 2021-22 which includes all tier 1 and anticipated tier 2 audits. Whilst it does not include tier 3 audits, there are arrangements in place to ensure all tier 3 audits are scrutinised and are beneficial to the directorate and clinical board. At the time of our review, we found limited evidence that the Health Board has approved a clinical audit plan for 2022-23.
- 34 Both the Surgery Clinical Board and Surgical Services Directorate have a programme for national, local, and bespoke clinical audits, but have no system to track delivery. They provide progress updates to the corporate QSE Committee through the Clinical Board Assurance Reports. There are arrangements in place to share and discuss clinical audit findings, learning, and good practice across the Health Board's governance structure and with regional networks.
- 35 A corporate QSE Committee update in September 2021 highlighted the activity of the Clinical Effectiveness Committee (CE Committee) since December 2020. The report outlined the progress of tier 1 audits and highlighted several key messages issues, learning, and actions arising from the reviews to discuss at the committee. We also found evidence of verbal updates provided to the corporate QSE Committee during its subsequent meetings. We comment on the purpose of the Health Board's CE Committee in **paragraph 75**.

- 36 The CE Committee update highlighted capacity and IT system issues within the Clinical Audit Team which are impacting on the support available for local (tier 2) clinical audit activity, the quality of assurance around the development of improvement plans, and the progress being made in addressing audit recommendations. Results from our data collection survey found that corporate resources for clinical audit have reduced over the last 3 years to enable the Health Board to achieve cost reductions. The team currently comprises 6.21 WTE (7 headcount) and, at the time of our review, there was one vacancy. The Health Board's benchmarking exercise and review of current resources and team structure has also identified that clinical audit requires investment to deliver desired improvements. In addition to increasing the team's capacity, the Health Board has also invested in the AMaT<sup>5</sup> audit management system to better utilise clinical audit as a source of assurance and establishing a process for monitoring and reporting local (tier 2) clinical audits.
- 37 Internal Audit completed a review of the Health Board's clinical audit arrangements during 2021. The review focussed on three areas: roles, responsibilities, and resources; programme planning and programme delivery; and board assurance. A limited assurance rating was given, and several key matters were identified in relation to the absence of a clinical audit strategy, policy, and procedures; inadequate resources and clinical audit IT system; absence of a clinical audit training plan; and limited oversight and scrutiny of local clinical audit activity.  
**(Recommendation 3)**

## Morbidity and mortality

- 38 Mortality and morbidity review meetings provide a systematic approach for peer review of adverse events, complications, or mortality to reflect, learn from and improve patient care. We found that the processes around universal mortality reviews were recently superseded by the commencement of the Medical Examiner function.
- 39 The Health Board has established a bi-monthly multi-disciplinary Mortality (Learning from Deaths) Group. The Assistant Medical Director for Clinical Governance and Patient Safety chairs the group. Meetings have a balanced agenda encompassing a range of issues including: Covid-19 mortality; mortality reviews; divisional updates; and detailed reviews of mortality data. Meetings are well attended by clinical staff with good quality reports, presentations, discussion, and challenge.
- 40 Mortality and morbidity feature in the corporate QSE Committee's Quality Indicator report. The February 2022 update provides information on the implementation of the new process for mortality reviews and identifies emerging themes and actions within the Health Board. For example, the report identifies communication as a

<sup>5</sup> Audit Management and Tracking

recurring theme and, as a consequence, the Health Board is recruiting staff to ensure there is timely and regular communication with families.

- 41 At an operational level, mortality data analysis is a standing item on the agenda for the Surgery Clinical Board's Quality, Safety and Experience Committee. However, there is limited evidence of detailed discussion. Furthermore, results from our divisional and directorate data collection surveys suggest there were arrangements in place pre-pandemic to review mortality and morbidity through regular meetings, with learning and good practice shared outside the meetings via distribution of minutes and updates provided to the Surgery Clinical Board's Quality, Safety and Experience Committee. However, they have not been able to maintain these arrangements during the pandemic.

## Values and behaviour

- 42 The Health Board's Values and Behaviours Framework sets out its vision for a quality and patient-safety-focussed culture. It focuses on being kind, caring and respectful, and emphasises, integrity, and personal responsibility. The Health Board has embedded values and behaviours in workforce processes, such as recruitment, appraisals, and induction. However, the quality of induction for substantive and temporary staff appear to vary in quality. Of the staff who completed the Health Board's internal patient safety survey<sup>6</sup>, only 36% agreed or strongly agreed that induction arrangements for new and temporary staff in their work area / department support safe and effective care.
- 43 Results from the Health Board's internal patient safety survey also revealed a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns:
- 45% agreed or strongly agreed that when an event is reported, it felt like the person is being reported, not the problem.
  - 36% agreed or strongly agreed when asked if they felt their mistakes are held against them.
  - 46% agreed or strongly that they were worried that mistake's they make are kept in their personal file.
  - 32% agreed or strongly agreed that staff are given feedback about changes put into place based on incident reports.
  - 51% agreed or strongly agreed that staff are informed about errors that happen in their team / department.
  - 57% agreed or strongly agreed that teams / department discuss ways to prevent errors from happening again.

<sup>6</sup> The Cardiff and Vale University Health Board's Patient Safety Staff Survey ran for a period of 4 weeks in 2021. The survey attracted responses from 988 staff. The findings are unlikely to be representative of the views of all staff across the Health Board. As a result, we have only used them to illustrate particular issues.

- 24% staff indicated a mistake is rarely or never reported if it is caught and corrected before affecting the patient.
- 21% staff indicated a mistake is rarely or never reported if it has no potential harm to the patient.
- 45% staff indicated a mistake is usually or always reported if a mistake could harm the patient. **(Recommendation 4)**

- 44 The most recent NHS Wales Staff Survey<sup>7</sup> showed a small but still significant proportion of staff expressing concerns relating to bullying, harassment, or abuse by another colleague, member of the public, or line manager over the past year (18.8%, 18.1% and 9.7% respectively). Fewer than half agreed or strongly agreed that the organisation takes effective action if staff are bullied or harassed by members of staff or a member of the public (40.3%). However, results from the Health Board's internal patient safety survey show that 67% of staff agreed or strongly agreed that people treat each other with respect in their team or department.
- 45 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. November 2021 figures show an overall organisational compliance of 72.26%<sup>8</sup>. Whilst this level slightly improved since September 2021, it is still below the target of 85%. The Health Board's internal patient safety survey found that 61.28% of staff disagreed or strongly disagreed that they have enough time at work to complete any statutory and mandatory training. The Surgery Clinical Board and Surgical Services Directorate have indicated that managers are allowing staff time to complete statutory and mandatory training, although this has been challenging over the last year due to pressures caused by the pandemic. Senior leadership and managers within the Surgery Clinical Board and Surgical Services Directorate encourage and monitor staff compliance through the appraisal process and revalidation events.
- 46 Personal Appraisal Development Review (now Values Based Appraisal) is a two-way discussion which helps staff understand what is expected of them in their role, become more engaged, and take responsibility for their own performance and development. Against a national target of 85%, the overall Health Board compliance rate for appraisals in November 2021 was 31.6% which has remained broadly consistent with the position reported in September 2021 of 31.9%. Compliance reported by the Surgery Clinical Board during our fieldwork was 27%. The Health Board reports that operational pressures are adversely affecting compliance. At an operational level, the Surgery Clinical Board are encouraging managers to use the Electronic Staff Record (ESR) system by enabling them to access training. However, enabling work has not delivered the level of

<sup>7</sup> The NHS Wales Staff Survey ran during November 2020 at the same time as the second surge in COVID-19 transmission and rising numbers of hospital admissions. The survey response rate was 22%, compared to an all-Wales average of 19%.

<sup>8</sup> The Health Board is required to report compliance to the Welsh Government monthly and the target for compliance for all health boards is 85%.

improvement anticipated over the COVID-19 pandemic period. (**Recommendation 5**)

## Listening and learning from feedback

### Patient Experience

- 47 The Health Board's standalone Patient Experience Framework which expired in 2020, was replaced in 2021 by the new Quality, Safety and Patient Experience Framework for 2021 to 2026. The new framework identifies patient experience and involvement as one of its eight key themes and includes the development and implementation of a Patient Safety Partner (PSP) framework and a 'What Matters to You' campaign.
- 48 Our work found that Clinical Boards provide patient experience updates to the corporate QSE Committee via their Quality, Safety, and Experience Sub-group meeting minutes, Clinical Board Assurance Reports, and the quality indicators progress report. We also note a standalone patient experience update was provided to the February 2022 corporate QSE Committee. The report provides an overview of the role of the Patient Experience Team and how it operates under the recent Health and Social Care (Quality and Engagement) (Wales) Act 2020. It also highlights key achievements, and areas of risk or concern.
- 49 The Surgery Clinical Board and Surgical Services Directorate use short surveys, suggestion boxes, and 'Happy or Not' kiosks to capture patient experience information. There are also plans to install patient / visitor ward information boards at the entrance to all ward areas. They share the compliments or concerns raised by patients and their carers with staff to help them understand the patient's perspective of care received and any action to be taken where necessary.
- 50 During the pandemic, the Health Board withdrew its monthly feedback surveys and 'Happy or Not' kiosks and adapted its methods for gaining patient feedback by introducing a range of online surveys. The 'Happy or Not' kiosks have now been reintroduced to gather feedback from the Mass Vaccination Centres. The Health Board also issues surveys to patients and staff as part of bespoke studies across a range of different services.
- 51 The Health Board has a Complaints and Patient Advice and Liaison Service (PALS) that sits under the remit of the Executive Director of Nursing.
- 52 The Health Board is rolling out the Once for Wales Service User Feedback System that will introduce real-time feedback and 'ward to board' reporting functionality. This will ensure a consistent approach across the organisation and enable it to monitor actions and undertake more effective thematic analysis.

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## Concerns and Complaints

- 53 Against a national target of 75% of complaints responded to within 30-days, the Health Board achieved 77% as at January 2022 which represents a slight decrease in performance of 88% in December 2021. However, the Health Board consistently exceeds the national target through its Corporate Concerns Team, whose approach is to resolve as many concerns as possible under early resolution.
- 54 The Health Board uses information from concerns, complaints, serious incidents (known also as Nationally Reportable Incidents), and never events to identify themes and trends which it includes in its Quality Indicators Report. The top reported categories for serious incidents since June 2021 have been pressure ulcers, patient accidents / falls, unexpected deaths, delayed diagnostic processes / procedures, and delayed access / admission. The main themes in relation to concerns are waiting times, communication, care, and treatment.
- 55 The Surgery Clinical Board reported 812 concerns received between 1<sup>st</sup> September 2020 to 30<sup>th</sup> September 2021. It has embedded its arrangements for tracking concerns, with tracker meetings across all directorates aligned to an overarching Clinical Board tracker database. This enables effective monitoring of timelines in responding to concerns and supports the ability to take prompt action where there are delays. The effectiveness of these arrangements and the support received from the Corporate Concerns Team is reflected in the Surgery Clinical Board's performance, with 86% of concerns closed within the 30-day target for the period 1<sup>st</sup> September 2020 to 30<sup>th</sup> September 2021. The latest assurance report from the Surgery Clinical Board to the corporate QSE Committee in February 2022 identifies the main themes arising from concerns as: clinical treatment / assessment, appointments, communication issues, admissions, and attitude / behaviour. However, there was limited evidence within the report to demonstrate how the Clinical Board is learning and acting on the main concerns themes.
- 56 The Assistant Directors of Patient Experience and Patient Safety provide a report and presentation annually to the corporate QSE Committee which outlines the quality, safety, and experience themes and trends identified across the Health Board during the year. The 2020-21 report mainly focuses on the Health Board's work to adapt its reporting and working requirements across the organisation during the pandemic. However, the accompanying presentation identifies themes and trends in relation to key aspects of quality and safety, including patient safety incidents, concerns, redress, mortality reviews, COVID-19 investigations, and national clinical audit.
- 57 There appears to be a generally positive culture within the Health Board in relation to learning lessons and improving patient safety. Results from the Health Board's internal patient safety survey found that:
- 65% staff agreed or strongly agreed that they are actively doing things to improve patient safety.
  - 58% staff agreed or strongly agreed that mistakes have led to positive change.

- 43% staff agreed or strongly agreed that after staff make changes to improve patient safety, and they evaluate their effectiveness.

## Listening to staff concerns

- 58 The Health Board is committed to listening and learning from staff experiences and concerns. In December 2021, it reviewed and updated its Incident, Hazard, and Near Miss Reporting Procedure to reflect changes made by the NHS Wales Delivery Unit to the way NHS bodies report serious incidents. The procedure outlines a range of mechanisms for staff to raise concerns, including the 'freedom to speak up' initiative, 'safety valve' and whistleblowing policy. However, whilst the procedure references the 'safety valve' process as an option for raising concerns, the Health Board no longer uses it.
- 59 The Health Board's 'freedom to speak up' initiative aims to develop a culture of openness across the organisation. It supports and encourages staff to raise any concerns they may have. During June 2021, the Health Board updated its internet site and established a new communication plan to raise awareness across the organisation.
- 60 Whilst the Health Board regularly reports concerns to its corporate QSE Committee, it was unclear whether this includes concerns raised by staff. Subsequently, we could not assess the effectiveness of the arrangements.
- 61 The Health Board encourages staff to use Datix to report incidents. Whilst all staff within Corporate Services, the Surgery Clinical Board, and the Surgical Services Directorate appear to have access to the Datix system, the results from our data collection surveys suggest only some have received training or support to use the system to report concerns, near misses or run reports.
- 62 There is a mixed picture in relation to the culture around listening to staff concerns. Results from the Health Board's internal patient safety survey found 67% agreed or strongly agreed that staff will freely speak up if they see something that may negatively affect patient care, and 60% staff agreed or strongly agreed that their supervisor / manager seriously considers staff suggestions for improving patient safety. However, 41% agreed or strongly agreed that staff felt free to question the decision or actions of those with more authority and 27% agreed or strongly agreed that staff are afraid to ask questions when something does not seem right.

### **(Recommendation 4)**

## Patient Stories

- 63 Patient stories feature on the agenda of meetings of the Board, corporate QSE Committee, other sub-committees of the Board such as the Mental Health Capacity and Legislation Committee, and the Clinical Board Quality, Safety and Experience Committees. Patient stories are regularly shared in public Board meetings using videos. The corporate QSE Committee note patient stories included in Clinical Board Assurance Reports and in the minutes of the Clinical Board Quality, Safety

and Experience Committees presented during the meeting. Learning and actions arising from patient stories are identified at Clinical Board level.

### **Patient Safety Walkarounds**

- 64 Patient safety walkarounds provide Independent Members with an understanding of the reality for staff and patients, help make data more meaningful, and provide assurance from more than one source of information. The Health Board has recommenced its programme of walkarounds having paused them during the pandemic. However, they are on a smaller scale whilst COVID-19 restrictions and considerations remain in place. Independent Members commented positively on the walkarounds. They indicated that the walkarounds help them to triangulate information, to gain a sense of staff morale, and to understand the day-to-day issues affecting staff. Reports arising from patient safety walkarounds are shared with the respective Clinical Board and reported to the corporate QSE Committee annually.

### **Internal / External Inspections**

- 65 Our 2021 Structured Assessment work found that the Corporate Governance Directorate presents a legislative and regulatory tracker report to each Audit and Assurance Committee meeting. The update provides an overview of the Health Board's progress in implementing recommendations made by inspection and regulatory bodies, such as the Health and Safety Executive, Health Inspectorate Wales (HIW), and Community Health Council. The Corporate Governance Directorate has recently enhanced the content of the report to provide more robust assurance to the Audit and Assurance Committee, as well as to provide a commentary on the Health Board's management of Welsh Health Circulars, and Patient Safety Solutions. However, there are opportunities for the Audit and Assurance Committee to strengthen its role in seeking assurance from the corporate QSE Committee. Doing so might help provide a greater level of assurance to the Board that appropriate action is being taken to address and monitor external recommendations relating to quality and safety.
- 66 The corporate QSE Committee receives updates on HIW and CHC activity. Updates provided to the Committee meeting in February 2021, June 2021, and February 2022 provide an overview of CHC reports, and HIW local inspections and thematic and national reviews. All update reports gave sufficient information to ensure awareness amongst Committee members of all activity that could potentially impact on the Health Board.

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## Governance structures and processes

- 67 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.
- 68 We found **strong collective responsibility for quality and safety amongst the Executive Leadership of the Health Board. However, the departure of key clinical Executives from the organisation potentially poses risks to roll-out and embedding the new Quality, Safety and Patient Experience Framework. Corporate and operational structures and processes for quality and safety are reasonably effective and the Health Board is taking steps to strengthen these arrangements further. However, resources require further investment to enable the Health Board to fully roll-out and embed its planned quality and safety improvements.**

### Organisational design to support effective governance

- 69 There is strong collective responsibility for quality and patient safety amongst the Executive Leadership of the Health Board, with the Executive Director of Nursing, Medical Director, and Director of Therapies and Health Sciences in particular providing visible leadership in this area. The Health Board's senior leadership is supported by a team of Assistant Directors who provide day-to-day leadership for a range of functions including quality and safety Improvement; patient safety; quality assurance; and clinical effectiveness. The Health Board's Director of Nursing is retiring in July 2022 and, therefore, the Health Board will need to recruit to this role. This potentially poses a risk to the Health Board, as both the Director of Nursing and previous Medical Director were instrumental in the development of the new Quality, Safety, and Patient Experience Framework and will have left the Health Board before it has been fully implemented and embedded across the organisation. Our review found that the Executive Management Board regularly discuss quality and safety as a standing agenda item at its twice weekly meetings.
- 70 Whilst there is collective responsibility and accountability for quality and safety at a corporate level, our work found that at an operational level there is evidence of 'silo' working and a lack of clarity among Clinical Directors around their responsibilities for quality and safety. We understand that the Health Board is addressing this through the job planning process.

### Quality, Safety and Patient Experience Framework and Structures

- 71 We comment in **paragraph 17** on the Health Board's new Quality, Safety and Patient Experience Framework for 2021-26 which was approved by the corporate QSE Committee in September 2021. The framework articulates a structure which includes a range of committees and groups focussing on specific aspects of quality and safety. Each committee / group is required to provide assurance to the

corporate QSE Committee which, in turn, provides assurance to the Board via the quality, safety and experience dashboard and signals from noise data tool. It is expected that the committees / groups in the quality, safety, and experience structure will ensure an increased focus on key quality areas, reduce the workload of the corporate QSE Committee, and provide greater assurance to the Board. Key quality and safety exception reports such as, HIW reports, infection prevention and control reports and significant national quality, safety, and experience reports provide further assurance.

- 72 Whilst the framework is reasonably comprehensive at a corporate level, it doesn't fully articulate the operational structure and processes for quality and safety, and how they align with the corporate structures to provide 'floor to board' quality and safety assurance. For example, each of the Health Board's Clinical Boards have a local Quality, Safety, and Experience Committee which are underpinned by directorate or site-based leadership Quality, Safety, and Experience groups. Clinical Boards provide assurance to the corporate QSE Committee through periodic assurance reports and the inclusion of minutes from the local meetings. The Health Board is still in the process of rolling out and embedding the new quality, safety and patient experience structure with some key committees and groups - such as the Organisational Learning Committee and Clinical Safety Group - yet to meet.

### **Corporate Quality, Safety, and Experience Committee**

- 73 The corporate QSE Committee is responsible for providing assurance and advice to the Board in relation to quality and patient safety. The corporate QSE Committee considers and seeks assurance from a range of quality and safety information. As part of our work, we observed the committee on several occasions, and found them to be well-chaired with good quality discussion, scrutiny, and challenge from Independent Members. However, our recent structured assessment work highlighted some concerns expressed via the 2020-21 Board Effectiveness Survey regarding the length of the committee agendas.
- 74 The committee's arrangements for providing assurance on quality and safety matters has improved. The committee reviews and scrutinises a range of quality and safety indicators and provides an overview of the Health Board's performance at each Board meeting.

### **Clinical Effectiveness Committee**

- 75 The monthly Clinical Effectiveness Committee (CE Committee) was established in December 2020 to provide a forum for senior clinicians to monitor the implementation of NICE<sup>9</sup> guidelines, to provide strategic direction for the Health Board's national and local clinical audit programme, and to receive reports from

<sup>9</sup> National Institute of Health and Care Excellence

sub-groups and escalate issues / provide assurance to the corporate QSE Committee and Board as appropriate. The committee has multidisciplinary membership and invites representatives from Clinical Boards to discuss items on its agenda.

## **Clinical Safety Group, Organisation Learning Committee, and Serious Incidents / Concerns Group**

- 76 The Health Board intends to further strengthen its quality and safety arrangements by establishing a Clinical Safety Group and an Organisational Learning Committee.
- 77 The Clinical Safety Group's draft Terms of Reference indicates that its role will be to provide advice and assurance to the corporate QSE Committee by overseeing Health Board plans; considering external review / investigation reports and their implications on patient and citizen experience; considering outcomes for patient feedback; reviewing compliance with Health and Care Standards; and monitoring implementation of the Quality, Safety and Experience Framework. The committee will have multidisciplinary membership from nursing, medical, and corporate staff.
- 78 The Organisational Learning Committee's draft Terms of Reference indicate that its role will be to provide strategic direction and leadership to ensuring cross divisional learning from themes and trends. It will also be responsible for agreeing actions for improvement and monitoring the sharing of good practice. The committee will report to the corporate QSE Committee for assurance purposes. Whilst the proposed committee membership includes staff from a range of professional backgrounds, we do note a lack of nursing representation.
- 79 The role of the Serious Incident / Concerns Group is to provide oversight around the management of complaints, claims, serious incidents, patients experience, never events, inquests etc. We comment on the positive impact this group has had on the Health Board's concerns / complaints performance in **paragraph 53**. Our observations of several Serious Incident / Concerns meetings found there to be a positive culture around quality, safety, and patient experience. Meetings were well chaired with open and honest discussions amongst attendees. Clear actions were identified and agreed and assigned to responsible officers.

## **Clinical Board Quality, Safety and Experience Committees**

- 80 The Quality, Safety, and Experience Committees within Clinical Boards are responsible for providing assurance and advice to the corporate QSE Committee. There are bi-monthly Surgery Clinical Board Quality, Safety, and Experience Committee meetings which are chaired by a Consultant Anaesthetist.
- 81 There is good multidisciplinary attendance at meetings from nursing, medical, and corporate staff. The structured meeting agenda aligns to the Health and Care Standards. There are also items relating to sharing feedback from the corporate QSE Committee and considering exception reports and escalation of key issues from Directorate Quality, Safety, and Experience Committees and specialties. This

ensures both 'floor to board' quality and safety assurance and enables sharing of key corporate quality and safety information down through the quality and safety structure.

## Directorate Quality, Safety, and Experience Committees

82 The Directorate Quality, Safety, and Experience Committees are responsible for providing assurance and advice to the Clinical Board Quality, Safety, and Experience Committees. Monthly Surgical Services Directorate Quality, Safety and Experience committee meetings are held and chaired by the Lead Clinician responsible for quality and safety. Meetings are well chaired and have good multi-disciplinary attendance from nursing, medical, and corporate staff. There is good quality discussion among participants with sufficient time given to each item allowing everyone to contribute to the discussion.

## Resources and expertise to support quality governance

- 83 There are several corporate teams working to support quality and safety issues across the Health Board. The Patient Experience Team and the Concerns Team report to the Executive Director of Nursing. This is in addition to the Quality Improvement, Clinical Audit, and Infection Prevention and Control Teams referred to in this report (see **paragraphs 28, 36, and 85**).
- 84 The Patient Experience Team (3.86 WTE, 4 headcount) provides a range of bespoke training to operational areas supporting staff, carers, and volunteers across the Health Board, alongside its more structured induction training for new staff. The Concerns Team (10.4 WTE, 14 headcount) provides training and support to operational staff in relation to early complaint resolution, breach of duty, putting things right, and other areas of bespoke training. Both the Patient Experience and Concerns Teams had no vacancies at the time of reporting. However, resources within the teams have reduced over the last three years to achieve cost reductions. Results from our data collection survey indicate that the Health Board does not have a corporate data analytics team.
- 85 The Health Board has a dedicated Infection Prevention and Control Team (7 WTE, 8 headcount), which provides formal and bespoke training and support to operational staff across the Health Board on matters relating to infection prevention and control. During the COVID-19 pandemic, the team worked in association with external / partner organisations and agencies such as Cardiff University, Cardiff Metropolitan University, Cardiff Council, and Vale of Glamorgan Council to provide PPE<sup>10</sup> and general infection prevention and control training and also ensured attendance at TTP<sup>11</sup> operational and board meetings. This has had a significant impact on the team's capacity to provide both support to the immediate pandemic

<sup>10</sup> Personal Protective Equipment

<sup>11</sup> Test, Trace and Protect

response and to provide advice and training across the Health Board on its regular infection and prevention control work. The team had no vacancies at the time of reporting.

- 86 At an operational level, the Surgery Clinical Board and Surgical Services Directorate have designated leads for many key aspects of quality and safety such as: managing concerns, patient experience, infection prevention and control, quality improvement, risk management, Datix, and data analytics. However, we found that some designated leads do not have protected time to fulfil several of these roles, particularly at the directorate level.
- 87 Indeed, the lack of resources and capacity for quality and safety activity was a consistent theme during our interviews with Health Board staff. Furthermore, results from the Health Boards internal patient safety survey identify this as a significant issue:
- 67% of staff disagreed or strongly disagreed that there is enough staff to handle the workload.
  - 43% of staff agreed or strongly agreed that staff in their team / department work longer hours than is best for patient care.
- 88 Corporate and operational resources for quality and safety, therefore, require further investment to enable the Health Board to fully roll-out and embed its planned quality and safety improvements. **(Recommendation 6)**

## Arrangements for monitoring and reporting

- 89 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.
- 90 We found that **corporate and operational agendas provide a wide coverage of quality and safety issues for discussion. There is sufficient information for scrutiny and assurance at both corporate and Clinical Board levels, and the Health Board's use of quality and safety data is maturing. However, there are opportunities for agendas to be more dynamic to reflect new and emerging quality risks and issues. Reporting on the four harms associated with COVID-19 requires strengthening. Furthermore, reporting requires further development at directorate level and around services commissioned by the Health Board.**

## Information for scrutiny and assurance

- 91 The Board's integrated performance report and balanced scorecard provide performance information against the NHS Wales Delivery Framework measures including complaints, serious incidents, mortality, and falls. The report provides a detailed commentary on quality and safety performance and includes links to other papers that provide further information on specific aspects of quality and safety.

For example, the report provided to Board in January 2022 included a link to a separate paper on pressure damage reduction.

- 92 The Board introduced a 'COVID-19 Update Report' in November 2020 (which was renamed "Systems Resilience Update" in November 2021) to provide updates on key aspects of the Health Board's activities during the COVID-19 pandemic, including in relation to quality and safety. The quality and safety element of the report provides an overview of operational pressures and their impact, as well as some commentary in relation to people experience and investigations into hospital acquired COVID-19. However, 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. The Board also receives a range of separate quality and safety related reports around topics such as stroke performance, nurse staffing levels, and the Public Services Ombudsman's Annual Report.
- 93 In June 2020, the corporate QSE Committee agreed a range of quality indicators to routinely monitor at each meeting through a quality, safety, and experience dashboard. Although work on the dashboard is still progressing, the committee continues to provide oversight of quality indicators through its Quality Indicators Report which includes measures on nationally reportable incidents, pressure damage, COVID-19 related incidents, never events, concerns, patient experience, and falls. Whilst the corporate QSE Committee also receives reports from all Clinical Boards which assist in providing assurance across the breadth of the Health Boards services, there are opportunities to strengthen reporting on the quality and safety of services, including services commissioned by the Health Board.
- 94 Clinical Boards provide regular assurance reports to the corporate QSE Committee on the quality and safety of services at an operational level. The report from the Surgery Clinical Board is aligned to the Health and Care Standards and contains performance information on a range of quality metrics, including never events, healthcare acquired infections, incidents, concerns, and patient feedback. The report also highlights key risks and mitigating actions and work completed in response to COVID-19. However, there was limited evidence that Clinical Boards consider the four harms associated with COVID-19 as part of the reporting to the corporate QSE Committee. **(Recommendation 7)**
- 95 At an operational level, the Surgery Clinical Board's Quality, Safety, and Experience Committee reviews various presentations, performance reports, and dashboards including data around serious incidents, Datix management, mortality reviews, pharmacy prescribing, medication, patient experience, concerns, and infection control. We found that supporting papers were not provided for some agenda items, with verbal reports and updates provided instead. Whilst verbal reports and updates are appropriate in some cases, a lack of supporting information limits opportunities for attendees to review information in advance and provide sufficient scrutiny and challenge at meetings.

## Coverage of quality and patient safety matters

- 96 The corporate QSE Committee's remit is clear in relation to providing oversight of quality and patient safety. Agendas are structured and include several standing items, such as Clinical Board Assurance Reports, Quality Indicators Report, reports on HIW activity, Primary Care updates, and review of the relevant Board Assurance Framework risks. The committee also receives exception reports and specific updates on key aspects of quality and safety such as pressure damage, regular review and approval of quality and safety related policies, and meeting minutes from all Clinical Board Quality, Safety, and Experience Committee meetings.
- 97 Whilst meeting agendas are structured, there are opportunities for them to be more dynamic to reflect new and emerging quality risks and issues. Furthermore, our work identified concerns around the size of agendas, presenting a risk that there is too much information to adequately scrutinise and seek assurance. However, as stated in **paragraph 71**, the establishment of additional committees and groups in the new quality, safety and experience structure should provide focus on key quality areas to provide assurance to the Corporate QSE Committee and, therefore, help to reduce the workload of the committee.
- 98 Operationally, the Quality, Safety and Experience committees within the Surgery Clinical Board and Surgical Services Directorate use standardised agendas which are aligned to Health and Care standards and cover key aspects of quality and safety such as: risk, patient stories, regulatory compliance and external accreditation, patient safety incidents, patient safety alerts, complaints, and infection control. However, the agendas for these meetings are also large which can result in meetings overrunning beyond their allocated time.
- 99 Results from our data collection surveys indicate that the COVID-19 pandemic did not impact the way in which the Surgery Clinical Board and Surgical Services Directorate monitors and reports quality and patient safety matters. They share minutes from meetings with the directorate, divisional and executive, management teams.

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# Appendix 1

## Management response to audit recommendations

**Exhibit [x]: management response** [This table will be completed once the report and detailed management response have been considered by the relevant committee(s).]

Recommendation	Management response	Completion date	Responsible officer
R1 AP recommendation text <ul style="list-style-type: none"><li>• AP recommendation bullet</li><li>– AP recommendation sub-bullet</li></ul>	<b>Table text bold</b> Table text <ul style="list-style-type: none"><li>• Table bullet</li><li>– Table sub-bullet</li></ul>	Table text	Table text

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telephone calls in Welsh and English.

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

Qualitas  
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## Management response

**Report title:** Review of Quality Governance Arrangements – Cardiff and Vale University Health Board

**Completion date:** 27/06/2022

**Document reference:** 2962A2022

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Ref	Recommendation	Intended outcome / benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	<p><b>Quality and Safety Priorities</b></p> <p>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</p>	Better alignment between operational and strategic quality and safety priorities.	Yes	Yes	<p>To work with all Clinical Boards to agree the QSE priorities aligning to the framework and Annual Plan and to the IMTP.</p> <p>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.</p>	<p>September 2022</p> <p>September 2022</p>	<p>Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality</p>

	strategic quality and safety priorities as articulated in the Health Board's 10-year strategy and new Quality, Safety, and Patient Experience Framework.						
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Ref	Recommendation	Intended outcome / benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	<p><b>Risk Management</b></p> <p>There is scope to ensure the corporate Quality, Safety and Experience Committee maintains greater oversight of risks scrutinised by other committees where there is a clear quality and safety impact. There is scope to improve the quality of risk information recorded on operational risks registers and the escalation and de-escalation of risk to / from the Corporate Risk Register. The Health Board, therefore, should ensure:</p>	<p>Quality, Safety and Experience Committee maintains greater oversight of all risks where there is a clear quality and safety impact.</p> <p>Strengthened risk management arrangements.</p>	Yes	Yes	a) All risks detailed within the Corporate Risk Register that might impact on quality and safety will continue to be shared at the Quality, Safety, and Experience Committee. In addition, risks detailed within the Board Assurance Framework that are shared at other committees, such as Work Force, which is discussed at the Strategy and Delivery Committee will, where the risk may have Quality and Safety implications, also be shared with the Quality,	October 2022	Director of Corporate Governance

	<p>a) the corporate Quality, Safety and Experience Committee seeks assurance from other Health Board committees where their risks potentially impact on quality and safety; and</p> <p>b) review and improve the quality of risk information recorded on operational risks registers and introduce an appropriate process for the escalation and de-escalation of risk to / from the Corporate Risk Register.</p>				<p>Safety and Experience Committee.</p> <p>b) The Health Board's Risk and Regulation Team operate a check and challenge system to manage the escalation and de-escalation of risks from the Corporate Risk Register. Training is also provided to risk leads to improve the detail recorded within risk registers. Both areas remain a work in progress and will continue to be implemented and improved.</p>	<p>Underway and an ongoing requirement - March2023</p>	
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Ref	Recommendation	Intended outcome / benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3	<p><b>Clinical Audit</b></p> <p>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</p>	Strengthened clinical audit arrangements.	Yes	Yes	<p>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.</p> <p>Compliance with internal audit findings will continue to be monitored via the Audit and Assurance Committee.</p> <p>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 -</p>	<p>October 2022</p> <p>October 2022</p> <p>Recruitment completed by September 2022</p>	Head of Quality Assurance & Clinical Effectiveness

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	<p>some progress in this area, it should:</p> <ul style="list-style-type: none"> <li>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</li> <li>b) ensure that recommendations arising from the Internal Audit review of clinical audit are</li> </ul>				<p>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.</p> <p>AMAT - Audit management and tracking system has been purchased and is being rolled out through a phased implementation</p>	<p>Implementation completed by March 2023</p>	
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	implemented as a priority.						
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Ref	Recommendation	Intended outcome / benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4	<p><b>Values and Behaviours</b></p> <p>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:</p> <p>that their mistakes are held against them or</p>	Better awareness and understanding of staff views on the arrangements for reporting errors, near misses, incidents, and for raising and listening to their concerns.	Yes	Yes	<p>A safety culture with a focus upon psychological safety is an enabler of the QSE Framework.</p> <p>Members of the team are undertaking an IHI (Institute for Healthcare Improvement) Leadership course, and their focussed piece of work will address these issues</p> <p>A project plan is being developed and will be part of the QSE implementation of the framework</p>	<p>QSE Framework to 2026</p> <p>May 2023</p> <p>Project plan completion October 2022</p>	Head of Patient Safety and Quality reporting to Executive Nurse Director as Executive sponsor for the programme

	<p>kept in their personal file;</p> <p>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</p> <p>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.</p>				<p>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.</p> <p>Work will be aligned with organisational development colleagues supported through the people and culture plan.</p>	<p>Annual surveys to be undertaken</p>	
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Ref	Recommendation	Intended outcome / benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R5	<p><b>Personal Appraisal Development Reviews (PADRs)</b></p> <p>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</p>	improved performance in relation to PADRs at both corporate and operational levels.	Yes	Yes	<p>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.</p> <p>This improvement plan has been developed with Trade Union Partners and will be delivered in collaboration with TU Partners.</p> <p>Recognising ongoing service pressures across the UHB as we manage the pandemic recovery phase</p>	<p>50% compliance rate – March 2023</p> <p>85% Compliance Rate – March 2024</p>	Assistant Director of OD, Wellbeing and Culture

	<p>performance in relation to PADR's at both corporate and operational levels.</p>				<p>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.</p> <p>These KPIs are reflected in the People and Culture Plan and are reviewed monthly.</p> <p>A focus on promotion and engagement of the new VBA approach (launched in 2019), will develop manager capability and team buy-in through effective and accessible training and development, engagement and support, including development in delivering an effective VBA, the importance of VBAs on staff wellbeing, performance, motivation and quality.</p>		
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					<p>A range of bite-size learning is also in development which will also provide employees with support in preparing for their VBA.</p> <p>Targeted intervention will support developments regarding pay progression.</p>		
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Ref	Recommendation	Intended outcome / benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R6	<p><b>Resources to support quality governance</b></p> <p>Resources within both the Corporate Patient Experience and Concerns Teams have reduced over the last three years and the COVID-19 pandemic has had a significant impact on the Infection Prevention and Control Team's capacity. At an operational level, the Surgery Clinical Board and Surgical Services Directorate have designated leads for many key aspects of quality and safety. However, they do not have protected time to fulfil several of these roles.</p>	Sufficient resource and capacity in place to support quality governance at both corporate and operational levels.	Yes	Yes	<p>The increase in concerns remains significant and resource is an issue</p> <p>There has been some investment through the Business case which is spans a 3-year period</p> <p>Management of resources through the pandemic was challenging for the Infection Prevention &amp; Control team. However as the pandemic reduces the focus for the IPC team is back on normal tier 1 IPC targets, we are now seeing the move back to normal business. Active recruitment also in place to recruit to outstanding vacancies.</p>	<p>May 2024</p> <p>September 2022</p>	<p>Assistant Director of Patient Experience</p> <p>Executive Director of Nursing</p>

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	<p>The Health Board, therefore, should ensure there is sufficient resource and capacity to support quality governance at both corporate and operational levels.</p>				<p>Recently surgery clinical Board have a dedicated QSE nurse who liaises with corporate teams</p> <p>The corporate team will work with the clinical board to identify QSE leads and responsibilities with an exercise to identify the time required to effectively deliver these agendas</p>	<p>Completed</p> <p>October 22</p>	<p>Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality</p>
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Ref	Recommendation	Intended outcome / benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R7	<p><b>Monitoring and Reporting</b></p> <p>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</p>	Greater monitoring and reporting of the four harms associated with COVID-19 by Clinical Boards and the Quality, Safety and Experience Committee.	Yes	Yes	<p>The revised template for the Clinical Boards QSE meetings will incorporate the 4 harms associated with COVID-19 reporting</p> <p>The notes and action logs of the clinical Boards will be shared at the QSE Committee meetings</p>	August 22	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality

	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 Experience Committee and Board.						
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Report Title:	C&V UHB Ultrasound Clinical Governance Group (USCGG)		Agenda Item no.	7.4
Meeting:	AUDIT AND ASSURANCE COMMITTEE	Public	X	Meeting Date: 05/07/2022
		Private		
Status <i>(please tick one only):</i>	Assurance <input checked="" type="checkbox"/>	X	Approval	Information
Lead Executive:	Fiona Jenkins, Executive Director of Therapies and Health Science			
Report Author (Title):	Interim Assistant Director of Therapies and Health Science			

## Main Report

### Background and current situation:

#### SITUATION

Following an internal audit of Ultrasound governance across the UHB, several shortcomings were identified. These centered around a lack of assurance of appropriate governance in the correct and safe use of ultrasound across the UHB and insufficient communication and escalation pathways.

#### BACKGROUND

The Ultrasound (US) audit report, published August 2021 (please see attached), found limited assurance for Ultrasound governance arrangements within C&V UHB. The two high priority recommendations were:

1. The design and implementation of ultrasound governance arrangements outlined within the Health Board's Ultrasound Risk Management Policy and Procedure.
2. Roles and responsibilities in the management of diagnostic and therapeutic ultrasound services.

**Be assured that the following actions have been taken to address the short fallings found in the August 2021 Ultrasound audit.**

- Review of the Ultrasound Clinical Governance Group (USCGG) and new ToRs written and ratified by the EDoTH to cover Diagnostic and Therapeutic Ultrasound. – **Complete: Please see attached "USCGG ToRs v0.8"**.
- Membership of the USCGG to be extended to include all areas of Diagnostic and Therapeutic US across the UHB. – **Complete: Please see attached "USCGG ToRs v0.8" for membership details**
- Suitable chair of the USCGG - **Complete: The Interim Assistant DoTH nominated. who will formally report into the Medical Equipment Group, chaired by the EDoTH.**
- Clear reporting pathway for USCGG ToRs - **Complete: Reporting into the Medical Equipment Group, chaired by the EDoTH, with reportable instances be directed to QSE, as per attached "USCGG ToRs v0.8"**.
- Change of name for the Medical Ultrasound Risk Management Procedure and Policy to Ultrasound Clinical Governance Procedure and Policy. – **Complete: Request formally sent to rename and appropriately index both Policy and Procedure.**
- Arrange USCGG regular meetings - **Complete: The inaugural USCGG meeting took place on 23rd Feb 2022, with further meetings taking place at a minimum frequency of 3 months.**
- Requirements to appoint US roles of Clinical Lead User, Speciality Lead User, and Educational Supervisor / Training Supervisor within relevant Clinical Boards will be actioned as part of the formation of the new USCGG. – **Partially complete: information requested from all departments**  
<https://forms.office.com/Pages/ResponsePage.aspx?id=uChWuyjgkCoVkM8ntyPrrIXT-fm7LhNmeHyPODDv-ZUNUHININWUzFJSEUzUjdPSU1aTkpXQ1lwRi4u>. **Complete in Medical Physics, Critical Care and Physiotherapy. Pending in other areas.**

- Creation and implementation of the US Safety Training will be actioned and implemented as part of the formation of the new USCGG. – **In progress: Progress with LED. Courses to be up loaded initially to Learning@Wales (due live by 1<sup>st</sup> Sept) then subsequently to ESR (6-12month go live time scale). The work will involve creation of on-line mandatory Ultrasound safety training for all users with the responsibility of compliance lying with the relevant Clinical Boards who will report compliance into the USCGG.**
- An annual audit template will be developed by the membership of the USCGG to include a balanced range of performance indicators on the effective management of U/S devices including training, competence and maintenance as part of the U/S governance framework. – **In progress – The USCGG has reviewed similar audit tools used by other services, including POCT. The draft audit tool will be shared and agreed at the next USCGG meeting (29/06/2022).**

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

**The following lists the short fallings found in C&V UHB Ultrasound Governance:**

From the Aug 2021 Ultrasound audit report:

**Objective 1: Design and implementation of ultrasound governance arrangements.**

- Lack of awareness of revised C&V UHB Medical Ultrasound Risk Management Policy (<https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/patient-safety-and-quality/t-patient-safety/ultrasound-risk-management-policy-pdf/>) and Medical Ultrasound Risk Management Procedure (<https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/patient-safety-and-quality/t-patient-safety/ultrasound-risk-management-procedure-pdf/>)
- Consideration of how Clinical Boards will provide US Governance assurance to EDoTH.
- Creation of an abridged US procedure and renaming of both policy and procedure to align with US structure and governance.
- Out of date Ultrasound Clinical Governance Groups ToRs.
- Unclear routine and embedded reporting arrangements in ToRs
- Charing of the USCGG fell short of the level of authority required.
- Poor attendance of USCGG

**Objective 2: Roles and responsibilities.**

- No formal documentation of roles and responsibilities assigned to staff in certain US areas and appropriately documented within certain Clinical Boards.

Reasonable assurance was found in training, noting an ambition of the USCGG to create a mandatory e-learning module for Ultrasound Safety training for all relevant staff.

**Recommendation:**

The Board / Committee are requested to:

Note the actions being taken (as set out in this report) to address the recommendations made by Internal Audit in the Ultrasound Governance audit report dated August 2021.

**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	<input checked="" type="checkbox"/>

4. Offer services that deliver the population health our citizens are entitled to expect	<input checked="" type="checkbox"/>	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>	Long term		Integration		Collaboration		Involvement	
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**Impact Assessment:**

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

**Risk: Yes/No**

The actions taken will greatly reduce the risk of staff not being adequately trained in Ultrasound use and the associated risk to patients from improper and unsafe use.

**Safety: Yes/No**

Improved patient safety by improving and controlling training compliance for staff.

**Financial: Yes/No**

**Workforce: Yes/No**

**Legal: Yes/No**

Improving governance will also ensure appropriate alignment with Medical Device Regulations.

**Reputational: Yes/No**

**Socio Economic: Yes/No**

**Equality and Health: Yes/No**

**Decarbonisation: Yes/No**

**Approval/Scrutiny Route:**

Committee/Group/Exec	Date:

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# Cardiff and Vale UHB

## Ultrasound Clinical Governance Group

### Terms of Reference and Operating Arrangements

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## CARDIFF AND VALE UHB ULTRASOUND CLINICAL GOVERNANCE GROUP TERMS OF REFERENCE

### INTRODUCTION

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

The Ultrasound Clinical Governance Group (USCGG) will be responsible for defining the scope of Diagnostic and Therapeutic Ultrasound (US), taking into consideration the clinical need for Diagnostic and Therapeutic US, its financial implications, technical feasibility, and in ensuring that appropriate measures are in place to monitor the accuracy and quality of Diagnostic and Therapeutic US and reporting. This will ensure optimal health and experience outcomes and improve patient safety across all of the UHB's US activities. The USCGG will also provide system level and strategic oversight to image storage arrangements. The USCGG report to Cardiff and Vale UHB's Medical Equipment Group which is chaired by the Executive Director of Therapies and Health Science who holds Executive responsibility for clinical ultrasound governance. See Appendix 1 – Governance and Reporting Framework.

Within Cardiff and Vale University Health Board, the USCGG advises on procurement decisions as well as seeking assurance on equipment life cycle management including monitoring, maintenance, replacement and disposal of equipment. The establishment and maintenance of service standards including training, competence assessment, supervision, operational delivery and audit are also within the Group's remit.

Key guidance.

1. Ultrasound Clinical Governance  
National Diagnostic Imaging Board, Department of Health, LONDON  
(2008)  
<http://www.18weeks.nhs.uk/Content.aspx?path=/achieve-and-sustain/Diagnostics/Imaging>.

2. 'Ultrasound Training Recommendations for Medical and Surgical Specialties'

RCR REF BFCR(05)2 The Royal College of Radiologists LONDON (2005)

**PURPOSE**

The purpose of the **Ultrasound Clinical Governance Group** is to;

- receive assurance that all US services have adopted and are adhering to the general requirements for good US governance,
- receive assurance on the achievement and maintenance of appropriate levels of competence, performance and patient safety related to the use of US equipment,
- provide regular written highlight reports and meeting minutes to the Medical Equipment Group (MEG),
- to provide assurance to the EDoTHS on all aspects of US clinical aspects, and escalating issues where assurance cannot be provided,
- through regular programmed review to maintain and develop the Medical Ultrasound Risk Management Policy and Procedure to ensure that it incorporates all contemporaneous clinical, professional and safety guidance,
- To seek assurance from each Directorate involved in US that suitable and sufficient Clinical Lead Users, Speciality Lead Users and Educational Supervisors / Training Supervisors are available within the UHB to assure continuing safe delivery of US clinical services, and escalate as necessary.
- recommend systems to ensure data is recorded accurately and consistently and stored safely across the UHB,
- advise procurement on criteria for evaluation of bids for US equipment, inform and facilitate better decision making and good governance in the purchase and use of US equipment within Cardiff

and Vale UHB,

- To maintain a robust system level governance framework and supporting infrastructure which ensures that US practitioners are trained, competent and work within the limits of their competence, and ensure all US practitioners are exposed to sufficient volume and complexity of procedures to maintain their skills and knowledge base. This will be assessed by a digital audit programme to include the development of a dashboard of balanced US service quality performance metrics where applicable,
- To develop and maintain an e-learning module to support the consistent adoption of best practice linked to the US Governance Policy and Procedure,
- Direct programmes of work where necessary to establish baseline US activity, review scope of existing practice and make recommendations on service improvement.
- develop an annual work programme to support the continuous improvement of US services at both a clinical service level and a UHB system level.

## DELEGATED POWERS AND AUTHORITY

The Group will, in respect of its assurance role, seek confirmation that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality and safe US services across Cardiff and Vale University Health Board.

To achieve this, the Group's work programme will be designed to ensure that, in relation to all aspects of US service delivery:

- There is clear, consistent strategic direction, strong leadership, good governance and transparent lines of accountability with Executive oversight in the delivery of US services.

The USCGG has a citizen centred approach, putting patients and patient safety above all other considerations.

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- The US services planned or provided across the UHB are consistently delivered, strategically aligned, based on sound evidence, compliant with relevant law, clinically effective and meet standards set by relevant professional, regulatory, external quality assurance and accreditation bodies.
- The UHB has the right systems and processes in place to deliver, from a patient's perspective, effective, efficient, timely and safe US services.
- The US workforce is appropriately selected, trained, supported and responsive to the needs of the service, ensuring that professional standards and registration/revalidation requirements are maintained.
- There is an ethos of continual quality improvement and regular methods of updating the US workforce in the skills needed to demonstrate quality improvement throughout the UHB.
- There is good team working across US services, with effective collaboration and partnership assured to provide the best possible outcomes for all service users.
- US risks are effectively and robustly managed and appropriately escalated within Clinical Boards and the wider UHB in a timely manner.
- All reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies US services, and in particular that:
  - recommendations made by internal and external reviewers are considered and acted upon in a timely basis; and
  - lessons are learned and fully evidenced from patient safety incidents, complaints and claims and disseminated as appropriate across the Clinical Directorates and Clinical Boards.
- Advise the MEG and relevant Quality, Safety and Experience Sub-Committee on the adoption of a set of US service quality performance indicators which will be regularly monitored, assessed and reported on.

These will include the following:

### **Clinical Governance**

- To support the implementation of the Clinical Governance Programme for Cardiff and Vale UHB.
- Monitor the co-ordination and implementation of Welsh Government's Health and Care Standards and other standards relevant to the delivery of US services.
- Contribute to the Annual Healthcare Standards Improvement Plan and monitor progress within the Clinical Boards who deliver US services.
- Receive and consider reports as appropriate from US clinical services, the MEG, the Decontamination Group, the Infection Prevention and Control Group, relevant Clinical Board Quality, Safety and Experience sub committees and Operational Health and Safety sub groups within the Clinical Boards. See Appendix 1 – Governance and Reporting Framework.
- Share and communicate US best practice and continuous quality improvement.
- To advise the Point of Care Testing (POCT) Group on the suitability of US POCT Devices.
- To receive exception reports from Clinical Boards, Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor which relate to the delivery of US services.

## **Patient Experience**

- Review reporting trends in US service delivery relating to patient safety incidents with particular emphasis on ensuring that lessons learnt and all actions necessary to reduce the likelihood of further incidents have been identified and consistently and uniformly taken across the UHB.

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- Receive and review progress reports relating to the requirements identified for patient safety and clinical governance activity relating to the provision of US services.
- Review reporting trends relating to clinical negligence claims involving US services with particular emphasis on ensuring that lessons learnt and all actions necessary to reduce the likelihood of further claims have been identified and taken.

### **Policies and Procedures**

- Authorise that US Clinical Procedures are appropriate on behalf of the UHB, and provide a summary of these to the Executive Quality, Safety and Experience Committee.

### **Concerns/ NHS Redress, Compliments and Claims**

- Receive reports from Clinical Boards on complaints, compliments and claims relating to US services and the reporting trends relating to the progress and outcome of the related processes, with particular emphasis on ensuring that lessons learnt and all actions necessary to reduce the likelihood of a repeat have been identified and taken.

### **Clinical Audit & Effectiveness**

- Receive reports on the progress and lessons learnt from clinical audit and effectiveness relating to US service delivery which will include updates on national standards implementation e.g. Royal College Guidance, Medicines and Healthcare products Regulatory Agency (MHRA), National Science Foundations (NSF)s, National Institute for Health and Care Excellence (NICE), National Confidential Enquiry into Patient Outcome and Death (NCEPOD) evidence-based practices.
- Undertake annual digital audits for each US service, to inform development of an Annual Audit Plan for the UHB, ensuring arrangements are in place to monitor and review related outcomes.

To receive summaries of US clinical audits from Clinical Boards and / or individual US service providers. This will include audits

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carried out by individual services for external regulatory authorities.

### **Clinical Risk Management**

- Monitor the arrangements in place to assess, control and reduce clinical risk associated with use of US within the Clinical Boards.

### **Audit Requirements**

- Demonstrate co operation with Auditors in reviewing US systems and processes, including timely response.
- Monitor, review and evaluate the timescales for implementation of Audit recommendations, and ensure that they are in line with the Audit Committee requirements.

### **Personal Development, Review, Training and Education**

- Receive progress reports from US service departments.
- Where appropriate direct Clinical Board / Directorate / Locality priorities.

### **Authority**

The Group is authorised to investigate or have investigated any activity within its terms of reference.

In doing so, the Group shall have the right to inspect any books, records or documents of the UHB relevant to the Group's remit in keeping with data protection and other relevant legal regulations. Patient/client and staff confidentiality will be respected at all times as appropriate. The Group may seek any relevant information from any:

Employee (and all employees are directed to cooperate with any reasonable request made by the Group); and

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

## Access

The Chair of the Group shall have reasonable access to Executive Directors and other relevant senior staff.

## Sub Groups

The Group may establish sub groups and task and finish groups to carry out specific aspects of business and feed their activity into the Group.

## MEMBERSHIP

### Members

The group will comprise of:

- Chair: Assistant Director Therapies and Health Science
- Vice Chair: Clinical Specialist – to be appointed at first meeting.
- Senior Nurse representation as nominated by the Executive Nurse Director
- Senior Medical representation as nominated by the Executive Medical Director
- Lead Sonographer representation as nominated by the Clinical Director of RMPCE
- Lead US Radiologist representation as nominated by the Clinical Director of RMPCE
- Non-Ionising Safety Lead, Principal Clinical Scientist (Medical Physics).
- Physiotherapy representation as nominated by the head of Physiotherapy.
- Clinical Engineering representation – to be nominated by the Head of Clinical Engineering.
- C&V UHB Directorates\* (involved in US) to provide representation. Where they have been appointed, the representative should be one of the following:
  - Clinical Lead User
  - Speciality Lead User

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- Educational Supervisor / Training Supervisor

\*Which must include representation from the following directorates and any others where diagnostic US is used:

- Obstetrics and gynaecology
- Radiology
- Sonography
- Cardiology
- Emergency Department

**Where members are unable to attend then alternates should be identified to ensure constant representation and attendance.**

### **Attendees**

Clinical Directors or their representatives may be requested to attend from time to time as required by the Group Chair.

### **By Invitation**

The Group Chair may extend invitations to attend Group meetings as required to the following:

- Directorate clinical leads
- Infection, Prevention and Control
- Those with specialist knowledge as required.

## **ULTRASOUND GOVERNANCE GROUP MEETINGS**

### **Quorum**

At least 5 members of the Group must be present to ensure the quorum of the Group, one of whom should be the Group Chair or Vice Chair.

### **Frequency of Meetings**

Meetings shall be held quarterly with a minimum of 4 meetings per year with the Chair will make every effort to be present at all meetings, and otherwise as the Chair of the Group deems necessary, consistent with the UHB's annual plan of Board Business.

## **Withdrawal of individuals in attendance**

The Group may ask any or all of those who normally attend to withdraw to facilitate open and frank discussion of particular matters.

## **Probity**

All interest must be declared so that the Group can inform and facilitate better decision and making and good governance in the purchase of US equipment.

## **RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS**

The Group, through its Chair and members, shall work closely with the other sub groups as appropriate, including joint (sub) committees, the Medical Equipment Group and the Decontamination Group to provide advice and assurance to the Quality, Safety and Experience Committee through the:

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

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

The Group shall embed the UHB's corporate standards, priorities and requirements through the conduct of its business.

## **REPORTING AND ASSURANCE ARRANGEMENTS**

The Group Chair shall:

- Bring to the attention of the Executive Director of Therapies and Health Science directly or via the Medical Equipment Group any significant matters under consideration by the Group;

Ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may

compromise patient care and affect the operation and/or reputation of the UHB,

- Escalate particular issues to the Quality Safety and Patient Experience sub committees where deemed appropriate.
- Access senior advice on procurement, finance, decontamination and IP&C where necessary and as required.
- Review the Terms of Reference annually to ensure collective responsibilities can be assured/ discharged.
- Routinely provide minutes of the USCGG to the MEG.

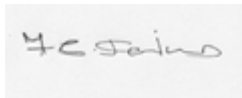
### APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

Not applicable.

### REVIEW

These terms of reference and operating arrangements shall be reviewed annually, or as required, by the Group.

**Agreed:**



**Singed:**

**Name:** Fiona Jenkins

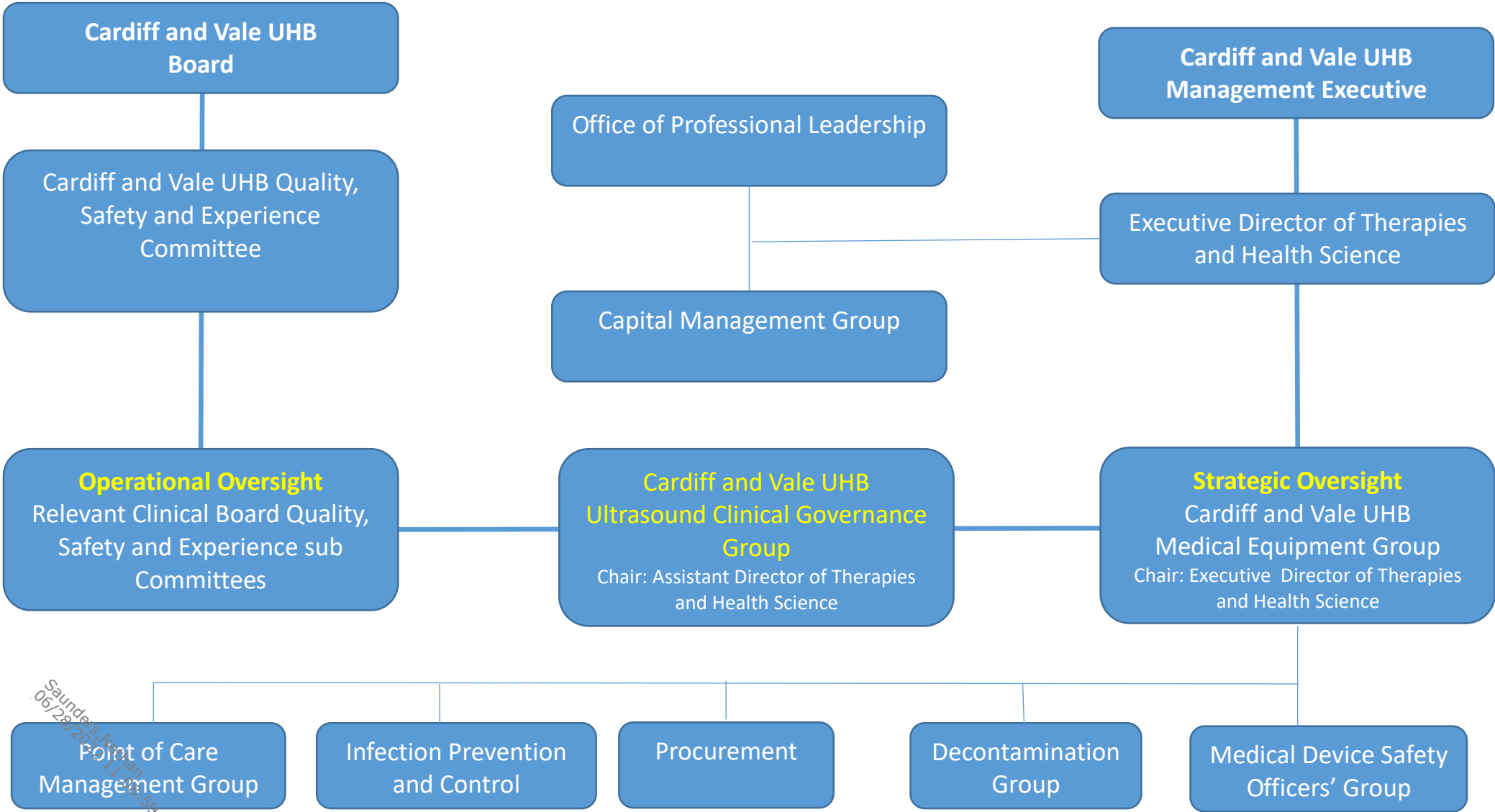
**Position:** Executive Director of Therapies and Health Science

**Date:** 25/01/2021

**Proposed date for review:** Dec 2022

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1 **Appendix 1: Governance and Reporting Framework**



# Ultrasound Governance

(Clinical Diagnostics and Therapeutics Clinical Board)

## Final Internal Audit Report

August 2021

Cardiff and Vale University Health Board

NWSSP Audit and Assurance



GIG  
CYMRU  
NHS  
WALES

Partneriaeth  
Cydwasaethau  
Gwasanaethau Archwilio a Sicrwydd  
Shared Services  
Partnership  
Audit and Assurance Services



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board



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Review reference:	CVU-2122-27
Report status:	Final
Fieldwork commencement:	17 May 2021
Fieldwork completion:	6 July 2021
Debrief meeting:	19 July 2021
Draft report issued:	27 July 2021
Management response received:	23 August 2021
Final report issued:	26 August 2021
Auditors:	Stuart Bodman, Principal Auditor Wendy Wright, Deputy Head of Internal Audit
Executive sign-off:	Dr Fiona Jenkins, Executive Director of Therapies and Health Science  Steve Curry, Chief Operating Officer
Distribution:	Matthew Temby, Director of Operations, Clinical Diagnostics and Therapeutics Clinical Board Sue Bailey, Director for Quality, Clinical Diagnostics and Therapeutics Clive Morgan, Assistant Director of Therapies, Clinical Diagnostics and Therapeutics Clinical Board Dr Kate Bryant, Consultant Clinical Scientist, Head of Non-Ionising Radiation, Medical Physics Dr Paul Williams, Principal Clinical Scientist, Ultrasound Quality Assurance Lead, Medical Physics
Committee:	Audit & Assurance Committee

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

### Acknowledgement

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

### Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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# Executive Summary

## Purpose

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

## Overview

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

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

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

## Report Classification

Limited



More significant matters require management attention.

**Moderate impact** on residual risk exposure until resolved.

Trend

-

## Assurance summary<sup>1</sup>

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

## Matters Arising

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

<sup>1</sup> The objectives and associated assurance ratings are not necessarily given equal weighting when formulation the overall audit opinion

## 1. Introduction

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

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

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

### Audit Risks

The potential risks considered in this review are as follows:

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

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

## 2. Detailed Audit Findings

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

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

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

The following matters arising were noted:

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

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

#### Medical Ultrasound Governance Arrangements

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

The following matters arising were noted:

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

*(Matters Arising 4 – High Priority)*

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

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

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

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

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

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

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

**Objective 4: Procurement of diagnostic and therapeutic ultrasound equipment.**

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

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

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

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

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

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

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

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

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

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

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## Appendix A: Management Action Plan

<b>Matter Arising 1: Lack of communication of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2) (Control Operation)</b>	<b>Impact</b>	
<p>It was evident through audit testing that there was a lack of awareness of the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2), although both were available on the UHB intranet site. For the sampled areas, none of the directorate management, clinical or medical ultrasound users in Obstetrics &amp; Gynaecology and Cardiology Directorates were aware of the existence of the finalised policy and procedure.</p> <p>The Ultrasound Clinical Governance Group in July 2020 reviewed draft iterations of the policy and procedure, and both directorates had representatives who attended.</p> <p>Once the policy and procedure had been formally ratified by the UHB Quality, Safety and Experience Committee in July 2020, there was no evidence of communication to all UHB Directorate Managers or the membership body of the Ultrasound Clinical Governance Group.</p>	<p>Potential risk of there being no effective clinical ultrasound governance framework in place.</p>	
<b>Recommendation 1</b>	<b>Priority</b>	
<p>The Executive Director of Therapies and Health Science should be provided with assurance that the revised Medical Ultrasound Risk Management Policy and Procedure (UHB 322 v2) has been adequately communicated within the Health Board.</p>	<p><b>High</b></p>	
<b>Agreed Management Action</b>	<b>Target Date</b>	<b>Responsible Officer</b>
<p>The Policy and Procedure will be promoted through the Medical Equipment Group, Medical Device Safety Officer's group, Clinical Board operational teams as well as through the Clinical Executive's Office of Professional Leadership.</p>	<p>October 2021</p>	<p>Assistant Director of Therapies and Health Science</p>

Matter Arising 2: Absence of Clinical Board assurance to the Executive Director of Therapies and Health Science (Control Operation)		Impact
<p>The Medical Ultrasound Risk Management Procedure provides direction to Clinical Boards regards required assurance to the Executive Director of Therapies and Health Science, which notes,</p> <p><i>"The Clinical Board Heads of Operations and Delivery are responsible for:</i></p> <p><i>Providing assurance to the Executive Director of Therapies and Health Science that medical ultrasound is managed in compliance with the UHB's policies and procedures."</i></p> <p>Given the further findings within this report relating to ultrasound governance (finding 4), it is unclear how the required assurance is determined and how it is communicated.</p>		<p>Potential risk of there being no effective clinical ultrasound governance framework in place.</p>
Recommendation 2		Priority
<p>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).</p>		<p><b>Medium</b></p>
Agreed Management Action	Target Date	Responsible Officer
<p>An annual audit template will be developed by the membership of the UCGG to include a balanced range of performance indicators on the effective management of U/S devices including training, competence and maintenance as part of the U/S governance framework.</p>	<p>March 2022</p>	<p>Assistant Director of Therapies and Health Science</p>
<p>Opportunities to develop a digital audit tool will be explored with corporate IM&amp;T teams.</p>	<p>March 2022</p>	<p>Assistant Director of Therapies and Health Science</p>

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<b>Matter Arising 3: Design and feedback of the Ultrasound Risk Management Procedure (Control Design)</b>	<b>Impact</b>	
<p>The audit provided opportunity to disseminate the procedure and obtain feedback from those that engaged with the audit. The following observations were noted:</p> <ul style="list-style-type: none"> <li>• Whilst the procedure is comprehensive, it is a lengthy document (23 pages of text) which covers an extensive depth of content to read and retain.</li> <li>• An abridged version of the procedure would be welcomed, capturing key themes and requirements, summarised into two or three pages, underpinned by the full procedure for clarification when required.</li> <li>• The naming of the policy and procedure suggests a focus on risk management, but the content is of ensuring sound structure and processes for ultrasound governance.</li> </ul>	<p>Potential risk of the design and implementation of ultrasound governance arrangements outlined within the Health Board’s Ultrasound Risk Management Policy and Procedure.</p>	
<b>Recommendation 3</b>	<b>Priority</b>	
<p>Following feedback through the course of the review, consideration should be given to:</p> <ul style="list-style-type: none"> <li>• Producing an abridged version of the Medical Ultrasound Risk Management Procedure, summarising key themes, to underpin the full procedure; and</li> <li>• The renaming of the procedure to reflect the actual content of Ultrasound Governance and to align with the role of the Ultrasound Clinical Governance Group.</li> </ul>	<p><b>Medium</b></p>	
<b>Agreed Management Action</b>	<b>Target Date</b>	<b>Responsible Officer</b>
<p>Provide an abridged version of the procedure, about 2 or 3 pages. Rename the policy and procedures to reflect more closely what they contain.</p> <p style="font-size: small; transform: rotate(-45deg); position: absolute; bottom: 10px; left: 10px;">Saunders Nathan 06/28/2022 11:08:59</p>	<p>26<sup>th</sup> August 2021</p>	<p>Paul Williams, Principal Clinical Scientist</p>

Matter Arising 4: Ultrasound governance arrangements require review (Control Operation)	Impact
<p>The following observations were noted regarding the ultrasound governance arrangements and were prevalent pre-COVID:</p> <ul style="list-style-type: none"> <li>• There is an Ultrasound Clinical Governance Group (UCGG) in place, with a formal terms of reference, dated April 2015.</li> <li>• The UCGG terms of reference has not been reviewed in tandem with the revised policy and procedure (published 17 February 2021).</li> <li>• The terms of reference for the UCGG notes the following roles: Chair, Deputy Chief Operating Officer, and Vice Chair, Assistant Director of Therapies and Health Science. The auditor was advised that neither positions have chaired the group since 2018. Acting chairpersons have been assigned but hold reduced authority in the UHB.</li> <li>• The auditor was advised by the sampled areas that attendance at the UCGG has been poor. There were no records of attendance held, and thus quorate arrangements were uncertain. Due to the lack of documentation, we were unable to validate the strength of the UCGG.</li> <li>• The terms of reference for the UCGG refers to 'relationships and accountabilities with the Board and its committees/groups', specifically referencing the Medical Equipment Group (MEG) and the Decontamination Group. Minutes of the MEG and Quality Safety and Experience sub-committee (Clinical Diagnostics and Therapeutics Clinical Board) did evidence the raising of ultrasound clinical governance concerns in 2019 by the acting Chair.</li> <li>• There is no evidence of routine reporting to and from the UCGG.</li> <li>• The auditor was advised that the acting Chair and Vice Chair of the UCGG do attend the Quality, Safety and Experience Committee, with opportunity to raise concerns, as outlined within the UCGG terms of reference, but it was unclear if there are any embedded reporting arrangements of a more formal nature.</li> </ul>	<p>Potential risk of no effective clinical ultrasound governance framework.</p>

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Recommendation 4	Priority	
<p>Ultrasound governance arrangements should be reviewed as follows:</p> <ul style="list-style-type: none"> <li>• The placing of the Ultrasound Clinical Governance Group (UCGG) within the Health Board’s governance structures.</li> <li>• The appointment of appropriate person(s) to Chair the UCGG meetings with sufficient seniority to escalate issues as they arise.</li> <li>• The reporting mechanisms to facilitate the escalation and cascade of ultrasound governance.</li> <li>• Membership of the UCGG should be sourced from all ultrasound using Directorates.</li> <li>• Actions and attendance (including quorum) are recorded for the meetings.</li> </ul> <p>On completion of review, the governance arrangements should be revised and formalised through an updated Terms of Reference.</p>	<p><b>High</b></p>	
Agreed Management Action	Target Date	Responsible Officer
<p>The UCGG ToR will be formally reviewed to ensure that it has appropriate governance arrangements. The UCGG will formally report through the Medical Equipment Group (MEG) which is chaired by the Executive Director of Therapies and Health Science. The MEG will receive minutes and a written report. The TORs for UCGG and MEG will be amended accordingly.</p>	<p>October 2021</p>	<p>UCGG / Assistant Director of Therapies and Health Science</p>
<p>The membership of the UCGG will be signed off by the Executive Director of Therapies and Health Science. Communication on expected attendance from clinical areas at the UCGG will be disseminated through the operational Clinical Board structures and the Office of Professional Leadership.</p>	<p>November 2021</p>	<p>Assistant Director of Therapies and Health Science</p>

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

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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:

	<b>Substantial assurance</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable assurance</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited assurance</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>No assurance</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Assurance not applicable</b>	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
<b>High</b>	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*
<b>Medium</b>	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
<b>Low</b>	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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AS/2022-11-08-59  
Nathan

Report Title:	Declarations of Interest, Gifts and Hospitality Tracking Report		Agenda Item no.	7.6
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date: 05.07.2022
		Private		
Status (please tick one only):	Assurance	Approval	x	Information
Lead Executive:	Director of Corporate Governance			
Report Author (Title):	Head of Risk and Regulation			

## Main Report

### Background and current situation:

As agreed by Audit & Assurance Committee an update on Declarations of Interest, Gifts, Hospitality & Sponsorship would be provided to each Audit Committee for approval.

As described in the November 2021 report the procedure for Declarations of Interest now requires employees to make a single declaration of interest during the period of their employment, only altering it if their circumstances change (for example undertaking secondary employment). The declarations of Gifts, Hospitality and Sponsorship is unaltered and remains an 'as required' process.

The Risk and Regulation Team have worked with Corporate Communications to design and implement a Communication Plan that informs staff members of the following:

- The requirement to now submit a declaration of interest once. But, reinforcing the requirement to update if personal circumstances change.
- That Declarations of Interest can now be made on ESR, and signposting to User and Manager guides.
- The continuing need to declare Gifts, Hospitality and Sponsorship with specific emphasis being given in Autumn (for Autumn International Rugby Tickets) and Christmas/New Year (for seasonal gifts).

In addition to this plan the Risk and Regulation Team and the Health Board's ESR lead delivered a 'Declarations of Interest Power Hour' on the 11<sup>th</sup> March to provide a guided example of how to make use of ESR to declare interests and also to answer queries raised by those in attendance. Similar sessions will be delivered throughout the year and in between sessions a recording of the meeting is available online for all staff at the following address (which you will need to copy and paste into your browser):

<http://nww.cardiffandvale.wales.nhs.uk/pls/portal/url/ITEM/DA2BFD3832514293E0500489923C75EC>

It is hoped that the number of declarations returned will increase significantly by enhancing visibility of the process, and the ease by which declarations can be recorded via ESR.

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

The following Declarations have been received and included on the register which covers the period 01 Apr 20 to 24 June 2022:

- 1,672 Declarations of Interests, Gifts, Hospitality & Sponsorship Forms have been recorded on the register. This represents a 11.2% increase in submissions following the April 2022 Committee Meeting.
- 77.5% of staff banded 8a and above have returned their declaration forms.

- The Declarations of Interests, Gifts, Hospitality and Sponsorship forms received are RAG rated by the Corporate Governance Officer to ensure appropriate action and monitoring. The RAG rating system is as follows:

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

- 97.33% of Declarations received are rated **Green** (328 Declarations).
- 2.66% of Declarations received are rated **Orange** (8 Declarations).
- 0.01% of Declarations are rated **Red** (1 Declaration).

The 9 entries recorded as medium and high potential conflicts can be summarised as follows:

- The 1 High Risk Conflict concerns a Health Board Director who has taken on secondary employment with a company that the Health Board has historically and continues to contract with. The arrangement has been and will continue to be overseen by senior executive colleagues to prevent any conflict from manifesting itself.
- The 7 medium risk conflicts can be broken down into two categories:
  - One declaration that would only result in a conflict in procurement scenarios and would be picked up by the Health Board's internal procurement systems in the event that a potential conflict could be perceived; and
  - Six instances of secondary employment or roles within external organisations that have been notified to appropriate line managers to be managed so as to avoid conflict arising.

A register of all interests can be found at the following link (which will need to be copied and pasted into a web browser to access): <https://cavuhb.nhs.wales/about-us/governance-and-assurance/register-of-interests-gifts-and-hospitality/>

Analysis of declarations of interest received suggests reasonable success from the recent 'advertising campaign'; there has been an above average increase in the quantity of declarations made, as well as increased use of ESR rather than the more administratively heavy use of hardcopy forms and email returns.

Additionally the ESR Manager will be asked to email reminders in July and January to those who have made declarations, to remind them of the requirement to update if their personal circumstances have changed.

### Recommendation:

The Committee are requested to:

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

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	x	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	x	Involvement	x
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### Impact Assessment:

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

Risk: Yes

There is a risk that non-declaration of an interest by staff members could result in breaches of legal and/or regulatory requirements, specifically in a procurement context. The ongoing management and development of the Health Board's Standards of Behaviour Policy and associated procedures mitigates this risk by ensuring that staff members are aware of their obligations in this regard.

Safety: Yes/No

N/A

Financial: Yes/No

N/A

Workforce: Yes/No

N/A

Legal: Yes/No

N/A

Reputational: Yes

Should staff members fail to comply with the Health Board's Standards of Behaviour Policy and examples of this are made public, there is a possibility that this could have an adverse reputational impact on the Health Board and its staff body. The ongoing management and development of the Health Board's Standards of Behaviour Policy and associated procedures mitigates this risk by ensuring that staff members are aware of their obligations in this regard.

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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Report Title:	Internal Audit Recommendation Tracker Report			Agenda Item no.	7.7
Meeting:	Audit and Assurance Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	05.07.2022
		Private	<input type="checkbox"/>		
Status <i>(please tick one only):</i>	Assurance	<input checked="" type="checkbox"/>	Approval	<input type="checkbox"/>	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

#### 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 in September 2019 and approved by the Committee as an appropriate way forward to track the implementation of recommendations made by internal audit.

The Tracker 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 and 2021/22.

#### 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 has increased from 84 individual recommendations to 91 during the period April 2022 to July 2022. The change can be attributed to the following:

- 14 entries reported as complete at the April Committee were removed from the tracker;
- 16 Entries related to the Advisory IM&T Control and Risk Assessment Audit have been removed from the Tracker to be monitored offline. At the time of reporting all 16 advisory recommendations remain recorded as partially complete);
- A further 37 entries have been added to the tracker since April 2022.

The audit reports added to the tracker since April 2022 are:

1. Surgery Clinical Board Medical Finance Governance Follow-up Final (1 entry, recorded as complete)
2. Deprivation of Liberty Safeguards Final (4 entries recorded as complete)
3. Charitable Funds Final (3 entries)
4. PCIC Business Continuity Final (4 entries)
5. Wellbeing at Maelfa (4 entries recorded as complete)
6. Verification of Dialysis Sessions (3 completed entries)
7. Raising Staff Concerns Final Report (5 entries – 3 of which are recorded as complete)
8. IT Service Management Final Report (8 entries – 2 of which are recorded as complete)
9. Delivery of Mental Health Services – Advisory Final Report (5 entries)

It should be noted that the historic Audit recommendations at entries 1 to 5 above were added retrospectively as confirmed and agreed at the April Committee meeting.

The following Audits (and associated recommendations) shared at the May meeting of the Committee meeting will be added to the Tracker at the September Committee meeting:

- COVID 19 Vaccination Programme (Phase 3) Final Report
- Health & Safety Final Report
- Wellbeing Hub at Maelfa Final Report
- Development of Genomics Partnership Wales Final Report
- Network and Information Systems (NIS) Directive Final Report
- Welsh Risk Pool Claims Final Report
- Nurse Rostering Children’s Hospital for Wales, Children and Women’s CB Final Report
- Nurse Bank Final Report

### Advisory Reports

As confirmed above, the Advisory IM&T Control and Risk Assessment Audit has been removed from the Tracker shared with the Committee to be tracked offline.

The Advisory Delivery of Mental Health Services Report has been added to the Tracker for noting on at this Committee meeting. The 5 advisory recommendations from this report will also be removed from the Tracker prior to the September Committee meeting, with implementation of recommendations tracked offline.

Moving forward all Advisory reports and recommendations will initially reported to and noted by the Committee and subsequently tracked offline. Following the removal of Advisory recommendations from the Tracker regular progress updates will be shared to establish whether best practice suggestions have been implemented.

Of the 91 recommendations listed within the Tracker, 25 are recorded as completed, 56 are listed as partially complete and 10 are listed as having no action taken or reported since the April Committee meeting.

A review of all outstanding recommendations has been undertaken since the last meeting of the Committee where the internal audit tracker was presented (April 2022). Each Executive Lead has been sent the recommendations made by Internal Audit which fall into their remits of work.

It should be noted that the narrative at Column J (Management Response/Executive Update) of the attached tracker are 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 I by an ‘NA’ entry.

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

	<b>Substantial Assurance</b>	<b>Reasonable Assurance</b>	<b>Limited Assurance</b>	<b>Rating N/A - Advisory</b>	<b>Total</b>
<b>Internal Audits 2019/20</b>	10	25	2	2	39
<b>Internal Audits 2020/21</b>	7	18	1	3	29
<b>Internal Audits 2021/22</b>	7	12	7	3	27

Attached at Appendix 2 are summary tables which provide an update on the April 2022 position as of the 23/06/2022.

**ASSURANCE** is provided by the fact that a tracker is in place. This assurance will continue to improve over time with the implementation of regular follow ups with 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 April 2022.

**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	
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**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

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Socio Economic: Yes/No	
N/A	
Equality and Health: Yes/No	
N/A	
Decarbonisation: Yes/No	
N/A	
<b>Approval/Scrutiny Route:</b>	
Committee/Group/Exec	Date:
N/A	

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Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update for February 2022: 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 - Reasonable	R1/6	Medium	The UHB Study Leave Procedure for Medical & Dental Staff should be reviewed and revised. The policy should more clearly specify: ☑ roles and responsibilities – of Directorates, Managers, Consultants; ☑ funding and budget guidance. ☑ monitoring and compliance arrangements including KPIs; and ☑ reporting arrangements. Once updated, the procedure flow chart that is appended should also be updated accordingly.	Executive Director of People and Culture	Executive Director of Workforce and OD & Medical Director	PC	Draft Procedure is still with the BMA. The BMA unfortunately did not meet the required deadline of the 7th Jan 2022, although they have assured us that the document will be tabled at LNC in March 2022. Therefore will not be presented to the Strategy and Delivery Committee in March 2022 as previously indicated. Meeting between BMA and Medical Director's team re-scheduled for June 2022.
2019-20	01/09/2020	Medical Staff Study Leave - Reasonable	R4/6	Medium	The following arrangements are reviewed and strengthened:- - budget setting, monitoring and reporting; - payment of honorary staff expenses; and - ability to access Trust funds to support study leave budgets.	Executive Director of People and Culture & Medical Director	Executive Director of People and Culture & Medical Director	PC	Was briefly discuss at LNC in Jan 2022, it was agreed that a meeting would be arranged by the Medical Director, Director of Finance, Chair of BMA & Assistant Secretary for BMA. Awaiting outcome of meeting. Meeting between BMA and Medical Director's team re-scheduled for June 2022.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R1/5	High	The UHB should ensure policies are reviewed and updated within appropriate timescales.	Director of Corporate Governance	Head of Corporate Governance	PC	This piece of work is partially complete. Due to other priorities (including the Annual Reprt and end of year work, further time was required to undertake this significant piece of work. As of the beginning of June, this work has been picked up and the Head of Corporate Governance is working with the Head of Corporate Business to complete this piece of work by the end of June 2022.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R2/5	Medium	Review the 'register' for completeness. Assess if all policies, procedures and other written control documents available on the intranet and internet are current and then ensure they are all recorded appropriately in the 'register'.	Director of Corporate Governance	Head of Corporate Governance	PC	Partially complete. Due to other priorities (including the Annual Reprt and end of year work, further time was required to undertake this significant piece of work. As of the beginning of June, this work has been picked up and the Head of Corporate Governance is working with the Head of Corporate Business to complete this piece of work by the end of June 2022.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R3/5	Medium	1. Review the readability of documents to make ways to write clearer, especially those available through internet to wider audience. From register, 372 out of 393, recorded as published on internet. 2. Correct and improve accessibility of documents. Review publishing process to ensure documents are circulated through correct location in internet and/or intranet sites. 3. A combined EHIA should be completed for all policies or where a Health Impact Assessment is not required this should be clearly stated. 4. The Corporate Governance Department should ensure the integrity of the 'Register', by reviewing accuracy of all key information.	Director of Corporate Governance	Head of Corporate Governance	PC	Partially complete. Due to other priorities (including the Annual Reprt and end of year work, further time was required to undertake this significant piece of work. As of the beginning of June, this work has been picked up and the Head of Corporate Governance is working with the Head of Corporate Business to complete this piece of work by the end of June 2022. The updated draft Management of Policies, Procedures and Other Written Control Documents Policy is scheduled to go to Board for approval in July 2022.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R4/5	Low	Review of record keeping process for when a request is made to create new written control document; from receipt of request to create, to issue of draft for consultation. Review of record keeping process for the consultation process; from request made, publishing and any feedback received.	Director of Corporate Governance	Head of Corporate Governance	PC	Partially complete. Due to other priorities (including the Annual Reprt and end of year work, further time was required to undertake this significant piece of work. As of the beginning of June, this work has been picked up and the Head of Corporate Governance is working with the Head of Corporate Business to complete this piece of work by the end of June 2022.
2019-20	01/12/2020	Management of Health Board Policies and Procedures	R5/5	Low	Review of record keeping process for notifying stakeholders of new, amended and exiting policies.	Director of Corporate Governance	Head of Corporate Governance	PC	Partially complete. Due to other priorities (including the Annual Reprt and end of year work, further time was required to undertake this significant piece of work. As of the beginning of June, this work has been picked up and the Head of Corporate Governance is working with the Head of Corporate Business to complete this piece of work by the end of June 2022.
2019-20	N/A	Pre-employment Checks	R10/10	Low	Temporary Staffing Department management to review the standard letter sent with the conditional offer and ensure it complies with the Identification Check NHS Standard.	Executive Director of People and Culture	Executive Director of People and Culture	C	Work current taking place, led by the Workforce Resourcing team to review and update all of our Trac adverts and associated documentation

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Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update for February 2022: 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.
2020-21	31/12/2020	Management of Serious Incidents	R3/6	Medium	Management should ensure that all outstanding actions are completed.	Executive Nurse Director	Assistant Director Patient Safety and Quality	C	Nationally reportable incident previously known as Serious Incidents are managed using the closure forms which should be completed by the Clinical Boards and submitted to the Asst. Director of Patient Experience to sign off. The NRI ( Nationally reported Incident ) policy has been implemented. Clinical Boards are regularly advised of the closure forms required through a robust monitoring process. The closure forms are quality checked through the Head of Patient Safety and/or Assistant Director prior to submission to the Delivery Unit. From 14th June 2021 the reporting of and management of Serious Incidents changed. They are now called NRIs (Nationally Reportable Incidents) and some categories which had previously been reported as an SI are no longer considered an NRI (example is adolescent in an adult setting and unexpected death in the community of a Mental Health patient). NHS Organisations now have longer to fact find before reporting (now 7 days from date of incident/knowledge of incident). NHS Organisations are now able to determine the level of and timeframe for investigation (which was previously the remit of the DU). Dependant on the findings of the investigation, one of 3 closure forms will be submitted dependant on whether there were any causative or contributory factors identified through the investigation process. The Head of Patient Safety and the Patient Safety Facilitators meet regularly with the Clinical Board Directors of Nursing to review progress and actions against the open and overdue NRIs to improve closure timeframes. we have in place a robust tracking system for NRI's and we have reformatted the NRI meetings to address clear terms of reference. immediate learning and mitigation and promote early contact with families and those affected.
2020-21	30/09/2021	UHB Core Financial Systems	R1/3	Medium	Management should ensure the FCPs are updated as soon as possible.	Director of Finance	Helen Lawrence, Head of Financial Accounts and Services – Sept 2021	PC	FCPs are currently being reviewed to ensure up to date and reflective of current procedures. The position was last reported to the Audit and Assurance meeting at its November 2021 meeting.
2020-21	31/03/2021	Consultant Job Planning 2nd Follow-up	R4/4	Medium	All completed job plans must be signed by the Consultant and the clinical manager responsible for agreeing them. The standard Job Plan documentation included in the UHB Job Planning guidance should be updated to incorporate the use of digital signatures.	Executive Medical Director	Kirsten Mansfield, Senior Medical Systems Advisor	C	The Allocate e-job planning system has been purchased and continues to be rolled out across the UHB. <b>Update Oct 2021</b> - As of 1st October 2021 54% of the Consultant and SAS grades have a job plan on the system. We are currently also working at aligning them to an annualised Job Plan cycle where all job plans will start from 1st April 2022 and will be reviewed yearly from then on. <b>Update Dec 21</b> - We now have 74% of job plans held in the system. Engagement is excellent and Job plan meetings are taking place across the board despite winter pressures and Covid. The plans are moving through the sign off process and we hope to reach our target of 85% compliance by April 1st. This allows for long term sickness and maternity leave. Engagement has been our biggest challenge with many feeling that the timing of implementation was ideal Regardless of this we have seen a significant increase in engagement and are moving closer to our target. <b>Update Mar 22</b> - 81% of job plans held in the Allocate, almost reaching our target of 85% by April. Concentration is now on getting them fully signed off and a plan for departments moving forward to ensure all consultants have a valid job plan as of 1st April each year. <b>Update Jun 22</b> - 83.5% of job plans now in Allocate. Still working towards all plans being signed off and renewed/updated each year. Final push from MD to follow shortly.
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.	Interim Chief Operating Officer	Director of Digital and Health Intelligence September 2021	PC	The Data Quality policy is complete but not yet reviewed. It will be completed and taken through the relevant committee for approval by end of Qtr4 21/22.
2020-21	30/09/2021	Data Quality Performance Reporting (Single Cancer Pathway) - Reasonable	R5/5	Low	Management should consider implementing an issues log to capture discrepancies in the data and help identify any negative trends.	Interim Chief Operating Officer	Cancer Services Lead Manager, 30 September 2021	C	<ul style="list-style-type: none"> <li>There are daily huddles between the service improvement manager, cancer tracking supervisor and trackers. This allows for 2-way feedback – issues noted from both management and tracking sides. This has been in place since Dec 21.</li> <li>Monthly validation on the data for completeness, this also picks up discrepancies and common issues identified are then fed back into the daily huddles.</li> <li>Weekly meetings using the PTL snapshot data with the services is also used to flag potential issues in the data.</li> <li>'housekeeping' document is updated based on feedback and findings from various sources such as month end validation, tracking meetings, etc. In addition SOPs for individual tumour sites are being pulled together.</li> <li>Business Analyst attends the weekly Cancer Services Management meeting as an IT contact for Cancer Tracking Module (CTM).</li> </ul>

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Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update for February 2022: 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.
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.	Director of Digital & Health Intelligence	Russell Kent, Head of Digital operations October 2021	PC	Jan 2022 Update - A comprehensive network audit and review is in flight and will be completed by March 2022. This report will provide revised patching and security update recommendations and policies, all of which will be enforced from May 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.	Director of Digital & Health Intelligence	Russell Kent, Head of Digital Operations November 2021	PC	Jan 2022 Update - Ivanti Helpdesk and Change Management module is scheduled to be installed in Jan 2022.
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	Director of Digital & Health Intelligence	Russell Kent, Head of Digital Operations December 2021	PC	The Network Team use a product called Castle Rock (SNMPc Enterprise Products) This product provides active monitoring and alerting for the majority of networking devices. There are monitoring and alerts on the core / data centre networking in the main sites at CAVUHB and CRI. This has been expanded to Woodland Hosue and UHL in the past 12 months.
2020-21	15/12/2021	Rostering in Community Children's Nursing Service	R4/7	Low	The CCNS Memorandum of Understanding: Home Based Continuing Care Packages should be updated, approved by senior management at both departmental and Clinical Board level for dissemination to parents / guardians as soon as is practicable so as to formalise mutual arrangements between the UHB and parent(s)/carers of children under the department's care.	Interim Chief Operating Officer	Paula Davies, Lead Nurse Alison Davies, Senior Nurse 15th December 2021	PC	MOU is with the legal team and awaiting clarification on a recent clinical issue. Once returned it will be sent out to families with a covering letter and opportunity to discuss with the management team via a telephone or virtual meeting. The memorandum is a comprehensive parental agreement that sets out the role and expectations of the UHB and parents working together in partnership.
2020-21	31/07/2021	Staff Recruitment	R1/3	Low	Management should consider developing a system that is able to record key recruitment data for the different recruitment 'areas' for registered nurses in order to assess the effectiveness of each one.	Executive Nurse Director	Clinical Board Directors of Nursing are re-setting establishments in ESR by July 2021.	PC	Information data re nursing workforce has been strengthened to what is currently available. This includes recruitment, turnover, sickness etc and numbers of staff deployable. Real recruitment figures are confirmed in month and predictions placed dependent on overseas nurses recruitment, post grad students leaving universities etc. This information is also available by Clinical Board NB some data is retrospective e.g. sickness figures. Each month a report is created to provide the actual position with regard to all of the above. Overseas nurses recruitment continues with a further 90 posts agreed. It is being considered that C&V join the All Wales OSN procurement led by shared services.
2020-21	31/12/2021	Engagement Around Service Planning - Reasonable	R1/5	Medium	Management should ensure that the Health Board's practical guide to engagement and associated flowchart is updated to reflect the current processes and made available on the HB intranet.	Director of Planning	Executive Director of Strategic Planning December 2021	PC	UHB will work with South Glamorgan CHC to review and update internal practical guide to engagement and associated processes. However, first step is to review the Local Framework for Engagement and Consultation on Changes to Health Services agreed between UHB and CHC in 2018, as this underpins the advice provided in the practical guide. Local Framework reviewed and updated internally by December 2021, including provision of advice from Corporate Governance. Sharing for discussion with CHC delayed pending outcome of mediation on a disputed service change, in which Local Framework is material. Once agreed, internal practical guide and associated suite of resources which have also been reviewed and updated, will be issued internally.
2020-21	31/12/2021	Engagement Around Service Planning - Reasonable	R2/5	Medium	In accordance with the Health Board's guidance on engagement, management should continue to ensure that the Community Health Council is engaged at the earliest opportunity, through the appropriate means as soon as a service change is recognised, and documentation is shared in a timely manner.	Director of Planning	Executive Director of Strategic Planning December 2021 - as part of the annual IMTP planning cycle	PC	Importance of timely completion of CHC Service Change Proforma for discussion with CHC when service change proposals are being developed will be reinforced with Clinical Boards; consideration given to building it into IMTP templates. Service Change Proforma has been reviewed and updated, pending discussion and agreement with the CHC. It forms a part of the Local Framework that has been reviewed as above and will be reissued to Clinical Boards once agreed between the UHB and CHC. Note decision to delay discussion with CHC pending outcome of mediation described in section 52

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2020-21	31/12/2021	Engagement Around Service Planning - Reasonable	R5/5	Low	In support of identified HB good practice, it would be beneficial for a common stakeholder mapping process to be adopted, to illustrate stakeholder selection by power and priority levels, to inform the engagement of service change / development.	Director of Planning	Executive Director of Strategic Planning December 2021	PC	The Engagement Plan Template, included as a supporting resource for the internal UHB Practical Guide to Engagement, has been reviewed and updated to include stakeholder mapping advice based on current best practice. Once the actions in section 52 on Local Framework have been completed, the Practical Guide and supporting resources will be re-issued to Clinical Boards and put on the UHB intranet.
2021-22	22/06/2021	Cancellation of Outpatient Clinics Follow-up Mental Health CB	R1/5	Low	Clarification of the approving forum and next review date should be added to the written procedure for the Cancellation of Outpatient Clinics.	Interim Chief Operating Officer	Clinical Board Director	PC	Document to be formatted to usual UHB standard, with version control, date, authorising body.
2021-22	31.03.2022	Ultrasound Governance CD&T CB	R2/5	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).	Executive Director of Therapies and Health Science	Assistant Director of Therapies and Health Science	PC	1. An annual audit template has developed by the membership of the USCGG to include a balanced range of performance indicators on the effective management of U/S devices including training, competence and maintenance as part of the U/S governance framework. This will be finalised at the next US Clinical Governance meeting on 29/06/2022 Opportunities to develop a digital audit tool will be explored with corporate IM&T teams. The online Ultrasound Training module will be uploaded to Learning@Wales in Sept 2022 and put on ESR at a later date (have been quoted 6-12 months for ESR upload). 2. Awaiting publication of the training module (Sept 22) 3. None 4. Report to Exec QSE June 2022
2021-22	30.09.2021	Ultrasound Governance CD&T CB	R5/5	Medium	In accordance with Sections 2 and 3 of the UHB Ultrasound Risk Management Procedure, the three key roles of Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor should be formalised within the sampled audit areas.	Executive Director of Therapies and Health Science	Directorate Ultrasound Governance Lead (Mark Denbow)	PC	1. The three key roles of Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor have been formalised within Medical Physics, Critical Care and physiotherapy. Follow-up requests go to all Clinical Board to ensure roles are in place 2. Delay in implementation as USCGG membership and ToRs had first to be agreed. 3. None 4. Report to Exec QSE June 2022
2021-22	31.01.2022	Clinical Audit	R1/9	High	A Clinical Audit Strategy should be developed, cognisant of the Business Case to support Quality, Safety and Experience Framework (2021 – 2026), currently under consideration by executive management, to ensure the Health Board aligns with HQIP guidance.	Executive Medical Director	Head of Patient Safety and Quality Assurance and Associate Medical Director	PC	A Clinical Audit Strategy will be developed considering the HQIP guidance. (Time frames of completing this action will be dependent on the timing of, and amount of investment has been agreed which may influence the approach)  5/1/21 Still Awaiting approval of investment, the basis for the strategy has been commenced but delayed due to long term sickness. Level of investment is required to inform the strategy as will impact on the approach taken.  15/6/22 - In progress. Investment was significantly less than required but has allowed for a Clinical Effectiveness Lead to be appointed, which occurred this week, this will increase capacity to move actions forward
2021-22	31.01.2022	Clinical Audit	R2/9	High	The Health Board should develop a Clinical Audit Policy and subsequent Procedure, which will require formal approval, to provide a mandate to direct staff on a consistent basis. The policy and procedures should be developed in keeping with HQIP guidance, so that national and local clinical audits are carried out consistently and comply with current information governance legislation and guidance.	Executive Medical Director	Head of Patient Safety and Quality Assurance and Associate Medical Director	PC	A Health board specific Clinical Audit policy will be developed and subsequent procedure which will provide a mandate to direct staff in a consistent way. The policy will be approved through the Clinical Effectiveness Committee Meeting (As with the clinical audit strategy time frames of completing this action will be dependent on the timing of and amount of investment has been agreed which will also influence the approach).  5/1/21 Still Awaiting approval of investment, the basis for the strategy and policy has been commenced but delayed due to long term sickness, level of investment will be required to complete as will impact on approach to guide staff.  15/6/22 - In progress. Investment was significantly less than required but has allowed for a Clinical Effectiveness Lead to be appointed, which occurred this week, this will increase capacity to move actions forward
2021-22	31.03.2022	Clinical Audit	R3/9	High	Management should continue as planned, to present the proposal for the future organisational structures to support Quality, Safety and Experience to management executive, to ensure identified resource issues are mitigated. Specifically, that the Health Board are able to: • Monitor the progress or completion of action plans / improvements in response to National Clinical Audits; • Monitor and support the development of Quality and Safety priority audits (Tier 2); and • Monitor the progress, completion and reporting of clinical audits and action plans that have identified the need for improvement.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	A Business Case to support the Quality, Safety and Experience Framework (2021 – 2026) is currently under consideration by Executive Management. The required investment will allow for purchase of the AMaT monitoring and tracking system and the team to progress this work. This action is dependent on the timing and level of investment.  5/1/21 Still Awaiting approval of investment.  15/6/22 . Investment was significantly less than required and will impact on the ability to undertake some action in a timely way. Investment has allowed for a Clinical Effectiveness Lead to be appointed (Interviewed this week), and a Clinical Effectiveness Facilitator (AMaT officer) (commence in post 20/6/22) AMaT audit tracker and quality assurance system has been purchased The investment will allow actions

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2021-22	31.03.2022	Clinical Audit	R4/9	High	Management should ensure they have appropriate systems and processes to effectively record, track and monitor clinical audit outcomes, comparable to the size of the Health Board.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	Currently submission of part A's and B's are being recorded, but neither the capacity or IT management system is in place to monitor and track the improvement plans (Part B) A management system for monitoring and tracking clinical audits has been identified (AMaT) along with the required resource to implement and administer the work has been included in the Business Case to support QS&E Framework (2021 – 2026) is under consideration by the Executive Management Team.  5/1/21 Still Awaiting approval of investment to purchase AMaT and required resource.  15/6/22 . Investment was significantly less than required and will impact on the ability to undertake some action in a timely way. Investment has allowed for a Clinical Effectiveness Lead to be appointed (Interviewed this week) , and a Clinical Effectiveness Facilitator (AMaT officer) (commence in post 20/6/22) AMaT audit tracker and quality assurance system has been purchased The investment will allow actions to move forward. A phased approach over 1 year has been planned, Implementation to commence July/August
2021-22	30.04.2022	Clinical Audit	R5/9	Medium	There is currently no Clinical Audit Training Plan in place to prioritise which Clinical Boards and Directorates require training. Potential risk of: • Clinical issues materialise if risks are not identified due to monitoring and governance arrangements not being in place Recommendation 5 Priority C	Executive Medical Director	Head of patient Safety and Quality Assurance/Senior Clinical Audit Coordinator	PC	An evaluation of training needs will be undertaken across the health boards to prioritise clinic audit training. Investment in the clinical audit team is required to deliver training and support clinical audit across the health board, as illustrated in the business plan.  5/1/21 Still Awaiting approval of investment. Clinical audit training has recommenced, however difficulties with capacity to continue to undertake this work fully without additional resource and long term sickness. The function of the clinical audit team has also had to focus on National Audits and meeting mandatory requirements over recent months.
2021-22	30.04.2022	Clinical Audit	R6/9	Medium	In conjunction with recommendation 2, the Clinical Audit Policy and underpinning procedure should detail the process for Clinical Boards to produce local Clinical Audit Plans. All Clinical Audit Plans should be made available to the Clinical Audit Team so that they are sighted on all local clinical audits that are being undertaken.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	The development of the Clinical Audit policy, strategy and purchase of AMaT will transform the way in which tier 2 local audits are registered and monitored and will allow centralisation of clinical audit plans and reports, improving accessibility and ownership to clinicians for their audits and improvement plans and for Clinical board to have ability to track progress. The Clinical Audit Policy and Strategy will detail roles and responsibilities with a clearly defined process for staff to follow and refer to. Training will be provided and aligned with the policy and strategy for clinical audit. Completion of this action is dependent on the timing and level of investment in response to the business case.  5/1/21 Still Awaiting approval of investment, the basis for the strategy and policy has been commenced but delayed due to long term sickness. It is difficult to progress this work without investment in the team and IT management system to establish the approach that will be taken. Long term sickness and clinical audit team having to prioritise National Mandatory audits has also had an impact
2021-22	30.04.2022	Clinical Audit	R7/9	Medium	In conjunction with recommendation 2, the mandate to complete a 'Clinical Audit Project Proposal Form' for all tier 2 and 3 audits, which are to be forwarded to the Clinical Audit Team, should be directed by Clinical Audit Policy and Procedures.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	The development of the Clinical Audit policy and strategy will include mandated guidance for the proposal, authorisation and registration of Tier 2 and 3 clinical audits aligned with the Health Board information Governance arrangements This action is dependent of the timing and level of investment in response to the business case.  5/1/21 Still Awaiting approval of investment, the basis for the strategy and policy has been commenced but delayed due to long term sickness. It is difficult to progress this work without investment in the team and IT management system. Long term sickness and clinical audit team having to prioritise National Mandatory audits has also had an impact  15/6/22 . Development of Clinical Audit strategy and policy are in progress which will include mandating aspects of the clinical audit process, engagement with clinical boards and directorates underway. Investment was significantly less than required and will impact on the ability to undertake some action in a timely way. Investment has allowed for a Clinical Effectiveness Lead to be appointed (Interviewed this week) , and a Clinical Effectiveness Facilitator (AMaT officer) (commence in post 20/6/22) AMaT audit tracker and quality assurance system has been purchased The investment will allow actions to move forward.

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2021-22	30.04.2022	Clinical Audit	R8/9	Medium	The governance arrangements to challenge and support local clinical audits requires clarity and to become embedded within the revised quality, safety and experience governance arrangements, to ensure the following: • There is effective oversight of local clinical audit plans and their delivery; • Local Clinical Audits are being reported upon and monitored, to ensure performance is being measured and action taken to implement change where needed, which is sustainable.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	The development of the Clinical Audit policy, strategy and purchase of AMaT will transform the way in which tier 2 local audits are registered and monitored, including implementation of any necessary improvements. The Clinical audit policy and strategy will include a clearly defined process for clinicians and clinical boards in relation to governance arrangements for the delivery and quality monitoring of clinical audit activity.  15/6/22 . Investment was significantly less than required and will impact on the ability to undertake some action in a timely way. Providing direct support and training will be very challenging as a result. This aspect will be reviewed as the second phase of the investment from the business case.
2021-22	30.10.2021	Clinical Audit	R9/9	Low	Whilst the remit of the Clinical Effectiveness Committee is developing and embedding, consideration should be given to the good practice sighted in another Health Board, and the potential remit of the Committee to consider pertinent risks that they have the ability to challenge and support.	Executive Medical Director	Head of Patient Safety and Quality Assurance	PC	Outlier status is a standard item on the Clinical Effectiveness Committee meeting agenda, outliers would remain on the agenda and actions updated until issues resolved. Clinical Leads and/or clinical boards are invited to attend CEC to discuss risks when identified, including any improvement plans and obstacles in place Implementation of a risk register has been added to the agenda for October Clinical meeting for consideration.  5/1/21 To be discussed in January CEC due to CEC meetings capacity
2021-22	31.03.2022	Five Steps to Safer Surgery	R1/7	High	Mechanisms need to be established that enable the Health Board to record Step One (Briefing) and Step Five (Debriefing) of Five Steps to Safer Surgery. Whilst considering options, attention should be given to the ability to report on quantitative data from Theatreman to identify areas of concern with steps two through to four.	Executive Medical Director	IT Service Manager and Interim Lead Nurse	PC	The Perioperative Care Directorate has worked in collaboration with Trisoft (The Manufacturer of TheatreMan, our Theatre Operating system within Cardiff & Vale UHB) to develop a mechanism for recording all 5 stages of the '5 Steps to Safer Surgery' electronically. This development will allow for quantitative data collection. All stages of the '5 Steps to Safer Surgery' will be compulsory. Prior to full implementation, the Theatre Informatics Team will need to undertake a period of testing to confirm that the correct pathways are active. The Perioperative Care Directorate will also need to ensure staff are aware of the change in process and provide any necessary training. Update :12/1/22 Trisoft have placed the questionnaires into other test environment and are awaiting our instruction to place into live. A help guide has been written but reports have not yet been explored due to the development not being attached to the current live system.
2021-22	31.03.2022 30.11.2021 31.03.2022	Five Steps to Safer Surgery	R2/7	High	Staff should be reminded of the importance for accurately completing the safer surgery checklist and if gaps are noted, these should be escalated and resolved appropriately.	Executive Medical Director	IT Service Manager  Interim Lead Nurse  Director of Nursing & Clinical Director	PC	In line with Agreed Management Action 1, The Perioperative Care Directorate aim to record all 5 stages of the 5 stages of the '5 Steps to Safer Surgery' electronically. This will eliminate duplication of information and all stages of the '5 Steps to Safer Surgery' will be mandatory fields within TheatreMan. Update : 31.12.21 This has been confirmed as being possible and we are awaiting a date from the Theatre IT team as to when this will be fully implemented. If a stage of the '5 Steps to Safer Surgery' is not completed staff will have to explain the reason why. Non-compliance reports can be generated and addressed with individuals involved. Update 31.12.21 Non compliance reports will be discussed at Theatre Manager 2:1's with the General Manager and Lead Nurse for Peri-Operative Care. A draft flow chart has been devised which shows escalation process for non-conformance.  The Perioperative Care Standard Operating Procedure (SOP) for 'Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' has been updated to provide guidance on how to escalate areas of non-compliance, this document will be agreed at the next Perioperative Care Policy Meeting and then Surgery Clinical Board for ratification. Update 31.12.21 will be agreed at the next Perioperative Care Policy Meeting  To improve the non-compliance culture associated with the '5 Steps to Safer Surgery' the Senior Team within Surgery Clinical Board have engaged with the Patient Safety Team and Natssips lead for the PST with the view of securing senior support from the Executive Team within Cardiff & Vale UHB challenge the noncompliance culture associated with the '5 Steps to Safer Surgery. Update 12.1.22 The PST and Natssip lead are supportive of this change

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2021-22	30.11.2021	Five Steps to Safer Surgery	R3/7	Medium	In conjunction with Recommendation 5, management should ensure that the processes within the 'Procedure for Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' (UHB Reference 58 v4), are effectively embedded within the Health Board and fully complied with for all surgical procedures.	Executive Medical Director	Interim Lead Nurse	PC	The Perioperative Care Standard Operating Procedure (SOP) for 'Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' has been updated to provide guidance on how to escalate areas of non-compliance, this document will be agreed at the next Perioperative Care Policy Meeting and then Surgery Clinical Board for ratification. Update 31.12.21 will be agreed at the next Perioperative Care Policy Meeting
2021-22	31.03.2022 31.03.2022	Five Steps to Safer Surgery	R4/7	Medium	Staff should be further educated around the value of the Five Steps to Safer Surgery and reminded of the requirement to actively engage in the process.	Executive Medical Director	Director of Nursing and Clinical Director	PC	To improve the non-compliance culture associated with the '5 Steps to Safer Surgery' the Senior Team within Surgery Clinical Board have engaged with the Patient Safety Team with the view of securing senior support from the Executive Team within Cardiff & Vale UHB challenge the non-compliance culture associated with the '5 Steps to Safer Surgery' Update 31.12.21 - This has been discussed and has been supported by the Medical Director and the CD for Surgery Clinical Board  The Perioperative Care Directorate has undertaken a benchmarking exercise to understand how other Health Boards educate new staff and reinforce the value of the Five Steps to Safer Surgery amongst existing staff members. The Benchmarking exercise highlighted how other Health Boards have developed a training video which is shared at induction. The Perioperative Care Directorate would like to develop a training video to educate new and existing staff members about the application and importance of the '5 Steps to Safer Surgery'. To maximise the effectiveness of the video Senior Leaders within the UHB will be invited to participate. Update: the directorate have been working with the other Theatre Managers across Wales to establish whether this could be a joint project with neighbouring health boards. A working group has been set up to take this forward.
2021-22	30.11.2021	Five Steps to Safer Surgery	R5/7	Medium	As part of the scheduled review in 2021 of the 'Procedure for Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' (UHB Reference 58 v4), the following should be included: • Step Five – Debriefing, of the Five Steps to Safer Surgery; and • Clarification of the process for employees to highlight non-compliance or concerns with Five Steps to Safer Surgery.	Executive Medical Director	Interim Lead Nurse	PC	The Perioperative Care Standard Operating Procedure (SOP) for 'Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' has been updated to provide guidance on how to escalate areas of non-compliance, this document will be agreed at the next Perioperative Care Policy Meeting. Update 31.12.21 will be discussed at next Perioperative Care Policy Meeting
2021-22	30.11.2021	Five Steps to Safer Surgery	R6/7	Medium	Risk surrounding Five Steps to Safer Surgery need to be incorporated within the Directorate / Clinical Boards risk management processes.	Executive Medical Director	Interim Lead Nurse	PC	A risk assessment for 'Word Health Organisation (WHO) Safety checklist' has been completed (22/07/2021). This will be updated to reflect the recommendations of this Audit and will be shared with the Directorate and Surgery Clinical Board. Update 31.12.21 The risk assessment has been updated and will be added to Surgery CB risk register.
2021-22	31.03.2022	Five Steps to Safer Surgery	R7/7	Low	Consideration should be given to the opportunities available to raise the profile of thematic issues of Five Steps to Safer Surgery outside of the Clinical Board, through the Health Board's revised Quality and Safety governance arrangements and to raise the profile of the work undertaken by the Peri-Operative Care Directorate to address common themes.	Executive Medical Director	Interim Lead Nurse	PC	The Perioperative Care Directorate has undertaken a benchmarking exercise to understand how other Health Boards educate new staff and reinforce the value of the Five Steps to Safer Surgery amongst existing staff members. The Benchmarking exercise highlighted how other Health Boards have developed a training video which is shared at induction. The Perioperative Care Directorate would like to Develop a Training video to educate new and existing staff members about the application and importance of the '5 Steps to Safer Surgery'. To maximise the effectiveness of the video Senior Leaders within the UHB will be invited to participate. 21/1/22 update- The representative from the PST has shared a story board for a video and accessed posters used by other HB's . It is hoped that this work will be taken forward by several health Boards in Wales A risk assessment for 'Word Health Organisation (WHO) Safety checklist' has been completed (22/07/2021). This will be updated to reflect the recommendations of this Audit and will be shared with the Directorate and Surgery Clinical Board. Update 31.12.21 A letter has been drafted to share with the staff the results of this audit and the actions that will be taken.
2021-22	31.03.2022 31.03.2022	Core Financial Systems	R1/2	Low	As a point of good practice, consideration should be given to the following updates to the Financial Control Procedures: - Referencing the Health Board's Standing Financial Instructions and Standing Orders within the procedures, to demonstrate the line of sight to key Health Board documents; and - The Accounts Receivable Control Procedure should include an owner and next review date.	Director of Finance	Head of Financial Accounts and Services Financial Services Manager	PC	Agree to update and reference Health Board's Standing Financial Instructions and Standing Orders within the procedures. Accounts Receivable Control Procedure has been updated with Owner Title and next review date.

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2021-22	31.03.2022	Core Financial Systems	R2/2	Low	A review of controls should be undertaken to ensure all leavers of the Health Board have their user access to the Oracle system removed in a timely manner, particularly those outside of central finance.	Director of Finance	Director of Finance	PC	Agree to review controls and implement more robust process to ensure all leavers have access removed in timely manner
2021-22	31.03.22	Theatre Utilisation (Surgery CB)	R1/4	High	Peri-operative Care should continue as planned to complete and seek approval of a Health Board Theatre Utilisation Procedure, in addition to a Policy. In doing so, the following should be incorporated: - The governance and assurance mechanisms to support and challenge efficient and effective theatre utilisation, which incorporates the escalation of issues for resolution; - Clarity of roles and responsibilities, including but not limited to the distinction between Peri operative Care and the Surgical Specialities; - Alignment with the Planned Care Programme of the Recovery and Redesign Portfolio (clinically led, risk-orientated and data driven); and - The actions to be taken where utilisation falls short of plans and schedules (action determined by % utilisation). Additionally, historical information which is no longer valid should be fully removed from the Intranet to avoid confusion and incorrect action occurring.	Interim Chief Operating Officer	General Manager Peri-operative Care	PC	The Peri-Operative Care Directorate have written and completed a procedure titled 'Operating Theatre Scheduling, Cancellation and Utilisation' with the support of 'FourEyes Insight Ltd' This will be the standard operating procedure which explains the process of how theatre lists should be utilised, who should attend the scheduling and utilisation meetings and how the meetings will be run. This policy will be approved by the Peri-Operative Care directorate Governance forum and has been sent to all stakeholders that use the Peri-Operative Care service and attend the scheduling and utilisation meetings. The SCB will continue to work with "Foureyes insight Ltd" until the end of June 2022 and the main focus will be on utilisation and efficiency. The Directorate is writing a Health Board policy which states the rules around the booking process of theatre lists and how performance and utilisation will be monitored and adhered to. This policy will need to be approved by the Perioperative care Directorate and Surgery Clinical Board but will also need executive approval by the Board. These two policies will incorporate the recommendations: - The governance and assurance mechanisms to support and challenge efficient and effective theatre utilisation, which incorporates the escalation of issues for resolution; Clarity of roles and responsibilities, including but not limited to the distinction between Peri-operative Care and the Surgical Specialities; - Alignment with the Planned Care Programme of the Recovery and Redesign Portfolio (clinically led, risk-orientated and data driven); and - The actions to be taken where utilisation falls short of plans and schedules (action determined by % utilisation). These policies/procedures will be available on the Health Board's intranet pages. The Policy and procedure will be found under the policies section within the Peri Operative Care Directorate web site. All old policies relating to theatre scheduling, utilisation and systems and processes in relation to these will be removed from Cardiff and Vale UHB intranet pages.
2021-22	31.03.22	Theatre Utilisation (Surgery CB)	R2/4	Medium	In conjunction with recommendation 1, which will provide clarity of roles and responsibilities mandated by procedure, all specialties should be reminded of their responsibility to close down their theatre sessions (at the end of each session), so that the information recorded is complete and accurate to enhance utilisation intelligence.	Interim Chief Operating Officer	General Manager Peri-operative Care	PC	The policy on Operating Theatre Scheduling, Cancellation and Utilisation clearly states the responsibilities and ownership with regards to ensuring that all theatre sessions are completed. Time frames will be set against individual directorates to ensure that the sessions are completed after receiving the information from the Peri-Operative Care directorate. If the timeframe is exceeded the policy will state the escalation protocols that will be followed.
2021-22	31.03.22	Theatre Utilisation (Surgery CB)	R3/4	Medium	The current systems and processes for managing theatre utilisation should be enhanced, to ensure that utilisation is maximised, cognisant of the risks faced by the Health Board. The policy and procedure developed as part of Recommendation 1 should reflect the enhanced systems and processes to help ensure they are consistently applied.	Interim Chief Operating Officer	Lead Nurse Peri-operative care Deputy General Manager Peri Operative Care General Manager Peri-Operative Care Head of Operations Surgery Clinical Board	C	Completed - The 'Operating Theatre Scheduling, Cancellation and Utilisation' Procedure/Policy fully details what systems should be used to ensure theatre utilisation is maximised. Four Eyes Insight Ltd continue to meet with all SCB specialities on a regular basis demonstrating and advising what systems should be used for them to maximise time in theatre. Posters have been developed and videos produced around the 'Golden Patient' and 6:4:2 process that have been sent to all users, displayed in theatres will soon be uploaded to the Perioperative Care Intranet Pages. A weekly 6:4:2 process SCRUM meeting takes place prior to the weekly Scheduling meetings with good representation and attendance from all SCB specialities and the scheduling meetings have been enhanced to scutinise planned elective care two weeks in advance. A review of 'what happened the week before' also takes place. FourEyes Insight are also working on a full suite of procedure documents, cards and workbooks that will be handed over when the project ends. These will be fully incorporated within the Perioperative Care processes once reviewed and agreed by the governance forum.

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2021-22	31.03.22	Theatre Utilisation (Surgery CB)	R4/4	Medium	The current systems and processes for managing theatre utilisation should be enhanced, to ensure that utilisation is maximised, cognisant of the risks faced by the Health Board. The policy and procedure developed as part of Recommendation 1 should reflect the enhanced systems and processes to help ensure they are consistently applied.	Interim Chief Operating Officer	General Manager Peri-operative Care	C	Opportunities to maximise theatre resources will be achieved through the following actions: • Increase the workforce within the Peri-Operative Care directorate to ensure that there is sufficient amount of staff to work in the theatres. 07/06/2022 - this is ongoing, staffing constraints are the main concern • Work with Specialist Services Clinical Board to ensure that the PACU service provision is increased 07/06/2022 - PACU can be flexed up if demand increases significantly but staffing constraints are the main concern • Work with Theatre IT to ensure that theatre overview reports are sent to appropriate teams. 07/06/2022 - Completed • Theatre overview is discussed with Theatre Managers and General Manger and Lead Nurse for Peri-Operative Care at their regular 2:1 meetings • Theatre overviews is discussed at Theatre scheduling meetings with each individual directorates • If utilisation falls below the agreed performance rate this is escalated to the appropriate Clinical Board. • Engagement with partner (FourEyes Ltd) to adopt best practise following GIRFT recommendations continues • Directorates will not be given extra sessions if their utilisation is below the agreed performance rate continuously and is due to reasons within their control. • Theatre performance reports are sent to Pre-assessment General Manager so that any issues of poor performance due to pre-assessment issues can be addressed. • The associate Clinical Director for Peri-Operative Care works closely with the deputy General Manager for Peri-Operative care to ensure theatre lists are fully booked and utilised. The Deputy General Manager discusses this at the theatre scheduling meetings with the Directorates. • Theatre performance and utilisation and the action points above have been written into the policy on Operating Theatre Scheduling, Cancellation and Utilisation
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.	Executive Director of People and Culture	Director of Nursing Strategic Nursing Workforce & Assistant Director of Workforce Resourcing	PC	The Nurse Retention Steering Group has now started to meet and a comprehensive nurse retention framework with a number of themes and actions has been developed, however progress has been slowed down due to the operational pressures Actions: • Steering Group meets 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'.
2021-22	31.03.2022	Retention of Staff	R5/5	Medium	Consideration should be given to mandating the Leavers' checklists through Health Board approved procedures, to minimise the risks to the Health Board.	Executive Director of People and Culture	Assistant Director of Workforce Resourcing	C	Incorporate the leavers checklist into a 'Leavers Toolkit' accessible for managers and staff. The Toolkit will also include the exit questionnaire process, details on completing a termination form, etc.
2021-22	30.04.2022	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.	Executive Director of People and Culture	Welsh Language Office & Assistant Director of OD	NA	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. Action plan templates are currently being drafted
2021-22	30.04.2022	Welsh Language Standards	R2/6	Medium	To continue as planned to ensure there are Welsh Language Champions across all Clinical Boards and Corporate Departments, to facilitate, support and ensure compliance with the Welsh Language Standards.	Executive Director of People and Culture	Welsh Language Office & Assistant Director of OD	PC	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.
2021-22	30.04.2022	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.	Executive Director of People and Culture	Welsh Language Office & Equality Manager	NA	Undertake a demand, capacity and resource review. Report initial findings to ESWLSG to shape recommendations / actions.
2021-22	28.02.2022	Welsh Language Standards	R4/6	Medium	The Equality Strategy and Welsh Language Standards Group should consider if they have appropriate capacity to provide effective oversight of the implementation of the Welsh Language Standards, and how they may wish to be further supported to ensure implementation of the Welsh Language Standards.	Executive Director of People and Culture	Welsh Language Officer Equality Manager ESWLSG Chair	PC	In future ESWLSG meetings, Flash Reports are to be submitted by each Clinical Board detailing actions and work undertaken in their areas regarding the WL and ED&I agendas
2021-22	15.03.2022	Welsh Language Standards	R5/6	Medium	To ensure complete implementation of Welsh Language Standard 79, the Welsh Language Policy (UHB 462) should be published and available to staff. A review of the Policy would benefit from: - Further signposting to supporting procedures and written control documents; and - The supporting documents should also be clearly dated, also noting the date of next review and the link to the Welsh Language Policy.	Executive Director of People and Culture	Welsh Language Officer Equality Manager Assistant Director of OD	C	Policy approved by Board

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2021-22	30.04.2022	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.	Executive Director of People and Culture	Welsh Language Officer Equality Manager	PC	A dashboard to reflect recommendations is currently in the early stages of development and will be hosted via Sharepoint. It will be presented to ESWSLG for comment / agreement.
2019-20	31.03.2019	Surgery CB Medical Finance Governance Follow-up Final	R1/6	High	The Directorate should ensure that consultants carry out all planned sessions wherever possible and appropriate reasons are recorded for the cancellation of clinics and theatres. Colorectal Consultants should ensure that they cover and backfill the other Consultants lists if they are unable to carry out the planned session.	Interim Chief Operating Officer	Directorate General Surgery & Clinical Director	C	Theatre sessions reviewed on a weekly basis by the specialty manager for General Surgery.  Improve annual leave data base has been developed for General Surgery which includes reason for absence. Robust annual leave database, all consultants using intrepid to request leave.  Joint job planning meeting is scheduled for the end of August, at which discussions will be held in relation to backfilling. The Directorate have seen improvements in terms of backfilling. All job plans uploaded to Allocate, 60% Colorectal Consultants Job planned, all colorectal consultants to work to an annualised timetable utilising 50 weeks of the year. Directorate team monitoring activity and theatre utilisation.
2019-20	Oct-20	Deprivation of Liberty Safeguards	R1/4	High	Staff should attempt to ensure that all Urgent assessments are undertaken within the stipulated seven days as detailed in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards.	Executive Nurse Director	TBC	C	<b>update 10/06/2022. WG Phase 1 funding bid successful recruiting to 2 x BIA and the target is all assessments will be completed within 7 days in preparation for implementation of LPS.</b> All attempts are made to ensure the DoLS assessments are carried out within the specified timeframes, however this remains a challenge with the current resource. Only 1.5 wte (out of 6 wte) staff are funded by health with the remaining staff funded by LA. This means that resource is shared between LA assessments also. This position will be reviewed in 2020 with introduction of LPS.
2019-20	Oct-20	Deprivation of Liberty Safeguards	R2/4	Medium	The Health Board should ensure that staff are provided with appropriate DoLS training and where areas have low compliance these areas should be targeted.	Executive Nurse Director	TBC	C	<b>Update 10/6/2022.LPS training in preparation for LPS will commence when WG release training framework and resources. MCA training is in place across UHB and will be supported by recruitment of 2 xBIA</b> DoLS training has remained challenging, as it is directly related to the ability of clinical areas to release staff. The inability to release staff for Mandatory and Statutory training remains high on the UHB risk register. Formal monthly training continues to be supported by staff, although attendance poor. Bespoke training (one hour) drop in sessions are now being provided. Training is also incorporated into the general Safeguarding Training to continue to raise awareness of DoLS, however these results are captured in the safeguarding training numbers and not a formal record of DoLS training.
2019-20	Oct-20	Deprivation of Liberty Safeguards	R3/4	Low	Staff should attempt to ensure that all Standard and Further assessments are undertaken within the stipulated 21 days as set out in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards.	Executive Nurse Director	TBC	C	<b>Update 10/6/2022 WG Phase 1 funding bid successful recruiting to 2 xBIA the target is all assessments will be completed within the 21 stipulated time frames in preparation for implementation of LPS.</b> All assessments that are deemed as a priority have to be undertaken before the Standard and further assessments as outlined in line with WG priority tool.
2019-20	Oct-20	Deprivation of Liberty Safeguards	R4/4	Low	The Health Board need to ensure that they produce a plan for implementing Liberty Protection Safeguards following the production of the Code of Practice.	Executive Nurse Director	TBC	C	<b>update 10/06/2022 The Code of practice consultation was released May 2022, delay due to Covid 19, the UHB has an implementation plan for phase 1. Which is in line with WG LPS implementation plan</b> The Whilst LPS will come into force in October 2020, we are unable to formulate a plan without the implementation of the code. Scoping meeting planned for 12th December 2019 to develop framework and code and produce work plan across wales for 2020.
2019-20	Mar-20	Charitable Funds	R1/3	High	Fund holders must be contacted and reminded that they should not allow funds to remain dormant and expenditure plans must be developed to ensure appropriate use of the funds. Where funds are not being utilised they should be reviewed and potentially re-allocated / transferred. To ensure there is a robust and adequate control system in place, the FCP should include more information on the treatment of dormant funds such as the requirement for periodic reporting and update of dormant funds and periodic exercises where dormant funds are reviewed by Finance etc.	Director of Finance	Deputy Director of Finance	NA	This is a strategically important issue for the charity and a policy on the treatment of dormant funds will be specifically considered by the CFC/Trustee. This policy will consider these findings and recommendations.
2019-20	Mar-20	Charitable Funds	R2/3	Medium	Staff should be informed of the standardised documentation to be used for the completion of donations. Management should inform relevant staff and ensure they are aware that: ☐ The donation form should be adequately completed. ☐ Donation form copies should also be timely forwarded to the key departments responsible for the processing of the donations. ☐ Thank you letters should also be timely dispatched to the donors.	Director of Finance	Head of Arts and Health Charity	NA	The Fundraising team will continue to engage with the Clinical Boards to ensure donation forms are completed correctly and submitted to the fundraising team within a timely manner.

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2019-20	Nov-19	Charitable Funds	R3/3	medium	Management should remind key staff responsible for processing the Charitable fund expenditure to ensure that transactions have the required supporting documents and undergo the expected approval as stated within the Financial Control Procedure. All transactions entered into Oracle should accurately match their supporting documents.	Director of Finance	Charitable Funds Finance Manager	NA	Staff will be reminded of the importance of ensuring that the correct supporting documentation exists at all times.
2019-20	Dec-19	PCIC Business Continuity	R1/4	Medium	Management should ensure that all Business Units and Service Areas which require a BCP produce a formally documented one as soon as possible.	Director of Operations PCIC	PCIC Business Manager	NA	PCIC Clinical Board management are aware that all Business Units and Service Areas have been involved in the BCP process although not all have a written document completed and approved. Reviews are planned or have taken place with all Business Units and finalised documents are anticipated to be received by the Clinical Board in November and December 2019. One BCP (OOHs) will be submitted to PCIC QSE in November 2019 along with a briefing paper and process flowchart and the Director of Nursing will present the paper and flowchart. The other BCPs are anticipated to be submitted to PCIC QSE in January 2019 and will then enter an annual review process within their Business Units.
2019-20	Dec-19	PCIC Business Continuity	R2/4	Medium	Management should ensure all terms of references are reviewed and updated as required.	Director of Operations PCIC	Individual members of SMT / December 2019 Business Unit Leads / December 2019 PCIC Business Manager / November 2019	NA	PCIC Clinical Board Senior Management Team will ensure the terms of reference for any meetings they chair are reviewed and refreshed, and that future review dates are established. The Business Units will be advised to review the terms of reference for their established meetings and ensure they are refreshed if needed. This will also be added to the agenda for November 2019's PCIC Clinical Board Meeting, under a standing Governance update on Internal Audit.
2019-20	Feb-20	PCIC Business Continuity	R3/4	Low	Management should ensure that all members of staff are made aware of the existence of a BCP, the risk associated with possible occurrences and how to respond in such an event.	Director of Operations PCIC	Business Unit Leads	NA	Business Unit Leads will be asked to ensure that all Service Areas make all team members aware of the existence of a BCP, where the document is located, key risks for their Service Area, and their role in the use of the document.
2019-20	Jan-20	PCIC Business Continuity	R4/4	Low	Management will ensure that all service areas which require a BCP have their plans signed off.	Director of Operations PCIC	PCIC Business Manager	NA	One BCP (OOHs) will be submitted to PCIC QSE in November 2019 along with a briefing paper and process flowchart and the Director of Nursing will present the paper and flowchart. The other BCPs are anticipated to be submitted to PCIC QSE in January 2019 and will then enter an annual review process within their Business Units. The PCIC Business Manager maintains logs indicating the status of each BCP in the approval process and this will then form the basis of a tracker to ensure plans are reviewed on an annual basis within the Business Units.
2019-20	Nov-19	Wellbeing at Maelfa	R1/4	Low	The PEP should be updated accordingly and resonate with other supporting documentation (i.e. terms of reference) (O).	Director of Planning	Director of Capital, Estates & Facilities	C	Accepted. The PEP will be updated accordingly.
2019-20	Nov-19	Wellbeing at Maelfa	R2/4	Low	As the project gains momentum, Project Board and Project Team members should be reminded of the importance of attendance to ensure all discussions / decisions taken are suitably informed.	Director of Planning	Director of Capital, Estates & Facilities	C	Good attendance at project teams and the terms of reference has recently been reviewed, updated and endorsed by the project team
2019-20	Nov-19	Wellbeing at Maelfa	R3/4	Low	Work stream leads should produce resource/ activity plans for the attention of the Project Team/ Board (O)	Director of Planning	Director of Capital, Estates & Facilities	C	Progress is reported at each project team
2019-20	Oct-19	Wellbeing at Maelfa	R4/4	Medium	Arrangements should be made to ensure the correct section of the contract is signed by both parties (O)	Director of Planning	Director of Capital, Estates & Facilities	C	All contracts are in place
2021-22	1.05.2022	Verification of Dialysis Sessions	R1/3	Low	Management should review the desk instruction, 'How to Reconcile Dialysis Session Invoices against electronic data received in VitalData' with a view to expanding many of the steps detailed, for clarity on what action to take, where to access and save key documentation.	Interim Chief Operating Officer	Renal Systems Analysts	C	The Renal Systems Analysts have carefully considered the Matters Arising 1 and will incorporate, expand, and add clarification to the information in "How to Reconcile Dialysis Session Invoices against electronic data received in VitalData" document based on the Audit observations. The document will be reviewed 'live' when performing reconciliation exercises for Feb and Mar session data, in Mar and Apr respectively. Update 15/06/2022: More detail included with screenshots, it is now clear what action to take and guidance on what to access and where. See Version 1.4

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2021-22	1.04.2022	Verification of Dialysis Sessions	R2/3	Medium	Management should ensure that all documentation / evidence that supports the monthly verification process for the provision of dialysis sessions is accessible to all members of the team, either through greater use of the department's shared drive or use of a team email account. With reference to Recommendation 1, management should also consider this recommendation when updating the instruction to support the verification exercise.	Interim Chief Operating Officer	Renal Systems Analysts	C	When considering the matter of lack of visibility or accessibility of information, which informs the verification process, there are 3 core areas of the process that we will review. They are: (1) Excel outputs - generating the raw data, creating a table for analyses to reconcile day-to-day comparison plus the re-runs of the output, (currently observed as held on Analysts' H:/ drive) (2) Word docs - the monthly activity queries to the six SE Wales Dialysis Units (currently created and E-mailed from Analysts' E-mail account) (3) Master workbook - the evolving Performance Monitor table (currently available on the Dept shared drive) [Note: all of the above is accessible and readily available from the source Renal Information System (VitalData) and can be extracted by running pre-defined code] With regard to (1), the raw data and any outputs will be visible on the Master workbook in addition to the Performance Monitor table – both available to view on the Dept shared drive. Update 15/06/2022: Processes reviewed. All of the above documents are accessible to the team as required; i.e. the Raw and Word (error) docs are together in a new shared drive folder structure [ref (1) and (2)] and the Master workbook (3), is a on a separate shared area for access by Finance and N&T staff, but in a controlled way
2021-22	1.04.2022	Verification of Dialysis Sessions	R3/3	Low	Management should consider enhancing the details recorded on confirmation orders raised within Oracle to pay invoices for dialysis sessions provided. Consideration should be given to adding the following information: • Invoice Number; • The relevant month sessions were provided; and • Number of sessions delivered.	Interim Chief Operating Officer	Renal Systems Analysts	C	Please note there is one Braun / Fresenius invoice per unit, per row in Oracle in relation to the number of sessions that have been delivered. Procurement have provided templates for each dialysis unit, e.g. "Invoice payment for renal dialysis unit services at Cardiff South". Once the row is selected, then the Invoice Number is evident. We can add to this narrative and continue to include the month and now introduce the number of sessions delivered, which is exactly what we would instruct payment for. Update 15/06/2022: All changes and additions to Oracle orders implemented; i.e. if an Oracle user selects the ISP and Unit they will see the Invoice Number, Month and No. of sessions
2021-22	Immediately	Raising Staff Concerns (Whistleblowing)	R1/5	Low	For future reference, sub-committees should receive a copy of the procedure they are being asked to formally adopt.	Director of Corporate Governance	Head of Corporate Governance	C	Agreed - This was an isolated occurrence as procedures and policies are usually attached to papers where they are referred to. This will be monitored continuously moving forward.
2021-22	31.03.2022	Raising Staff Concerns (Whistleblowing)	R2/5	Medium	The Risk and Regulation Team should consider making the 'Standard Operating Procedure for Managing Concerns from Staff' visible to all staff via the Health Board website (as previous), with hyperlinks to the 'All-Wales Procedure for NHS Staff to Raise Concerns'.	Director of Corporate Governance	Head of Risk and Regulation	C	Complete - The SOP is now available online at the following link: <a href="https://cavuhb.nhs.wales/staff-information/your-health-and-wellbeing/general-health-and-wellbeing-resources/freedom-to-speak-up/responding-to-a-concern/files/managing-concerns-sop-english/">https://cavuhb.nhs.wales/staff-information/your-health-and-wellbeing/general-health-and-wellbeing-resources/freedom-to-speak-up/responding-to-a-concern/files/managing-concerns-sop-english/</a>
2021-22	31.03.2022	Raising Staff Concerns (Whistleblowing)	R3/5	Medium	To enhance the timeliness of the Freedom to Speak Up Communication Campaign, dedicated resources should be assigned to the campaign to ensure the biannual aspirations are achieved, which will remind staff of the channels available to them to raise concerns.	Director of Corporate Governance	Head of Risk and Regulation	PC	Agreed – The Freedom to Speak up Campaign was relaunched via internal and external communications channels the week commencing 07/02/2022. Regular biannual updates will continue to be issued in conjunction with the Health Boards communications team. The next update will be circulated during the summer of 2022 following which it is proposed that this recommendation be reported as complete.
2021-22	31.05.2022	Raising Staff Concerns (Whistleblowing)	R4/5	Medium	To build on existing arrangements, the following enhancements should be made to the Risk and Regulation team's Freedom to Speak Up Staff Concerns Log: • To ensure the status of Datix entries reflects the Risk and Regulation team's log; and • Greater clarity of action taken in response to a concern and the decision reached to address a concern.	Director of Corporate Governance	Head of Risk and Regulation	PC	Agreed – A cleanse of the Freedom to Speak up Log and Datix will be undertaken by the Head of Risk and Regulation - this has been slightly delayed following the introduction of a new DATIX system for which plans are being made to make F2SU entries appropriately confidential.
2021-22	31.05.2022	Raising Staff Concerns (Whistleblowing)	R5/5	Medium	In accordance with the All-Wales Procedure for NHS Staff to Raise Concerns, the executive lead for the Procedure, in conjunction with the Director of Corporate Governance should determine the appropriate reporting arrangements to the Board or sub-committee.	Director of Corporate Governance	Executive Director of People and Culture and Director of Corporate Governance	C	Agreed - This will be reported into the Strategy and Delivery Committee on a Bi Annual Basis as part of the Workforce report

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Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update for February 2022: 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.
2021-22	30.09.2022	IT Service Management (ITIL)	R1/8	High	1.1a The re-structuring of the service desk provision should be based on the ITIL Framework. 1.1b The implementation of the new call handling system should incorporate the facility for users to raise calls via an on-line portal. 1.1c Existing and new staff should be encouraged to attain ITIL Accreditation.	Director of Digital & Health Intelligence	Head of Digital Operations	PC	1.1a June 2022 Update: A Business Case for additional staff within the IT support team In conjunction with a new ITIL compliant Service Desk software solution (Ivanti Service Manager – ISM), will allow CAVUHB to implement an ITIL based organisational chart. This process will begin from 16/06/2022 and is planned to take approximately 4-6 months. 1.1b June 2022 Update: The new Service Desk (ISM) implementation provides a digital front door which includes incident and problem management as well as service requests, change and asset management. There is a Self Service User Portal available on all CAVUHB issues devices. 1.1c June 2022 Update: 27x Staff have attended ITIL training with over 20x attaining the Foundation accreditation already. Further courses are scheduled every six months to train more Digital & HI teams. Advanced courses will be run annually based on demand.
2021-22	30.09.2022	IT Service Management (ITIL)	R2/8	High	2.1a Procedures and guidelines should be developed for the Service Desk. These should clarify how to deal with incoming calls, the information to collect, the approval process for proposed resolution actions and the routing of these calls. 2.1b As part of these procedures a set of predefined calls should be developed for the most common / simple calls and incidents to enable these to be resolved on first contact.	Director of Digital & Health Intelligence	Head of Digital Operations	PC	2.1a June 2022 Update: CAVUHB continue to use the services of a dedicated Ivanti ITSM Implementation Expert. As part of the deployment Standard Operating Procedure documents have been implemented. A standalone and dedicated automation server has been installed and is waiting for configuration. June 2022 Update: CAVUHB are working with DHCW to allow the automation server access to Azure AD and the Ivanti Cloud Service. This work continues and is hoped to be completed by the end of June 2022. 2.1b - June 2022 Update: The ISM implementation now contains an FAQ and Staff Help portal which will continue to be developed and expanded as part of the product use.
2021-22	30.09.2022	IT Service Management (ITIL)	R3/8	High	3.1a Procedures and guidance on the classification and prioritisation of calls should be drawn up and issued with training provided as appropriate. Staff should be instructed to ensure that calls and incidents are classified and prioritised correctly in accordance with the guidance. 3.1b The planned replacement for the HEAT system should not allow free text in the call category, call type and priority fields. 3.1c The call category, type and priority fields should be mandatory to complete with call handlers selecting the appropriate entry from a drop-down menu.	Director of Digital & Health Intelligence	Head of Digital Operations	NA	3.1a June 2022 Update: Automation for call category, call type and priority fields has been implemented as standard. Exceptions can be made, although require additional approval within the Service Desk management structure. 3.1b June 2022 Update: The majority of Free Text fields for call category, call type and priority fields have been removed. We have had to implement a small number of exceptions, as requested by two teams. 3.1c June 2022 Update: Call category, call type and priority fields are all mandatory when creating incidents and service requests.
2021-22	30.09.2022	IT Service Management (ITIL)	R4/8	High	4.1a A formal process to ensure call activity is maintained should be established, and completed calls should be closed appropriately.	Director of Digital & Health Intelligence	Head of Digital Operations	C	4.1a June 2022 Update: A new single digital portal for staff to create, view and close incidents and service desks has been created. Accurate ISM and call metrics are beginning to be available. Calls and requests for staff automatically close after four requests have been ignored. Cases which have not been progressed within a timely fashion are reported automatically and flagged. Staff have clear visibility of their case progression via the portal.
2021-22	30.09.2022	IT Service Management (ITIL)	R5/8	Medium	5.1a A Service Catalogue setting out the service level that the service desk and the Digital Directorate is providing for each service should be drawn up. 5.1b 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.	Director of Digital & Health Intelligence	Head of Digital Operations	PC	5.1a - June 2022 Update: The creation of a Service Catalogue has begun all of the Digital Operations teams have been completed and some 40 have been created. As each team and department are onboarded to ISM their SRs are created. 5.1b - June 2022 Update: Basic SLAs have been associated to all Incidents and Service Requests. With the additional resourcing from the ,now approved staffing Business case, we will be in a position to implement reasonable SLAs and compliance reporting.
2021-22	30.09.2022	IT Service Management (ITIL)	R6/8	Medium	6.1a Target times should be set for the resolution and closure of calls in line with the timescales specified within the Hosting and Back-up Agreements. 6.1b Performance indicators should be developed based on the call resolution and closure target times, and these should be regularly monitored and reported at an appropriate level / to an appropriate forum within the Digital & Health Intelligence Directorate	Director of Digital & Health Intelligence	Head of Digital Operations	PC	6.1a - June 2022 Update: High level SLAs have been configured within the new Service Desk. Built-in reports provide basically functionality. The need to have a dedicated reporting server is currently under review. 6.1b - June 2022 Update: Reference 6.1a Reporting Server.
2021-22	30.09.2022	IT Service Management (ITIL)	R7/8	Medium	7.1a A Problem Management process should be fully defined together with an associated SOP and guidance for staff.	Director of Digital & Health Intelligence	Head of Digital Operations	PC	7.1a - June 2022 Update: Problem Management is scheduled to be implemented in Phase 2 ISM which forecast for July/Aug 2022.
2021-22	30.09.2022	IT Service Management (ITIL)	R8/8	Medium	8.1a Service management should consider defining a standard mechanism and process for operational knowledge management.	Director of Digital & Health Intelligence	Head of Digital Operations	C	8.1a - June 2022 Update: FAQ and Knowledge articles are starting to be populated within the new ISM system.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update for February 2022: 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.
2021-22	N/A	Arrangements to Support the Delivery of Mental Health Services (Advisory)	R1/5	Not rated	Looking ahead, the Mental Health Clinical Board should attempt to maintain the data collection tool as a 'live' document, as a means of holding a concise and accurate overview of services, which can inform future planning of services.	Interim Chief Operating Officer		PC	Share the Tool with Directorate Teams and any intra-Clinical Board teams to ensure full coverage. Add risk rating to consolidate tool and ensure there is consistency and easy access to raise any service risks to Clinical Board level if they meet the threshold. Yearly review and use of tool in Performance Reviews to ensure risks are being addressed. Ensure the templates are available on the S Drive for collation, addition and historical reference.
2021-22	N/A	Arrangements to Support the Delivery of Mental Health Services (Advisory)	R2/5	Not rated	Management should utilise the information collated through this review to inform an update of the Health Board's Mental Health webpages, to better inform members of the public of the services offered to support mental health.	Interim Chief Operating Officer		PC	Pathway Mapping work in relation to 111 'Press 2' is currently being undertaken. This should be in concert with Comms team and the National 111 groups to ensure simple, accessible routes to urgent care are unified.
2021-22	N/A	Arrangements to Support the Delivery of Mental Health Services (Advisory)	R3/5	Not rated	Management should consider the means of responding to, and addressing the issues highlighted through the data collection exercise. This may involve consideration of: • Quick wins which can be addressed at speed; • To seek support from the Health Board's IM&T Service and Digital Health and Care Wales; • The physical location of teams if IT issues cannot be resolved; • The impact on staff wellbeing when IT equipment is prohibiting efficient and effective working, at a time of heightened demand; • Alternative ways of working resulting from the impact of the pandemic; • The barriers prohibiting solutions and how these might be addressed; and • If the issues cannot be addressed within the Clinical Board, how these might be escalated within the Health Board.	Interim Chief Operating Officer		PC	Review of S Drive Risk Registers and ensuring that all Directorate Risk Registers are available for review. Any risk that cannot be adequately mitigated to be escalated to Clinical Board. Support required from Corporate Governance to rate, escalate and provide external view on mitigation.
2021-22	N/A	Arrangements to Support the Delivery of Mental Health Services (Advisory)	R4/5	Not rated	The Mental Health Clinical Board would benefit from reviewing their risk management arrangements, particularly the Clinical Board and Directorate risk registers, and the mechanisms of escalation associated with the risks. The Clinical Board may wish to seek support from the Risk and Regulation Team to undertake the review.	Interim Chief Operating Officer		PC	Escalation of key priority areas to Management Executive through work with Director of Service Planning and Director of Digital Transformation
2021-22	N/A	Arrangements to Support the Delivery of Mental Health Services (Advisory)	R5/5	Not rated	The risk and challenges identified in this review should be further explored for solutions, to consider how to further address the gaps in controls or assurance and whether these may look inwardly within the Health Board or externally to partners for support.	Interim Chief Operating Officer		PC	Internally, support from Corporate Governance will be requested. Corporate Governance Team are already providing some support around the Corporate Risk Register.

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**INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2019/20 (July 2022 Update)**

Recommendation Status	Update April 2022				Update April 2022				Update April 2022			
	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	1	1		2	4	4		6	2	2
No date set												
<b>Total</b>	<b>4</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>10</b>	<b>2</b>	<b>4</b>	<b>4</b>	<b>10</b>	<b>6</b>	<b>2</b>	<b>2</b>

Total number of recommendations outstanding as of 23<sup>rd</sup> June 2022 for financial year 2019/20 is 24 (10 of which are complete) compared to 8 outstanding recommendations noted at the April 2022 Audit and Assurance Committee Meeting. This increase can be attributed to the addition of historic entries added to the Internal Audit racker retrospectively.

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**INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2020/21 (July 2022 Update)**

Recommendation Status	Update April 2022				Update April 2022				Update April 2022			
	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							6			1	4	
Overdue more than 12 months						2						
<b>Total</b>					<b>8</b>	<b>2</b>	<b>6</b>		<b>5</b>	<b>1</b>	<b>4</b>	

Total number of recommendations outstanding as of 23<sup>rd</sup> June 2022 is 13(\*) (3 of which are listed as complete) compared to the position in April 2022 when a total of 31 outstanding recommendations were noted.

\* It should be noted that 16 recommendations from the IM&T Control and Risk Assessment advisory review are not included in the above table as the report was not rated. All 16 recorded entries are recorded as partially complete and are overdue by over 6 months, but less than 12 and no longer feature within the Internal Audit Tracker. These entries will continue to be tracked offline.

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**INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2021/22 (July 2022 Update)**

Recommendation Status	Update April 2022				Update April 2022				Update April 2022			
	High	C	PC	NA	Medium	C	PC	NA	Low	C	PC	NA
Date not reached		1	2	1		1	3					
Overdue under 3 months			7				7	2		3		
Overdue by over 3 months under 6 months						7	6				4	
Overdue over 6 months under 12 months							4					
Overdue more than 12 months											1	
<b>Total</b>	<b>11</b>	<b>1</b>	<b>9</b>	<b>1</b>	<b>30</b>	<b>8</b>	<b>20</b>	<b>2</b>	<b>8</b>	<b>3</b>	<b>5</b>	

Total number of recommendations outstanding as of 23<sup>rd</sup> June 2022 is 54(\*) (12 of which are listed as complete) compared to the position in April 2022 when a total of 45 outstanding recommendations were noted.

\* It should be noted that 5 recommendations from the Arrangements to Support the Delivery of Mental Health Services advisory review are not included in the above table as the report was not rated. All 5 recorded entries will be removed from the Internal Audit Tracker following the July Audit and Assurance Committee Meeting and will continue to be tracked offline.

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Report Title:	Audit Wales Recommendation Tracking Report		Agenda Item no.	7.8	
Meeting:	Audit and Assurance Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	05/07/2022
		Private	<input type="checkbox"/>		
Status <i>(please tick one only):</i>	Assurance	<input checked="" type="checkbox"/>	Approval	<input type="checkbox"/>	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 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:

Twenty External Audit Recommendations are recorded on the Tracker all of which have been brought forward from April's Audit and Assurance Committee ("the Committee"). No additional entries have been added since the April Committee meeting.

Of the 20 recommendations recorded on the Tracker, 3 are recorded as complete, the remaining 17 are recorded as partially complete.

The status of the recommendations are as follows:

- 3 recommendations are over 12 months overdue.
- 2 recommendations are over 6 months overdue (but less than 12).
- 5 recommendations are over three months overdue (but less than 6), two of which are reported as complete.
- 2 recommendations are less than 3 months overdue; and
- 8 recommendations remain on target to be completed within the agreed implementation date.

A review of all outstanding recommendations has been undertaken with executive and operational leads for each recommendation since April 2022. This work will continue and be reported at each Audit and Assurance Committee to provide regular updates in the movement of recommendations.

The table at Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken during the years **2019/20**, **2020/21** and **2021/22** as at 23<sup>rd</sup> June 2022.

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

#### Recommendation:

The Committee are requested to:

- 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	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect		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		Collaboration	x	Involvement	x
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**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:

N/A

N/A


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### Audit Wales Recommendations 2019/20 – 2021/22 (July 2022)

External Audit	Complete	No action	Partially complete	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	1	-	4	2	1	2	-	-	5
Audit of Financial Statement – Report Addendum - Recommendations	-	-	1	-	-	-	-	1	1
Clinical Coding Follow-up from 2014	-	-	1	-	-	-	-	1	2
Follow-up of Operating Theatres	-	-	2		-	2	-	-	2
Implementing the Wellbeing of Future Generations Act	-	-	1	-	-	-	1	-	1
Radiology Services: Update on Progress	1	-	-	1	-	-	-	-	-
Structured Assessment 2021 (Phase 2)	1	-	1	-	1	-	1	-	2
Taking Care of Carers	-	-	6	5	-	1	-	-	6
<b>Total</b>	<b>3</b>	<b>-</b>	<b>17</b>	<b>8</b>	<b>2</b>	<b>5</b>	<b>2</b>	<b>3</b>	<b>20</b>

From the above table it can be seen that since the last report to Committee in April 2022, there have been no recommendations added to the tracking report. The number of recommendations currently stand at 20 of which three actions are complete. There are three outstanding actions which are 1+ years overdue, two are 6+ months overdue, two are less than three months overdue and five are greater than 3 months overdue. Seven actions have not exceeded their agreed implementation date with one showing no date specified.

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Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update
2019-20	No date specified	Clinical Coding Follow-up From 2014 not yet completed	R2	<p><b>Medical Records:</b></p> <p>R2 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include:</p> <p>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;</p> <p>b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS);</p> <p>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;</p> <p>e) reducing the level of temporary medical records in circulation;</p> <p>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</p> <p>g) revisiting the availability of training on the importance of good quality medical records to all staff.</p>	Director of Digital and Health Intelligence	James Webb	PC	<p>Please provide the following information for each recommendation:</p> <ol style="list-style-type: none"> <li>1. A general update;</li> <li>2. Has there been a change to the implementation date, if so why?</li> <li>3. Any specific challenges that you are encountering or have encountered;</li> <li>4. The last date the recommendation was shared at its assurance committee.</li> </ol> <p>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.</p>
2019-20	Mar-20	Audit of Financial Statements Report Addendum - Recommendations	R4	<p>4: the Phase 2 and Phase 3 continuing healthcare claims require concluding</p> <p>The Health Board should establish the reason for the ongoing delay with each of the remaining Phase 2 and Phase 3 claims and it should seek to conclude them promptly.</p>	Director of Finance	Deputy Finance Director	PC	<p>Phase 2 – all cases completed</p> <p>Phase 3 – 2 claims remain incomplete – all claims have been reviewed but these are not ready for completion yet. One case required a face to face meeting which had not been possible due to Covid, meeting was held at the end of May 2022 with written negotiation now in process. The other claim was awaiting correct legal authority which has now been received and claim is progressing through negotiation process.</p>
2019-20	Dec-21	Implementing the Wellbeing of Future Generations Act	R2	<p>2 Develop a campaign to educate the public about what types of services will be available at each of the centres and hubs.</p>	Director of Planning	Director of Operations, PCIC	PC	<p>Programme of business cases in development with engagement on design detail of services required to meet local needs taken forward as part of business case. First scheme (Maelfa) in construction on track to be completed Dec 2021 and planning for Penarth and Ely hubs well underway. <b>Additional support secured in relation to planning of key future schemes which will include public and key stakeholder input. Work to be undertaken by end March 22.</b></p>
2020-21	Mar-22	Follow-up of Operating Theatres	R1	<p>Ensure that momentum is maintained to deliver the benefits of the theatre improvement project which relate to process improvement, such as Day of Surgery Admission and pre-operative assessment:</p> <ul style="list-style-type: none"> <li>• prioritise the expansion of the pre-operative assessment service across specialties where doing so will achieve maximum benefit in improving quality and safety of care.</li> </ul>	Chief Operating Officer	Denis Williams	PC	<p>POAC was successful in securing additional investment through recovery monies to increase POAC activity. Through this investment a number of additional staff have been appointed. The POAC service will move into a redesigned facility to support POAC flow in June 2022. Work with external partners "Foureyes" to review the POAC service has gone well with a focus on booking, clinic flow, standardisation of clinic templates with the aim to reduce preventable cancellations. Once the services is fully embedded in the new facility there will be a focus on increasing the number of booked clinics vs walk in. We are also developing electronic POAC documentation with a view to being paperless to increase efficiency.</p>

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update
2020-21	Mar-22	Follow-up of Operating Theatres	R4	Create standards for professional management and leadership and ensure that team leaders meet that standard.	Chief Operating Officer	Ceri Chinn	PC	<p>Please provide the following information for each recommendation:</p> <ol style="list-style-type: none"> <li>A general update;</li> <li>Has there been a change to the implementation date, if so why?</li> <li>Any specific challenges that you are encountering or have encountered;</li> <li>The last date the recommendation was shared at its assurance committee.</li> </ol> <p>Good progress is being made with regular 2:1 Theatre Manager/Lead Nurse and General Manager meetings and also regular 2:1 Clinical Leader, Lead Nurse and General Manager meetings. There is also a Directorate Management meeting on a bi-weekly basis and Clinical Leaders meeting with Theatre Managers occurs on a regular basis. These meetings offer the opportunity to ensure that the Managers and Leaders within the Directorate are being supported and any issues can be discussed through a standardised agenda. Update 07/06/2022 - These meetings occur on a regular basis, are scheduled in advance either monthly or bi-monthly and are well attended. There are agendas and minutes are recorded that are fed back during Directorate Management Team Meetings by each of the Theatre Managers. Actions are discussed and closed when completed. Workforce Manager appointment has been made and we are awaiting a start date. This role will ensure that the staff engagement work that is being carried out will continue and will drive not only workforce redesign but also the professional standards of the directorate. This project approach will be implemented by the end of the year 2021 and progress will be monitored. Update 07/06/2022 - The Workforce Manager commenced employment on 20/12/2022. The current status of main focus/priorities that are discussed at the bi-weekly Directorate Management Meeting and 1:1 with the General Manager are 1) General establishment review, good progress being made that also links in with the whole workforce structure project 2) Band 7 Anaesthetic Associate role - The JD has been finalised and the role will be discussed at the All Wales Recruitment Meeting before approaching the Executive Board for funding approval. 3) Work is progressing well to recruit additional Anaesthetic Practitioners 4) The Workforce Manager is working closely with the Cardiology and Trauma &amp; Orthopaedic Theatre Teams to resolve ongoing cultural and staffing behaviours. A development booklet for clinical leaders has been developed which outlines the professional standards for our clinical leaders. A development plan will be developed by the workforce programme manager to support clinical leaders to achieve these. Update 07/06/2022 - The booklet has been provided to all Clinical Leaders who are in the process of completing this. This document will be discussed at each Value Based Appraisal on an annual basis and any issues addressed as appropriate.</p>
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.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	<p>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. <b>June 22 Update:</b> 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.</p>
2021-22	May-22	Audit of Accounts Report Addendum - Recommendations	R1/6	The Health Board should issue its annual related party declarations to associate members	Director of Corporate Governance	Head of Risk and Regulation	C	<p>Complete - This was undertaken as part of year end arrangements for 2021/22.</p>
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 replacement is not currently feasible, the Health Board should ensure that robust mitigating arrangements are in place. Looking forward, the Health Board needs to be proactive, with better planning for its timely replacement of unsupported IT operating systems and devices.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	<p>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.</p> <p><b>June 2022 Update:</b> Work continues to identify legacy server operating systems. This progress is affected by the patient and clinically critical systems/applications existing on them. AV has now been deployed to all servers and a patching/maintenance windows are being agreed with departments and services. All CAVUHB Workstations will have been migrated to Win10 before end June 2022.</p>
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.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	<p>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.</p> <p><b>June 2022 Update:</b> A comprehensive audit of all backups and associated devices has been completed. New disk based storage totalling 1.5PB has been procured. Implementation of this new backup solution is planned for July/Aug 2022 working with HPE consultants.</p>
2021-22	Feb-22	Audit of Accounts Report Addendum - Recommendations	R4/6	The Health Board should update its IT change control policy and procedure	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	<p>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.</p> <p><b>June 2022 Update:</b> The Change Control module with Ivanti has been configured and is going through UAT testing and approval. It is expected to be completed and fully "Live" by the Mid to late July 2022.</p>
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.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	<p>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.</p> <p><b>June 2022 Update:</b> Additional HPE Servers and storage DR hardware has been procured as part of the 21/22 capital allocation. UHL has been confirmed as the Primary DR location for CAVUHB, a secondary localised contingency location in Woodland House has also been identified. New cabinets will be installed and appropriate electrical/UPS protection work is scheduled for June/July 2022. Both locations are expected to be in use by Aug 2022.</p>

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update
2021-22	Feb-25	Taking Care of the Carers	R1/6	<b>Retaining a strong focus on staff wellbeing</b> 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 being at higher risk from COVID-19.	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	<b>Please provide the following information for each recommendation:</b> 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.  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).  The UHB People and Culture Plan 2022-25 sets out the actions we will take over the next three years, with a clear focus on improving the wellbeing, inclusion, capability and engagement of our workforce through the 7 themes, and monthly flash report highlight progress in each area, with regular updates to the Strategy and Delivery Committee, Local Partnership Forum; Strategic Wellbeing Group and Strategic Portfolio Steering Group. With COVID Restrictions being removed by Welsh Government, including the requirement to 'shield', the organisation has communicated guidance to staff via national guidelines which can be found at <a href="https://gov.wales/public-health-advice-employers-businesses-and-organisations-coronavirus-html">https://gov.wales/public-health-advice-employers-businesses-and-organisations-coronavirus-html</a> . The People and Culture Team continue to provide support and guidance to managers to manage risk in more complex situations.
2021-22	Mar-25	Taking Care of the Carers	R2/6	<b>Considering workforce issues in recovery plans</b> 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.	Executive Director of People and Culture	Executive Director of People and Culture  Assistant Director of Organisational Development  Assistant Director of Resourcing	PC	The impact of COVID-19 on the health and care system has been immense as has the toll on our staff of simply doing their jobs in such unprecedented conditions. Even with COVID restrictions being lifted, the challenges of increasing service demand, waiting lists and financial strain continue. The People and Culture Plan sets out the actions we will take 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 have recently been documented in a flash report, demonstrating progress and outcomes in all areas over the past 6 months.
2021-22	Mar-22	Taking Care of the Carers	R3/6	<b>Evaluating the effectiveness and impact of the staff wellbeing offer</b> 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 engaged and involved in the evaluation process.	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	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 currently being collated in all areas where targeted interventions are being developed, to ensure an effective means of measuring impact and outcomes.
2021-22	Nov-23	Taking Care of the Carers	R4/6	<b>Enhancing collaborative approaches to supporting staff wellbeing</b> 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.	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	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.
2021-22	Feb-25	Taking Care of the Carers	R5/6	<b>Providing continued assurance to boards and committees</b> 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.	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	Quarterly updates to the Board / more regular reports for management executive team meetings Updates and discussions at Local Partnership Forums and LNCs - latest updates LNC 23/5/22 Update, discussion and feedback at Clinical Boards Bi-monthly Wellbeing Strategy Group meetings - latest update 01/06/2022 Ongoing evaluation of staff wellbeing offer, including access, impact and value - specific evaluation of OH Services currently being analysed 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 - Strategic Portfolio Steering Group 25/5/22; EQIA 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 from end of June 2022 until end of August 2022, enabling weekly 'check ins' and temperature checks.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update
2021-22	Mar-23	Taking Care of the Carers	R6/6	<b>Building on local and national staff engagement arrangements</b> 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.	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	<p>Please provide the following information for each recommendation:</p> <ol style="list-style-type: none"> <li>A general update;</li> <li>Has there been a change to the implementation date, if so why?</li> <li>Any specific challenges that you are encountering or have encountered;</li> <li>The last date the recommendation was shared at its assurance committee.</li> </ol> <p>Existing staff engagement mechanisms include:</p> <ul style="list-style-type: none"> <li>NHS Wales Staff Survey - planned for October 2022 (as per information from HEIW)</li> <li>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</li> <li>Freedom to Speak Up - CAV part of all Wales working group</li> <li>HR Processes and Procedures</li> <li>Respect and Resolution Policies and Procedures</li> <li>Trade Union Representatives</li> <li>Existing Staff Networks – LGBTQ+; One Voice (Black, Asian, Minority Ethnic); Long Covid; Access Ability Network launched April 2022</li> <li>14,000 voices campaign (on-site visits / staff groups / teams etc)</li> <li>Five, online 'Ask the CEO / Exec etc' sessions held bi-monthly</li> <li>Localised engagement aligned to specific strategic projects, e.g. Shaping our future clinical services</li> </ul>
2021-2022	Feb-23	Radiology Services: Update on Progress	R2/7	Over the next year, increase appraisal rates for non-clinical radiology staff to at least the level of all other radiology staff.	Chief Operating Officer	Chief Operating Officer	C	<ol style="list-style-type: none"> <li>The current appraisal rate for non-clinical radiology staff is 88.5% at end of May 2022</li> <li>Brought forward, a focussed plan has been implemented to bring appraisal rates above target</li> <li>We will continue to monitor appraisal rates for all staff groups in radiology through our monthly performance review meetings</li> <li>May 30th 2022, RMPCE performance review</li> </ol>
2021-2022	01/01/2022 Jan 2022 Dec 2021 Dec 2021 Jan 2022 Jan 2022 Apr 2022	Structured Assessment 2021 (Phase 2)	R1/2	The Health Board has taken a number of positive steps to enhance public transparency of Board business since our 2020 structured assessment report. However, there is scope for the Health Board to strengthen public transparency further by: a. ensuring all recordings of public Board meetings are uploaded to the Health Board's website in a timely manner after each meeting, and ensuring that links to previous meetings remain active; b. making recordings of public Committee meetings available on its website or publishing unconfirmed minutes of Committee meetings as soon as possible afterwards; c. uploading all Committee papers to the Health Board's website in line with agreed timescales; d. updating the membership details of Committee on the Health Board's website as soon as changes are approved; e. listing the matters to be discussed in private by Committees on the agenda of their public meetings on an ongoing basis; f. signpost the public to Board and Committee papers and recordings of public Board meetings via the Health Board's social media channels on an ongoing basis; and g. ensuring counter-fraud and procurement papers are considered by the Audit and Assurance Committee in public, with only sensitive matters reserved for private meetings.	Director of Corporate Governance	Head of Corporate Governance	C	<ol style="list-style-type: none"> <li>The Corporate Governance Department publish recordings of the Public Board meetings in a timely manner, typically within 2/3 days of the relevant Board meeting. The intention is to make each recording available on the website for a period of 12 months. Thereafter, copies of the recordings would be available upon request.</li> <li>As of December 2021 the Corporate Governance Team have been recording public Committee meetings and from the New Year the recordings have been published on the Health Board's website, typically within 2/3 days of the relevant meeting. There have been a couple of "teething" issues and where this has occurred a copy of the unconfirmed minutes from the relevant meeting have been published in place of a recording of the meeting in the interests of transparency. From the New Year we have "livestreamed" the public Committee meetings.</li> <li>This has now been completed and SOPs amended to ensure, that going forward, all relevant Committee papers received by the Corporate Governance Team are routinely published in line with agreed timescales (i.e. 7 clear working days before the Committee meeting).</li> <li>This has now been completed and SOPs amended to ensure that Membership details are updated, on an ongoing basis, once approved by the Board.</li> <li>Noted. This has been implemented with effect from January 2022.</li> <li>Noted. Since the New Year we have been signposting the public to our Board and Committee meetings by issuing a monthly "tweet" via the Health Board's social media platforms, in advance of the forthcoming meetings for the month concerned.</li> <li>This recommendation has been implemented since April 2022.</li> </ol>
2021-2022	Apr-22	Structured Assessment 2021 (Phase 2)	R2/2	The Health Board's approach to planning remains robust. However, the Health Board's arrangements for monitoring and reporting on plan delivery are less robust. The Health Board, therefore, should strengthen its arrangements for monitoring and reporting on the overall delivery of its Annual Plan and future Integrated Medium Term Plans by: a. ensuring these plans contain clear summaries of key actions / deliverables, timescales, and measures to support effective monitoring and reporting; and b. providing more information to the Board and Strategy and Delivery Committee on progress against delivery of these plans to enable full scrutiny and assurance	Director of Corporate Governance	Executive Director of Strategic Planning	PC	<ol style="list-style-type: none"> <li>It is intended that the IMTP for 22/23 will have clear actions, timescales and deliverables which can be tracked. This is already well established for the Recovery Programme and the Strategic Programmes so we will ensure it covers the other areas included within the IMTP.</li> <li>We will look at how best to report on the key deliverables set out in the Annual Plan/IMTP to ensure the Board is able to scrutinise and seek assurance. We will do this in a way that aims to minimise duplication with the Performance Report that is provided to the Board regularly.</li> </ol>

Report Title:	Regulatory Compliance Tracking Report		Agenda Item no.	7.9	
Meeting:	Audit and Assurance Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	05.07.2022
		Private	<input type="checkbox"/>		
Status <i>(please tick one only):</i>	Assurance <input type="checkbox"/>	Approval <input type="checkbox"/>	Information <input checked="" type="checkbox"/>		
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

## 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 is provided by means of a Legislative and Regulatory Compliance Tracking report.

An internal audit into the Corporate Governance Legislative and Regulatory Compliance Tracker was undertaken during July and August 2021. The outcome of that audit, provided an agreed 'reasonable' assurance rating.

Following the implementation of recommended best practice work has continued to refine and improve the content of the Legislative and Regulatory Compliance tracker so that it provides more robust assurance to Committee members. Most notably, this covering report continues to include commentary on the Health Boards management of Welsh Health Circulars and Patient Safety Solutions: Alerts and Notices which will continue to be reported as a matter of course.

Whilst progress has been made additional work remains ongoing to ensure that the feedback shared by recommendation owners and shared with the Committee is provided in a consistent and easy to read manner across each of the trackers shared with the Committee.

### 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.

In addition to the above the below updates are also shared in relation to the Health Board’s Management of Welsh Health Circulars (WHCs) and Patient Safety Solutions: Alerts and Notices (PSN’s). Separate Tracker documents are held for the monitoring of WHC’s and PSN’S and are managed by the Risk and Regulation and Patient Safety teams respectively.

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 Green Yellow Orange Red	Comments
2021006	Elections to Senedd Cymru Mag 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.

A regular update on progress made against WHC recommendations is reported at Management Executive Meetings so that the full Executive Team is sighted on the most recently issued WHC’s and progress made against each circular. An update was last shared with the Management Executive Team on the 30<sup>th</sup> May 2022. Since the April 2022 Committee meeting the following Circulars have been added to the tracker and triaged to executive colleagues for action:

- Wales rare diseases action plan 2022 to 2026 (WHC/2022/017)
- The national influenza immunisation programme 2022 to 2023 (WHC/2022/16)
- Changes to the vaccine for the HPV immunisation programme (WHC/2022/015)
- Health boards, special health authorities and trusts financial monitoring guidance 2022 to 2023 (WHC 2022/013)
- Donation and transplantation plan 2022 to 2026 (WHC/2022/12)
- Health boards, special health authorities and trusts financial monitoring guidance 2022 to 2023 (WHC 2022/013)
- Donation and transplantation plan 2022 to 2026 (WHC/2022/12)
- NHS Wales national clinical audit and outcome review plan annual rolling programme for 2022 to 2023 (WHC/2022/002)

As of the 24.06.2022 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.

Patient Safety Solutions: Alerts and Notices

PSN’s are monitored and managed by the Patient Safety and Organisational Learning Manager (“PSOLM”) who maintains a tracker of all PSN’s that are received and ensures that each PSN is shared with relevant clinical and corporate directorates for action. The PSOLM also regularly chases colleagues to ensure that actions are undertaken and reported through the use of compliance forms which record completion of required actions. Once a PSN is recorded as complete the PSOLM notifies the relevant Welsh Government delivery Unit and copies of all such notifications and completed compliance forms are logged by the PSOLM and the Risk and Regulation Team.

An extract from the PSN Tracker is copied below.

G Saunders Mathan  
 06/28/2022 11:08:59

Document Number	Notice	Type of Document	Status	Notified	List	Due	Date PS Team	Date sent to Distribution	Date Responses	Date Compliance	CW	Medicine	CD&T	MH	PCIC	Spec Service	Surgery	Dental	Corporat
PSN062	<a href="https://du.nhs.wales/files/notices/psn062-liguefiel">https://du.nhs.wales/files/notices/psn062-liguefiel</a>	Patient Safety Notic	Active	04/10/2021	04/10/2021	25/02/2022					15/10/2021	05/10/2021	08/10/2021		11/10/2021		14/10/2021	11/10/2021	
PSN057	<a href="#">Patient Safety Notices\PSN057 Adrenal Crisis\PSN057</a>	Patient Safety Notic	Active	28/05/2021	28/05/2021	31/01/2022					21/06/2021	01/06/2021	01/06/2021		02/06/2021	30/09/2021			

An update on progress made against PSN's was shared at the December 2021 Quality, Safety and Experience Committee for further scrutiny.

No additional PSN's have been noted or recorded since the last update shared at the April 2022 Committee Meeting

### Regulatory Tracker

The Regulatory Tracker attached to this report is up to date as of the 24<sup>th</sup> June 2022 and will continue to be updated throughout the organisation and reported to the Committee on a bi-monthly basis as well as being reported to Management Executive meetings for executive oversight.

Following April's Committee Meeting a total of 2 completed entries were removed from the register. A further 3 entries have been reported as complete since April's meeting and are recorded on the attached tracker.

Following April's Committee Meeting no additional entries have been added to the register in the following areas:

- **Cardiff and Vale of Glamorgan Food Hygiene Ratings**  
Three additional/new entries have been added following inspections at UHW (x2) and Barry Hospital
- **Clinical Coding**  
A new entry, which incorporates 5 recommendations, 4 of which are complete, has been added following a Clinical Coding Audit undertaken by Digital Health Care Wales.
- **Welsh Water**  
Two additional entries have been added following Welsh Water inspections at University Hospital of Wales and St David's Hospital.

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

The procedure for tracking such progress will also enable the 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.

### **Recommendation:**

The Committee are requested to:

- (a) Approve the assurance provided by the Regulatory Tracker and the confirmation of progress made against recommendations.
- (b) To note the continuing development 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	
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**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: 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:


Saunders, Nathan  
06/28/2022 11:08:59

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)
<b>ALL WALES THERAPEUTICS AND TOXICOLOGY CENTRE</b>														
<b>ALL WALES QUALITY ASSURANCE PHARMACY</b>														
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	Currently reviewing actions for action plan submission 13.06.2022		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	8/6/22 32 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.		pc
<b>BRITISH STANDARDS INSTITUTE</b>														
<b>CARDIFF AND VALE OF GLAMORGAN FOOD HYGIENE RATINGS</b>														
Capital Estates and Facilities	Catering and Hospitality	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Aroma Units , UHW	22.02.2022	Unannounced 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.	31.03.2022	An update was shared at the April Health and Safety Committee Meeting		C
Capital Estates and Facilities	Catering and Hospitality	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Central Production UHW	12.05.2022	Unannounced inspection	Executive Director of Finance	Health and Safety Committee	Head of Catering Services	N/A	A Food Hygiene rating of 2 was received which, in the main, was due to kitchen drains leaking into a non food store room located below the production kitchen	23.06.2022	An update will be shared at the July 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 Hygiene Ratings	Barry Hospital	14.06.2022	Unannounced inspection	Executive Director of Finance	Health and Safety Committee	Head of Catering Services	N/A	A Food Hygiene rating of 5 was achieved with no major contraventions.	14.09.2022	An update will be shared at the July Health and Safety Committee meeting providing assurance to the Health Board.		C
<b>CAPITAL EXPENDITURE INTERNAL REVIEW</b>														
Estates	Estates Management and Finance	Internal	Procurement Arrangements	01.09.2021	Internal Review	Executive Director of Finance	Finance Committee	Director of Capital Facilities and Estates	N/A	A total of 21 recommendations were made concerning the governance and contracting arrangements regarding Procurement Processes within the Capital, Estates and Facilities Directorate.	31.12.2021	Of the 21 recommendations 20 are recorded as complete. The remaining action, which relates to the review of contract documents is nearing completion as the CEF team await final documents from appointed solicitors.		PC
<b>Clinical Coding</b>														
Digital Health	Clinical Coding	DHCW	Clinical Coding	24.06.2022	Clinical Coding Audit	Director of Digital Health Intelligence	Digital Health 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.		PC
<b>COMMUNITY HEALTH COUNCIL</b>														
<b>FIRE AND RESCUE SERVICES</b>														
Mental Health	Capital and Asset Management	Fire and Rescue Services	Vale Mental Health Services Barry, Hospital	14.04.2021	Regulatory Reform (Fire Safety) Order 2005	Executive Director of People and Culture	Health and Safety	Head of Health and Safety	10/12/2021	Duty of Works: EN01 - (EN3/21) Article 8 - Duty to take general fire precaution's is not being complied with EN3/21 Schedule states: "During the inspection carried out on 14th April 2021 there was evidence of illicit smoking found throughout the premises. These matters have previously been raised by this Authority and also within previous FRA's carried out by the UHB fire safety advisor. This is unacceptable. The UBN's smoking policy should be appropriately managed to ensure that smoking and ignition sources are controlled and monitored to reduce the potential for accidental and deliberate fire setting."	19.05.2021	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.		PC
Medicine	Capital and Asset Management /UHW - Ward A4	Fire and Rescue Services	UHW Ward A4	29.09.2021	Regulatory Reform (Fire Safety) Order 2005	Executive Director of People and Culture	Health and Safety	Head of Health and Safety	06.04.2022	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 Article 21: Training	31.03.2023	Measures have been agreed with and implemented by senior managers of the UHB's Estates Service Board. Consequently the enforcing authority inspector has agreed to extend the date of this notice for 12 months to enable all works to be completed.		PC
<b>HEALTH EDUCATION AND IMPROVEMENT WALES</b>														
<b>HEALTH INSPECTORATE WALES</b>														
Children & Women	Maternity	HIW	Maternity Services	TBC	HIW	Executive Nurse Director	QSE Committee	Head of Midwifery	TBC - Matter on Hold	HIW are undertaking a national review of maternity services across Wales (Phase 2). <b>Letter received 13/1/21 from HIW Phase 2 on hold.</b>	Details of community maternity sites sent to HIW 17.07.20 and self assessment sent 24.07.20.	On hold. An update on all HIW inspections are shared at each Quality, Safety and Experience Committee. Updates were last shared at the June QSE Committee.		N/A
Mental Health	Community Mental health	HIW	Community Mental Health	TBC	HIW	Executive Nurse Director	QSE Committee	Director of Nursing for Mental health Services	TBC	National Review of Mental Health Crisis prevention in the Community	N/A	The terms of reference have been published by HIW and the final report was due to be published in December 2021 and is awaited.		PC

HEALTH AND SAFETY EXECUTIVE														
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 Accountability. 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 to complete outstanding recommendations. An update was shared at the Digital Health and Information Committee in June 2022.		PC
JOINT EDUCATION ACCREDITATION COMMITTEE														
Specialist Services	Haematology	JACIE	South Wales BMT Programme	TBC	6th edition of JACIE standards	Executive Director of Medicine	QSE Committee	Executive Director of Medicine	01.02.2023	Minor deficiencies noted	01.10.2019	Programme received formal re-accreditation notice - There are ongoing discussions with the executive board regarding a new facility for BMT/Haematology as the service will not achieve re-accreditation post the next inspection cycle.  <b>No update since November 2021</b>		PC
MEDICAL GENETICS														
MHRA														
CD&T	Pharmacy	MHRA	Pharmacy UHL	TBC	Good manufacturing practice (GMP) and good distribution practice (GDP)	Executive Medical Director	QSE Committee	Clinical Director of Pharmacy and Medicines Management	TBC	3 majors 2 others	31.03.2020	Escalated from MHRA Inspection Action Group 1st July 2020 Outstanding Estates issues to resolve to meet requirements of the regulator		PC
NATURAL RESOURCES WALES														
OFFICE FOR NUCLEAR REGULATION														
QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES														
RESEARCH AND DEVELOPMENT														
UKAS														
Surgery	Perioperative	UKAS	Perioperative	15.07.2021	UKAS Re-Validation	Executive Director of Therapies and Health Science	QSE Committee	Executive Director of Therapies and Health Science	TBC	2 Minor recommendations noted.	15.07.2022	Re-validation. Audit Minor 1, was for audit of audits. We should have someone independent from HSDU to audit our audits, SSU Llandough will Audit HSDU and we will audit SSU. <b>Update</b> , Llandough SSU has audited UHW HSDU. HSDU are in the process of auditing SSU Llandough. all working instructions have been amended for future use and audits. Minor 2, not currently registered to MHRA. <b>Update</b> , HSDU is in the application process. update, HSDU are now registered to MHRA. all evidence of both minors has been compiled and ready to be closed out at the next audit.		c
WELSH WATER														
Capital Estates and Facilities	UHW	Welsh Water	UHW	13.05.2022	Site Inspection	Executive Director of Finance	Health and Safety Committee			Contraventions of sections 73-75 Water Industry Act 1991 and Water Supply (water fittings) Regulations 1999 (The Regulations) relating to contamination, waste, misuse, erroneous measurement and undue consumption of water at the premises.112				
								Director of Capital Estates and Facilities	20.06.2022		20.06.2022	Update following reinspection awaited		N/A
Capital Estates and Facilities	St Davids	Welsh Water	St Davids Hospital	20.05.2022	Site Inspection	Executive Director of Finance	Health and Safety Committee			Contraventions of sections 73-75 Water Industry Act 1991 and Water Supply (water fittings) Regulations 1999 (The Regulations) relating to contamination, waste, misuse, erroneous measurement and undue consumption of water at the premises.				
								Director of Capital Estates and Facilities	29.06.2022		29.06.2022	Update following reinspection awaited		N/A
WSAC														
Surgery	Audiology	WSAC	Newborn hearing screening wales	04.11.2021	Audiology / Newborn Hearing Screening QS	Executive Director of Therapies and Health Science	QSE Committee	Paediatric Cochlear Implant Lead - Razun Miah/Rhian Hughes/Ellen Thomas	01.11.2024	Results awaited.	01.01.2022	Results have not yet been released by PHW.		NA
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	01.01.2022	5 recommendations made relating to Standards, 1a.3, 2a.8, 3a.5 & 3a.6, 6a.1 and 7b.1. All recommendations are reported as partially complete with action plans in place.		PC
WEST MIDLANDS QRS														

Sally Sanders-Nathan  
06/08/2022 11:59

Report Title:	Risk Management Review			Agenda Item no.	7.9
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	05/07/2022
		Private			
Status <i>(please tick one only):</i>	Assurance	x	Approval	Information	
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

## Main Report

### Background and current situation:

Internal Audit undertook an Audit of the Health Board's Risk Management processes and procedures in March 2021 and issued an overall Reasonable Assurance rating (a copy of the Audit Report was shared at the April 2021 Audit and Assurance Committee ("the Committee") meeting).

As part of the Health Board's response to that Audit a revised Risk Management and Board Assurance Framework Strategy and Risk Management Procedure (with supporting Risk Assessment and Risk Register) were prepared and subsequently approved at the Health Board's July 2021 Board meeting. The changes to the documents did not represent a substantial re-write of the content, instead they were included to bolster the original documentation and provide evidence of the Health Board's compliance with examples of best practice such as the ISO 31000 standards relating to risk management.

Since July 2021 Risk Management processes have continued to develop within the Health Board as processes and procedures have become more embedded within the Clinical Boards and Corporate Directorates.

Internal Audit completed a further review of the Health Board's Risk Management processes in June 2022 (A copy of the Report following that review is included as agenda item 9.1(ii) for the Committee meeting at which this report is being shared). That review found that *'The Health Board has progressed with the implementation of the recommendations raised in the 2020/21 audit of risk management, improvements are noted throughout this report.'*

Whilst progress has been made against the recommendations raised in the 2020/21 review, there is scope to improve the Health Board's processes and the following additional recommendations have been made:

- 1) Consideration should be given to the roles and responsibilities associated with the 'check and challenge' process of proposed corporate risks, beyond the Risk and Regulation Team, and whether there would be value in holding a risk management steering group (**Priority – Low**)
- 2) Risk owners should be reminded of their roles and responsibilities to ensure that the risk management information held within the risk registers is complete and regularly reviewed and updated (**Priority – Medium**).
- 3) Continued efforts should be made to provide risk management training to risk owners, to maintain momentum of risk management maturity within the Health Board (**Priority – Low**).

Saunders Anna  
06/28/2022 11:58:59

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

Whilst efforts to continually improve the Health Board’s Risk Management processes will continue to be made, including putting in place arrangements to adequately respond to the above recommendations, it is not thought necessary to amend the Health Board’s existing Risk Management and Board Assurance Framework Strategy and Risk Management Procedure (with supporting Risk Assessment and Risk Register).

During 2022/23 it is hoped that an All Wales Datix digital risk management software solution will be agreed which should help to strengthen the Health Board’s Risk Management processes. A further update on this work will be shared in September 2022.

**Recommendation:**

The Board are requested to:

- 1) Note the contents of this Risk Management Review update;
- 2) Receive assurance that the Health Board’s Risk Management processes and procedures have received Reasonable Assurance from Internal Audit.
- 3) Agree that the Health Board’s Risk Management and Board Assurance Framework Strategy and Risk Management Procedure (with supporting Risk Assessment and Risk Register) do not, at the time of the Committee meeting, require updating.

**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	x
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	x	Long term		Integration		Collaboration	x	Involvement	
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**Impact Assessment:**

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

**Risk: Yes**

By virtue of the nature of this report a review of the Health Board’s Risk Management processes and procedures has been undertaken.

**Safety: No**

**Financial: No**

**Workforce: No**

Legal: No	
Reputational: No	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
<b>Approval/Scrutiny Route:</b>	
Committee/Group/Exec	Date:
N/A	N/A

Saunders, Nathan  
06/28/2022 11:08:59

Report Title:	Procurement Compliance Report - Single Tender Actions		Agenda Item no.	7.10
Meeting:	Audit Committee	Public	X	Meeting Date:
		Private		
Status <i>(please tick one only):</i>	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  
06/28/2022 11:08:59

**ASSESSMENT AND ASSURANCE****Non-Compliant Activity (7)**

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

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at Risk/Breach	Clinical Board	Reason	Action /Status
Agency Staffing	£46,337.50	N/A	2 Months	Mental Health	No Procurement involvement in engaging with supplier.	Ongoing - STA being in put for compliance going forward
Prometheus Safe and Secure	£11,566.50	N/A	Ongoing	Mental Health	No Procurement involvement in engaging with supplier.	Ongoing - Procurement requested department submit an STA form for compliance going forward
Purchase of Restoreflow	£6,775.00	N/A	2 months	Surgery and Dental	No Procurement involvement, supplier issued kit and department utilised without placing order on Oracle.	Resolved – Supplier informed of No PO, No Pay policy and department advised to raise orders as per policy.
The Music Licence - PRS and PPL	£17,755.99	N/A	1 year	Executives – Corporate	Long standing licence for retrospective invoice. No Procurement involvement in original setup.	Ongoing – outstanding debit paid, licence on workplan and discussion.
Finders Fee to Doctors Relocate	£12,000.00	N/A	1 month	Medicine	Global shortage of Doctors, however, no Procurement involvement in recruitment via this supplier.	Resolved – Doctor now on payroll.
Court Action Invoices	£5,600.00	N/A	N/A	Children and Women	No Procurement involvement, Finance requested payment of invoice .	Resolved – One off invoice payment.
PMS Micad System	£9,312.72	N/A	1 year	Capital Planning, Estates and Facilities	No Procurement involvement in engagement.	Resolved – Contract on workplan for any future requirement.

Sanders, Nathan  
09/28/2022 11:08:59

**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 (1)**

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

Contract Title	Value at Risk	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status
OSN Accommodation	£6,000.00	N/A	1 month	Executives – Nursing	Urgent accommodation required	Resolved – no further action

**Contracts engaged at risk as a result of Covid-19 requirements (1)**

Contract Title	Value at Risk	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action/Status
Car Parking Management	£177,081.53	N/A	4 months	Capital Planning Estates and Facilities	Payment of retrospective invoice for additional cost due to the decision to provide free parking within the hospital grounds due to Covid.	Resolved – no further action

**Report of Single Tender/Quotations Actions**

**Retrospective – (2 Return)**

The report outlines all SQA/STA (2) requests during the period the 1<sup>st</sup> April 2022 to 31<sup>st</sup> May 2022.

Clinical Board	Supplier	Name of Project	Retrospective Value of Contract Excl VAT	STA Type
PCIC	Womens Aid	IRIS GP Based DVA Programme	£12,000.00	Capability with existing equipment or service
PCIC	BAWSO	IRIS GP Based DVA Programme	£12,000.00	Capability with existing equipment or service

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 (8) requests during the period the 1<sup>st</sup> April 2022 to 31<sup>st</sup> May 2022. 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	Supplier	Name of Project	Total Value of Contract Excl VAT	Type
Capital Planning, Estates and Facilities	Leaseplan	ALAS Leasplan Vehicles extension	£52,769.48	Urgent Operational Requirement
C,D&T	DQD Engineering	Maintenance of Water Generation System	£26,479.60	Sole Supplier of Goods or Services
Specialist	Fysicon	Fysicon Maintenance Contract	£69,302.50	Capability with existing equipment or service
Executives	The Maltings	Provision of Off-Site Document Storage and Retrieval Services	£18,319.70	Urgent Operational Requirement
Executives	The Prince's Foundation	International Young Health Leaders Institute Launch	£18,000.00	Sole Supplier of Goods or Services
PCIC	Voice Connect	Patient Partner Virtual Receptionist Service	£20,776.08	Sole Supplier of Goods or Services
C,D&T	Blueteq Limited	Production and Development of a Pricing and Access Scheme Administration System (PASAS) for NHS Wales	£75,000.00	Sole Supplier of Goods or Services
Medicine	Inhealth	Nursing and Decontamination Staff for Endoscopy Lists within UHL	£109,200.00	Urgent Operational Requirement

### 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	2021/22			2022/23		
	Non-Compliant Breaches	Exemption	Covid-19	Non-Compliant Breaches	Exemption	Covid-19
AWMGS	1	0	0	0	0	0
Children and Women	2	1	0	1	0	0
Capital Planning, Estates and Facilities	7	8	1	2	0	1
Clinical, Diagnostics and Therapies	6	0	1	1	0	0
Executives	14	8	3	2	2	0
Medicine	3	0	0	0	0	0
Mental Health	0	0	0	0	0	0
PCIC	1	0	0	0	0	0
Specialist	6	0	0	0	0	0
Surgery and Dental	4	0	1	2	0	0
<b>TOTALS</b>	<b>44</b>	<b>17</b>	<b>6</b>	<b>10</b>	<b>2</b>	<b>1</b>

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

Clinical Board	2020/21		2021/22		2022/23 (Year To Date)	
	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	N/A – Previously recorded as part of CD&T		4	3	3	3
Children and Women	3	0	2	0	2	0
Capital Planning, Estates and Facilities	3	1	2	0	1	0
Clinical, Diagnostics and Therapies	28	4	14	1	5	0
Executives	20	4	9	3	11	0
Medicine	6	3	6	1	1	0
Mental Health	3	0	1	0	0	0
PCIC	8	2	2	0	1	2
Public Health Commissioning Team	0	0	1	0	0	0
Specialist Services	7	1	6	2	3	0
Surgery Services and Dental	9	3	5	1	1	0
<b>Grand Total</b>	<b>87</b>	<b>18</b>	<b>52</b>	<b>11</b>	<b>28</b>	<b>5</b>

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

**Five Ways of Working (Sustainable Development Principles) considered**

*Please tick as relevant*

Prevention		Long term	X	Integration		Collaboration	X	Involvement	X
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**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  
06/28/2022 11:08:59

Report Title:	Counter Fraud Progress Report		Agenda Item no.	7.1
Meeting:	AAC	Public	Meeting Date:	05/07/2022
		Private		
Status <i>(please tick one only):</i>	Assurance	Approval	Information	X
Lead Executive:	Catherine Phillips - Executive Director of Finance			
Report Author (Title):	Gareth Lavington – Head of Counter Fraud			

### Main Report

#### Background and current situation:

This report builds on the interim Counter Fraud progress report verbally presented and provided in written form at AAC on 5<sup>th</sup> May 2022. This report provides an update of all the work undertaken by the CF team at CAVUHB on behalf of CAVUHB between the dates 01/04/2022 and 20/06/2022 (Quarter 1) (submission date of papers)

The reports seeks to provide assurance that the planned activity in the Annual Plan is being carried out and that the CF fraud provision for CAVUHB is robust and fit for purpose.

It is asked that the committee note the content of the report.

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

Progress made against the Annual Counter Fraud Plan.  
Current Investigations.  
Any ongoing key issues

#### Recommendation:

The Board / Committee are requested to: Note the content 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	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	
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
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**Impact Assessment:**

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

**Risk: Yes**

Financial loss which in turn can negatively affect patient care

**Safety: No**

**Financial: Yes**

Possible financial loss as a result of fraud which will lead to impact upon patient care.

**Workforce: Yes**

Reduction of available workforce due to financial loss; demotivation; lack of morale.

**Legal: Yes**

Use Statutory legislation to conduct investigations and support prosecutions

**Reputational: Yes**

Negative publicity resulting in negative publicity that undermines public confidence in the Health Board.

**Socio Economic: No**

**Equality and Health: No**

**Decarbonisation: No**

**Approval/Scrutiny Route:**

Committee/Group/Exec

Date:

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**GIG**  
CYMRU  
**NHS**  
WALES

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

**NHS WALES**  
**Cardiff and Vale University Health Board**

**Counter Fraud Progress Report**  
**01/04/2022 - 20/06/2022**

**GARETH LAVINGTON**  
**COUNTER FRAUD MANAGER**  
**CARDIFF & VALE UNIVERSITY HEALTH BOARD**

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## 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 from the 1<sup>st</sup> April 2022 to the 20<sup>th</sup> June 2022.

The report's format has been adopted in order to update the Audit and Assurance Committee about counter fraud referrals, investigations, activity and operational issues.

At 20<sup>th</sup> June 2022, 85 days of Counter Fraud work have been completed against the agreed 440 days in the Counter Fraud Annual Work-Plan for the 2022/23 financial year. The days have been used strategically in preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; and the creation and planning for renewed infrastructure in relation to the organisation's counter fraud response, staff awareness, investigating referrals in relation to fraud and financial crime and attending court.

This report builds upon the interim period 1 report that was delivered to AAC on 12<sup>th</sup> May which detailed the work covered until 25<sup>th</sup> April. This report provides full progress made within the CAVUHB counter fraud team from 1<sup>st</sup> April – 20<sup>th</sup> June (Quarter 1).

The breakdown of these days is as follows:

TYPE	Days
Proactive	15
Reactive	70

## 2. Progress

The Annual Counter Fraud Plan, the Annual Counter Fraud Report, and the NHS Counter Fraud Authority functional return have all been completed and

approved by Director of Finance, Audit Committee, (and in the case of the functional return) the Audit Committee Chair.

## Staffing

On the 1<sup>st</sup> April 2022 the new Counter Fraud Manager commenced employment with CAVUHB. This means that the Counter Fraud department now has a team of four personnel. Three are fully accredited (ACFS) the fourth member of the team has now successfully completed the ACFS course. Certification is expected in July 2022. The new Counter Fraud Manager is a fully accredited LCFS and qualified fraud investigator. This team has the responsibility to provide the Counter Fraud service for five other NHS organisations and this staffing level allows for a maximum provision of 440 days Counter Fraud work per annum to Cardiff and Vale University Health Board.

## Activity

### *Infrastructure/Annual Plan*

During this reporting period, the main focus has been placed upon developing and getting underway the implementation the Counter Fraud Plan for 2022-2023. This plan has been written and approved at executive level and is now aligned fully to the NHSCFA requirements as stipulated in Government Standard 13. The plan states proposed actions throughout the year. In tandem with any investigation work that is referred and requires action, the main focus of the team in the first quarter of the reporting period (April-June) has been to review and improve the Counter Fraud infrastructure in relation to awareness of fraud in the NHS, awareness of the Counter Fraud Team, addressing any shortcomings in relation to reporting routes and contact for staff members, and identifying the presence and status of relevant policy documents. So far this has led to the following actions been undertaken -

- a. The creation and implementation of a dedicated generic email address – the aim is for this to lead an additional reporting route open to staff that will compliment existing routes; will assist in recording activity generated as a

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result of awareness work; and will double as a dedicated incident reporting and logging tool which automatically collects data and allows for accurate recording of outcome metrics. **Complete**

- b. The creation of a comprehensive activity database that will assist in maintaining a detailed record of work undertaken with a view to saving resource time in relation to corporate governance. **Complete**
- c. The creation of a new, up to date, interactive and dedicated Counter Fraud enquiry form and a separate Awareness session request form. Accessible by links and QR coding. These are easily available to all staff and aim to provide an additional, more effective, and speedy route to the team that compliments the national reporting line. The enquiry form is provided below (click on following link [Counter Fraud Enquiry Form](#) ) **Complete**
- d. Review of the Counter Fraud Bribery and Corruption Policy – the CAVUHB Counter Fraud Bribery and Corruption Policy is in date but requires review and updating by December 2022. **Ongoing**
- e. Review of CF digital presence – Counter Fraud have very little presence within CAVUHB digitally. Enquiries and meetings with Comms Department undertaken. Agreed that a bi-monthly newsletter will be completed by the team and forwarded to comms for inclusion in staff messaging that takes place. Whilst the newsletter is a useful method of updating staff with all things fraud it acts also as an awareness tool highlighting the presence of the team, the work it does and the easy methods that staff can use to make contact. Further to this all fraud alerts, bulletins to be shared with comms team in a timely manner and distributed accordingly by them throughout relevant CAVUHB staffing cohorts. Work is underway to develop a fit for purpose Intranet Site that can be accessed by all NHS organisations that a service is provided to. At this time the intranet pages are out of date by a number of years and very difficult to find. The new site is being developed on the Share point APP of Microsoft Office 365. Further to this, discussions have been held with the Communications Department with a view to getting a regular presence on the new Staff App that is due for roll out in the next few months. This strategy aims to build and re-enforce an anti-fraud culture throughout the organisation. **On-going**

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- f. Joint working protocol with Internal Audit agreed with Head of Internal Audit and regular meetings scheduled throughout the year to assist in this protocol. Two meetings held. **Complete**
- g. Review of Counter Fraud e-Learning arrangements – whilst eLearning available on ESR – as previously reported it is not a mandatory module at this time and it not very accessible. Work is underway with the LED team at CAVUHB to develop a modern fit for purpose Conter Fraud learning page on the All Wales Learning @ Wales Platform. Access has now been gained and development of this platform by the CF team is underway and it is aimed that this will be up and running early in quarter 2. When complete this will be available to all CAVUHB staff as an education, learning and awareness tool. It will be signposted internally within the organisation and the aim is that staff can access all the available resources at the click of a button. **Ongoing**
- h. Counter fraud awareness sessions at Corporate Induction on hold at this time whilst as corporate induction in its traditional style is not being carried out. When the learning platform above is complete and operational it is aimed that signposting through the new corporate induction process will direct staff there to appraise themselves of fraud and fraud resources within the NHS. **Ongoing**

### *Alerts/Bulletins*

During this reporting period, **four fraud alerts** have been issued by the CAVUHB CF team:

1. To all relevant staffing cohorts in relation to a frequent attender at Hospitals (Restricted)
2. To all relevant finance staffing cohorts in relation to mandate fraud (Appendix 1)
3. To all staff in relation to a prevalent scam in relation to Dell Computers – referred to cyber-crime team and action fraud (Appendix 2)
4. To all staff in relation to a possible ESR phishing scam (Appendix 3)

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### *Awareness Sessions*

During this reporting period one general fraud awareness session has been delivered to CAVUHB staff – Directorate of Child Health.

Further arrangements are underway to deliver sessions to staff in relation to general fraud awareness and mandate fraud.

### *Newsletters*

During the reporting period one newsletter has been produced, published and communicated to all staffing groups. (Appendix 4)

### *Fraud Prevention Notices and IBURN notices*

During this reporting period one FPN has been issued by the NHS CFA. This was in relation to the risks associate with Credit Card terminal fraud taking place in the NHS. The FPN content was based upon offences of this nature and type being committed in other NHS Trusts in the UK. A brief investigation was carried out. Findings of this investigation were that the organisation does operate Credit Card Terminals but the weaknesses reported in the FPN that afforded the opportunity for exploitation were not prevalent within the Health Board. Best practice support materials issued to relevant stakeholders. Assurance provided that the advice given was already being followed. Reported upon CLUE database accordingly and closed.

During this reporting period one IBURN notice has been issued in relation to an Imposter acting as a consultant Doctor providing educational services externally to NHS providers. The IBURN notice raised issues in relation to patient safety and Fraud. Investigation carried out internally with patient safety team with a negative result. Further enquiries conducted with NWSSP Accounts Payable and Supplier Maintenance teams, provided further assurance that the suspected fraudster has not supplied any services to CAVUHB. IBURN notice issued to relevant stakeholders for future reference and the investigation recorded upon Clue accordingly and closed.

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### Referrals/Enquiries

During this reporting period the CAVUHB CF team have received 17 referrals via the online enquiry form from CAVUHB staff. These have been wide ranging in relation to a number of areas including, staff overpayment, email phishing attacks, working elsewhere whilst sick, and suspicions re an agency application/worker. Of these referrals eight (8) have been informally resolved with no offences being disclosed and no further action being taken by the team. Five (5) referrals have been promoted to investigation and reported upon Clue with formal investigation underway (As detailed below). Four (4) referrals remain open and not promoted to investigation awaiting findings of initial assessment being undertaken by directorate/HR.

### Investigations

At 1<sup>st</sup> April 2022 there were nine (9) investigations open in relation to Cardiff and Vale Health Board as detailed in the below table.

Offence	Date Opened	Status	Date Closed	Outcome/Comments
Prescription Fraud	28/05/2020	Closed	08/06/2022	Criminal Conviction
Salary overpayment	21/09/2021	Closed	24/05/2022	No offences disclosed – Financial investigation showed money not spent and was returned upon request.
Salary Overpayment	09/07/2021	Open	NA	Monies being recovered via salary and therefore NFA re theft criminally. Further concerns discovered over log on times of employee. Enquiries ongoing by HR and await findings.

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Overpayment of Salary	11/01/2022	Closed	24/05/2022	Not furthered to prosecution. Civil recovery via debt collection being made. NFA by CF team.
Overpayment of Salary	11/01/2022	Open	NA	Re-Payment Plan Arranged waits confirmation.
Overpayment of Salary	24/03/2022	Closed	19/04/2022	Financial Investigation carried out. Subject contacted and monies being re-paid via a plan.
Overpayment of Salary	24/03/2022	Closed	24/05/2022	Financial Investigation carried out. Monies repaid in full. NFA by CF team
Overpayment of Salary	24/03/2022	Closed	19/04/2022	Financial Investigation carried out. Monies repaid in full. NFA by CF team
Patient living overseas and using primary care pharmacy for prescriptions	30/11/2021	Closed	20/05/2022	Full investigation carried out. Subject legitimately using primary care and secondary care. Travels abroad for further private treatment for extended periods. No issues/No offences

*NOTE: A full breakdown of the salary overpayment issues that have been referred to CF within the last 12 months is underway in order provide further detail in regard of the amounts of monies recovered as a direct result of CF involvement. This will be reported when complete.*

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As stated above the team have promoted 5 new referrals to investigation during this period as detailed below.

Offence	Opened	Status	Closed	Outcome/Comments
Working for an agency whilst on Sick Leave	04/04/2022	Open	NA	Allegation that a nursing employee on sick leave carrying out shifts for an agency. Enquiries ongoing
Running a business whilst on Sick Leave	12/05/2022	Open	NA	Enquiries ongoing. HR and directorate conducting initial assessment.
Overpayment of Salary	12/05/2022	Open	NA	Enquiries complete. No possibility of furthering to a criminal prosecution due to the issues involved. Referred back to HR and directorate for a decision to be made whether to request repayment of salary.
Prescription Fraud – GP staff member issuing prescriptions to self	24/05/2022	Closed	26/05/2022	Enquiries complete. No offences disclosed after investigations carried out at surgery. Information received via reporting hotline anonymously and believed malicious.

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Overpayment of Salary	30/05/2022	Open	NA	Enquiries commenced and financial checks commenced
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Therefore at the time of report submission (20/06/2022) there are six (6) live fraud investigations being carried out in CAVUHB.

*Other*

Following an enquiry raised by the primary care (pharmacy team) in relation to suspicious claiming by a community pharmacist in relation to the pilot Compensatory Claiming mechanism a formal meeting was held. No offences of fraud disclosed but 'sharp practice' suspected. Fraud proofing advice provided only. This has led to approval from Welsh Government to add a declaration to the National Electronic Claim and Audit Form (NECAF) stating

“Making a false declaration on this form may constitute a criminal offence contrary to the Fraud Act 2006 which is punishable by a maximum penalty upon conviction of 10 years imprisonment. All instances of suspected fraud will be reported to the relevant Counter Fraud Team at your Heath Board for investigation.”

It is aimed that this will act in a deterrent capacity when service claims are made by community pharmacies.

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## Appendices

### Appendix 1



Fraud Alert - Recent  
Mandate Fraud Risk

### Appendix 2



Fraud Alert - Dell  
Scam Phone Call - C

### Appendix 3



Fraud Alert CAV  
ESR Email.pdf

### Appendix 4



Fraud Newsletter  
May 2022.pdf

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# Fraud Alert – Mandate Fraud

For attention of all staff working in NHS finance and payroll teams, particularly those responsible for setting up bank account details and processing bank payments:

Please be reminded that mandate fraud is a real risk to the organisation that has the potential, if successful, to cause substantial financial loss.

Recent attempts to change bank details have involved fraudsters impersonating the following legitimate supply companies:

**Vanguard Healthcare Solutions, 4C Strategies Ltd, Inovus Ltd,  
Accomplish Group Ltd, Centre Great Ltd**

Staff are reminded to be extremely vigilant in relation to changes to banking details relating to the companies named above and also to any other company/ supplier to your organisation.

Staff are to ensure that they follow the robust financial procedures in place and to refresh their knowledge using the guidance issued by the NHS Counter Fraud Authority Quick Guide.

Should any staffing group require an awareness input in relation to this area from the Counter Fraud Team then please click on the awareness session request form below.

Likewise, If you or your staffing group require a copy of the NHS CFA quick guide to mandate fraud please follow this [LINK](#) or email us at the below address.

## Counter Fraud Enquiry Form (LINK)

Report any concerns or queries to the Counter Fraud Team using the link above or QR code.



## Awareness Session Request (LINK)

Request an Awareness Session/ Input from Counter Fraud using the link above or QR code.



## [CounterFraudEnquiries.CAV@wales.nhs.uk](mailto:CounterFraudEnquiries.CAV@wales.nhs.uk)

Gareth Lavington

Tel: 029218 36265

[Gareth.Lavington2@wales.nhs.uk](mailto:Gareth.Lavington2@wales.nhs.uk)

Counter Fraud Manager

Emily Thompson

Tel: 029218 36262

[Emily.Thompson@wales.nhs.uk](mailto:Emily.Thompson@wales.nhs.uk)

Local Counter Fraud Specialist

Nigel Price

Tel: 029218 36481

[Nigel.Price@wales.nhs.uk](mailto:Nigel.Price@wales.nhs.uk)

Local Counter Fraud Specialist

Henry Bales

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[Henry.Bales@wales.nhs.uk](mailto:Henry.Bales@wales.nhs.uk)

Local Counter Fraud Specialist

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# Fraud Alert

## Social Engineering – Phone Calls Regarding Dell Computers

Information has been received at Cardiff and Vale Counter Fraud Department from a local Health Board regarding a recent suspicious phone call that had been made to a member of staff.

A member of staff reported they had received a telephone call from a person reporting to be from Dell computers. The caller was asking for details about their work's computer.

Staff should not provide any information about details of their computers or their login information to someone over the telephone.

You will only be contacted over the telephone by the ICT Department if you have logged an incident with the ICT Service Desk. If you have logged an incident there will be a call reference number (you would have received a confirmation email after logging the call) and you **must** ask the caller on the telephone to provide you with this (**do not read it out to them**). If you are suspicious about the person on the end of the telephone, immediately end the call, and report it to the ICT Department.

If you are worried about family members, friends or yourself being scammed there is plenty of advice available online at:

**ActionFraud**  
National Fraud & Cyber Crime Reporting Centre



## Local Counter Fraud Team

If you would like more information about fraud or to raise a concern please contact one of your Local Counter Fraud Specialists by Email, Phone or drop into the office.

Gareth Lavington

Tel: 029218 36265

[Gareth.Lavington2@wales.nhs.uk](mailto:Gareth.Lavington2@wales.nhs.uk)

Counter Fraud Manager

Nigel Price

Tel: 029218 36481

[Nigel.Price@wales.nhs.uk](mailto:Nigel.Price@wales.nhs.uk)

Local Counter Fraud Specialist

Emily Thompson

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Local Counter Fraud Specialist

Henry Bales

Tel: 029218 36264

[Henry.Bales@wales.nhs.uk](mailto:Henry.Bales@wales.nhs.uk)

Local Counter Fraud Specialist

Office: Counter Fraud Department, 1st Floor Woodland House, Maes-Y-Coed Road, Cardiff, CF14 4HH

Report any suspicions or concerns about fraud in the NHS to the NHS Counter Fraud Authority  
at <https://cfa.nhs.uk/reportfraud> or by calling **0800 028 4060** (available 24 hours)

All reports are treated in **confidence**, and you have the option to report **anonymously**. Alternatively, you can also speak to your LCFS.

# Fraud Alert

## Phishing Email—ESR

Information has been received at Cardiff and Vale University Health Board Counter Fraud Department from a member of staff regarding a recent suspicious email they had received.

A member of staff reported they had received a suspicious email alleging to be from NHS Electronic Staff Record (ESR) system stating that their bank details had been altered and if this was not done by them or to check the details to click a link in the email to check their details are correct.

If you receive a similar email please do **NOT click the link**, please report the email to the Fraud Department. If you wish to check your ESR system then please use existing links you have or enter the website address manually in the address bar.

Never click links in emails that you have any suspicion may not be genuine!

If you are worried about family members, friends or yourself being scammed there is plenty of advice available online at:

**ActionFraud**  
National Fraud & Cyber Crime Reporting Centre



## Local Counter Fraud Team

The counter fraud department has a **new online reporting tool** which can be accessed from the link or by scanning the QR Code below. There is also a new generic email inbox which can be used to contact the Fraud Department. Any information provided is treated **confidentially**.

### Counter Fraud Enquiry Form



[CounterFraudEnquiries.CAV@wales.nhs.uk](mailto:CounterFraudEnquiries.CAV@wales.nhs.uk)

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Tel: 029218 36265

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Local Counter Fraud Specialist

## Welcome to the May 2022 edition of the Counter Fraud Newsletter

The Counter Fraud Department has gone through some changes recently, the contact details for all of the team members is on the second page of the newsletter. We have also recently introduced a generic email account for that can also be used to contact the team:

[CounterFraudEnquiries.CAV@wales.nhs.uk](mailto:CounterFraudEnquiries.CAV@wales.nhs.uk)

It is probably important at this point to remind everyone that although we are based in Cardiff and Vale UHB we do provide the counter fraud services to all six organisations listed above, so please do not be put off by the CAV email if contacting us from one of our other organisations!

## [Counter Fraud Enquiry Form \(link\)](#)

- Click on the above link or scan the QR code to access our new form that can be used for any general enquiry to the counter fraud department and/or to report any concerns you may have in relation to a fraud or possible fraud being committed against the organisation.
- It is completely anonymous, we will only know your details if you choose to supply them.
- All enquiries are treated confidentially whether you provide your details or not.
- Providing your details often makes it easier to investigate a report.



## [Fraud Awareness Sessions \(link\)](#)



- Click on the above link or scan the QR code to access a new form that allows you to request an input for your department/team/organisation for Counter Fraud Awareness.
- These sessions can be in person or via Teams and can be a general awareness session or more specific to your needs (such as providing specific sessions on Mandate Fraud etc).

## Fraudulent practice manager brought to justice by NHS counter fraud investigation

Julie Ann Stevenson, a 63-year-old former NHS Practice Manager at Castle Surgery, Neath, has been sentenced for the crime of defrauding the Practice and the NHS Pension Authority over an 18-month period, thus gaining in excess of £35,000 in remuneration and pension that she was not entitled to.

She was sentenced to 6 months' imprisonment, suspended for 12 months at Swansea Crown Court.

More details can be found here: [Fraudulent practice manager brought to justice by NHS counter fraud investigation. nhs.uk](https://www.nhs.uk/news/2022/06/28/fraudulent-practice-manager-brought-to-justice-by-nhs-counter-fraud-investigation/)

## Fraud E-Learning Package - ESR

There is an online Fraud Awareness learning package that can be accessed through ESR. Although this is not a mandatory package at this time it is a valuable course that will take under half an hour to complete.

It has been estimated that the NHS' vulnerability to fraud, bribery and corruption leads to a loss of £1.14 billion (2019-2020) we all have our part to play in protecting the organisation from this activity. You are encouraged to learn more by carrying out the learning provided.

The course can be accessed here: [Fraud Awareness E-Learning](https://www.nhs.uk/learning/online-learning/packages/fraud-awareness/)

**NHS fraud. Spot it. Report it. Together we stop it.**

## Local Counter Fraud Team

The counter fraud department has a **new online reporting tool** which can be accessed from the link or by scanning the QR Code below. There is also a new generic email inbox which can be used to contact the Fraud Department. Any information provided is treated **confidentially**.

[Counter Fraud Enquiry Form \(link\)](#)

[CounterFraudEnquiries.CAV@wales.nhs.uk](mailto:CounterFraudEnquiries.CAV@wales.nhs.uk)



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Local Counter Fraud Specialist

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Report Title:	<b>Revised Controlled Document Policy and Procedure</b>		Agenda Item no.	8.1	
Meeting:	Audit and Assurance Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	5 July 2022
		Private	<input type="checkbox"/>		
Status <i>(please tick one only):</i>	Assurance <input type="checkbox"/>	Approval <input checked="" type="checkbox"/>	Information <input type="checkbox"/>		
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Corporate Business				

### Main Report

#### Background and current situation:

The Corporate Governance Directorate have responsibility to coordinate the production, publication and archiving of Cardiff and Vale University Health Board Policies and other Controlled Documents. The responsibilities and processes necessary to enable these activities are described in UHB 001 (Management of Policies, Procedure and other Written Control Documents Policy) and in UHB 242 (Written Control Documents – Development and Approval Procedure).

UHB 001 required review in accordance with its published review date. This review has occurred and has not resulted in any substantial alteration.

UHB 242 also required review in accordance with its published review date. Following review, the document has been amended to achieve the following:

- To provide a clearer definition of the various types of controlled documents to be used within the Health Board.
- To provide a clearer articulation of the process to be adopted when drafting new controlled documents.
- To update the document and reflect recent changes to committee titles and purpose.

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

The amendments to these documents are a necessary step in the improvement of controlled document management and are consistent with recommendations made in an internal audit of the Management of Health Board Policies and Procedures.

#### Recommendation:

The Committee are requested to:

**APPROVE** the adoption of the amendments to UHB 001 (Management of Policies, Procedure and other Written Control Documents Policy) and UHB 242 (Written Control Documents – Development and Approval Procedure).

#### Link to Strategic Objectives of Shaping our Future Wellbeing:

*Please tick as relevant*

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

		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	<input checked="" type="checkbox"/>	Long term	<input type="checkbox"/>	Integration	<input type="checkbox"/>	Collaboration	<input type="checkbox"/>	Involvement	<input type="checkbox"/>
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**Impact Assessment:**

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

**Risk: Yes**

Improved management of controlled documents provides greater access to potential risk control processes and procedures.

**Safety: Yes**

Improved management of controlled documents provides greater access to potential risk control processes and procedures.

**Financial: No**

**Workforce: No**

**Legal: Yes**

Improved management of controlled documents provides greater evidence of Cardiff and Vale University Health Board's statutory compliance.

**Reputational: No**

**Socio Economic: No**

**Equality and Health: No**

**Decarbonisation: No**

**Approval/Scrutiny Route:**

Committee/Group/Exec	Date:

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<b>Reference Number:</b> UHB 001 <b>Version Number:</b> 6	<b>Date of Next Review:</b> XXXX  <b>Previous Trust/LHB Reference Number:</b> N/A
<b>MANAGEMENT OF POLICIES, PROCEDURES AND OTHER WRITTEN CONTROL DOCUMENTS POLICY</b>	
<p><b>Policy Statement</b></p> <p>Cardiff and Vale University Health Board (C&amp;V UHB) has a responsibility to ensure compliance with legislative, statutory and regulatory requirements. Policies, procedures and other written control documents develop and describe our ‘ways of working’ and outline how staff should perform their roles to meet these requirements. A robust and clear governance framework for the management of documents is essential to minimise risk to patients, employees, contractors, the public and the organisation itself; therefore, the Health Board has developed a system to support the development or review, approval, dissemination and management of these documents.</p> <p>This policy outlines the process for development, consultation, approval, dissemination, and review of key organisational documents such as policies, strategies, procedures, guidelines and protocols.</p>	
<p><b>Policy Commitment</b></p> <p>Our documents will be written in plain language so that all staff, stakeholders and where appropriate our patients and the people we serve, are clear about what is expected. It will be possible to find them easily on our internet and/or intranet sites. Where appropriate our documents will be available in the Welsh Language and they will also be supported by other media or format, for example podcasts.</p> <p>Each document will have an “owner” who has responsibility for making sure that it is regularly reviewed and kept up to date.</p> <p>A combined Equality and Health Impact Assessment will be completed for <b>all</b> policies (and where appropriate procedures and other written control documents).</p> <p>Our staff and stakeholders will be actively consulted during the development of all policies (and where appropriate procedures and other written control documents).</p> <p>There will be clear and appropriate methods for the approval of policies and other written control documents and a comprehensive register will be maintained for all such documents.</p>	
<p><b>Supporting Procedures and Written Control Documents</b></p> <p>This policy and UHB 242: Written Control Documents – Development and Approval</p>	

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Procedure describe the following with regard to written control documents:

- The process for developing/updating documents
- The requirements regarding equality and health impact assessment
- Style and formatting
- Consultation and approval arrangements
- Recording, storage and archiving
- Communication and publication
- Any learning, education or development needs

**Other supporting documents are:**

UHB 142: Records Management Policy.

UHB 183: Records Retention and Destruction Protocol.

UHB 202: Safety Notices and Important Documents Management Policy.

UHB 228: Producing Written Information for Patients Guidance.

UHB 246: Information Governance Policy.

### Scope

This policy applies to all of our staff in all locations including those with Honorary Contracts.

**This policy relates to organisation wide key documents. However, its principles also apply to any local key documents to ensure that they are appropriately authenticated and regularly reviewed to ensure a reliable, accessible and valid source of best practice for staff.**

<b>Equality and Health Impact Assessment (EHIA)</b>	The policy relies on the generic EHIA for Administrative Type Policies
<b>Policy Approved by</b>	Audit and Assurance Committee
<b>Group with authority to approve procedures written to explain how this policy will be implemented</b>	Health System Management Board
<b>Accountable Executive</b>	Director of Corporate Governance

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**Summary of reviews/amendments**

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	N/A	17/09/09	New policy
2	12/09	N/K	Minor amendments
3	06/11	07/11	Amendments throughout document to reflect changes in approval processes and recognise mechanism required to develop Directorate documentation.
4	01/07/14	08/07/14	Amendments to reflect new policy format
5	30/11/17	05/12/17	Change in titles Reference to new Equality and Health Impact Assessment launched in September 2016 Changes in supporting Procedure to reflect Committee changes
6	XXXX	XXXX	Changes in supporting Procedure to reflect changes in approval process.

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## Written Control Documents - Development and Approval Procedure

### Introduction and Aim

To ensure that Cardiff and Vale University Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will develop and describe our “ways of working” in policies, procedures and other written control documents. In this regard, the Management of Policies, Procedures and Other Written Control Documents Policy (UHB 001) has been produced.

This procedure translates the principles from that policy into more detailed guidance, including individual responsibilities for developing and reviewing written control documents. This is summarised at Table 1: Steps Involved in Document Creation/Amendment (page 8).

Unless otherwise stated, the phrase ‘*key documents*’ will be used in this procedure when a point is equally relevant to a range of control documents whether they be strategies, policies, procedures, guidelines etc.

### Objectives

This procedure ensures consistency in the format, compilation, approval and dissemination of all control documents, so that they are:

- Developed and reviewed when required;
- “Owned” – each document will have an owner who has responsibility for making sure that it is regularly reviewed and kept up to date.
- Written in plain language so that they can be understood and people are clear of what is expected.
- Subject to Equality and Health Impact Assessments (EHIA) where required;
- Recorded, stored and archived in accordance with the UHB Records Management Retention and Destruction Protocol;
- Appropriately co-produced and consulted on;
- Considered and approved by the appropriate forum/senior officer (with delegated powers);
- Shared with staff and stakeholders where required;
- Supported by appropriate learning, education and development where required; and,
- Available to the public, in line with Freedom of Information Act requirements and our Publication Scheme.

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### Scope

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

In addition to the responsibilities detailed within the procedure, staff also have a responsibility for making sure that they meet the requirements of their role profiles and any other responsibilities delegated to them.

<b>Equality and Health Impact Assessment</b>	The procedure relies on the generic EHIA for Administrative-type policies.
<b>Documents to read alongside this Procedure</b>	UHB 001: Management of Policies, Procedures and Other Written Control Documents Policy.
	UHB 142: Records Management Policy.
	UHB 183: Records Retention and Destruction Protocol.
	UHB 202: Safety Notices and Important Documents Management Policy.
	UHB 228: Producing Written Information for Patients Guidance.
	UHB 246: Information Governance Policy.
<b>Approved by</b>	Audit and Assurance Committee

<b>Accountable Executive or Clinical Board Director</b>	Director of Corporate Governance
<b>Author(s)</b>	Head of Corporate Governance

#### Disclaimer

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

### Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	18/09/2014	24/09/2014	Content previously included within Management of Policies, Procedures and Other Written Control Documents Policy. The revised policy is in the new shorter format and this procedure has been written in support of the new policy.
1.1	10/12/2015	16/12/2015	Title of Appendix 2 corrected

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2	30/11/2017	05/12/2017	Revised Procedure. Titles amended Reference to new EHIA that replaced EQIA Changes in Committee structure and inclusion of R&D
3	XXXX	XXXX	Revised to reflect change to UHB 001: Management of Policies, Procedures and Other Written Control Documents Policy.  Definitions moved from appendix to main body.  Document Approval process revised.  Committee titles updated.

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## 1. Definition of Terms

**1.1 Note.** These definitions are adapted from a range of sources. There are no single legal definitions and the terms can mean different things to different organisations.

**1.2 Strategy.** A long term plan designed to achieve particular goals or objectives. A strategy is often a broad statement of an approach to accomplishing these desired goals or objectives. A strategy may be supported by policies and procedures. Strategies always require an Equality & Health Impact Assessment (EHIA).

**1.3 Policy.** A formal written statement of intent, describing the broad approach or course of action that the Health Board is taking with a particular issue. The formulation of policies allows the Health Board to produce formal agreements, which clearly define the commitment of the organisation and the obligations of individual staff. An Operational Policy is a statement outlining the objectives, principal functions and modes of operation of an entire hospital or a department, particular service or activity.

Policies are usually underpinned by evidenced based procedures and guidelines. Policies are mandatory and usually require an EHIA.

**1.4 Procedure.** A standardised method of performing clinical or non-clinical tasks by providing a series of actions to be conducted in an agreed and consistent way to achieve a safe, effective outcome. Procedures set out the operational processes to be followed to meet objectives, usually the objectives required by a strategy or policy. They must include reference to any evidence used. Procedures are considered mandatory. The equality impact of a procedure that supports a policy may be covered by that policy's EHIA but consideration should always be given to the need for a specific EHIA.

**1.5 Protocols.** Protocols are an agreed framework that provides step by step guidance. They are different from policies and procedures as they lack the 'mandatory' element and by allowing for professional judgement, individual cases and competencies can play a role as they are flexible working documents.

Within a protocol it must be clear by whose authority is it being implemented, and what the scope of the protocol is. If a protocol is not to be followed it is necessary to record the alternative action that is to be taken and the rationale for this. Protocols may have potential to impact on people with protected characteristics and therefore consideration should be given to conducting an EHIA.

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**1.6 Guidelines.** Guidelines give general advice and recommendations for dealing with specific circumstances. They differ from procedures and protocols by giving options of how something might be carried out. They are used in conjunction with the knowledge and expertise of the individual using them.

Guidelines are not prescriptive. However, whilst guidelines are not mandatory, it could prove difficult to defend a case where agreed guidelines had not been followed and the rationale for this has not been recorded or justified.

**1.7 Standard.** A standard is a statement, reached through consensus, which clearly identifies the desired outcome. A standard is usually used within audit as a measure of success. Standards may be published as a standalone document or may be incorporated into a strategy or policy.

Standard statements are accompanied by a description of the structure and process needed to attain specified observable outcomes.

Standards are not generally prescriptive; however, it could prove difficult to defend a case if a standard is not adhered to.

## 2. Responsibilities

### 2.1 Executive and Clinical Board Directors

2.1.1 The delegated responsibilities of Executive and Clinical Board Directors are set out in the Scheme of Delegation. They have responsibility for:

- a. Verifying that there is a need for a new written control document and ensuring that there is no duplication or conflict with other written control documents within their sphere of influence.
- b. Ensuring that appropriate written control documents are produced and kept up to date by identifying a document author (including reallocating responsibility if the author leaves or moves to another role).
- c. Personally checking for accuracy of content prior to submission to a committee/group for approval.
- d. Maintaining a list of up to date policies and written control documents, supported by the Head of Corporate Governance.
- e. Ensuring that there are arrangements in place to capture, respond to and review documents when external organisations (e.g. Health and

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Safety Executive, Royal Colleges) publish new and updated information which require action by the Health Board.

f. Ensuring that consultation has taken place and impact assessments, including the equality and health impact assessment, have been completed where necessary. Where these have not been undertaken a reason for this will be provided.

g. Ensuring that any training requirements specific to the document have been referenced.

h. Establishing an appropriate date for review of the key document.

i. Ensuring that, where a process of audit and/or review has been agreed, this is maintained and reported on.

## 2.2 Document Authors

2.2.1 Authors are employees who have been given the task of writing or reviewing a key document. Employment documents should always have at least two authors i.e. a management representative and a staff representative.

2.2.2 Authors are responsible for the review of their documents. If an author leaves the Health Board or takes up a non-related post, the responsibility for the ongoing maintenance of the document is taken on by their replacement. Where no direct role replacement is appointed, responsibility reverts to the post holder's line manager. The Executive Director and Clinical Board Director will be informed of the situation to allow them to identify a replacement author if it is not appropriate for the responsibility to stay within that department.

2.2.3 Authors must:

a. Liaise with Executive or Clinical Board Directors to make sure policies and written control documents are implemented appropriately and, where necessary, compliance with these documents is formally audited.

b. Make sure that documents are reviewed in line with the review date or amended as a result of changes to practice, organisational structure or legislation.

c. Work with the Executive/Clinical Board Director and the Head of Corporate Governance to ensure appropriate engagement and consultation with relevant individuals and groups.

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d. Inform the Executive or Clinical Board Director of any learning, education, development or resource issues needing to be addressed prior to the granting of approval.

e. Undertake the necessary impact assessments, including EHIA.

f. Consider the findings and make sure that appropriate action has been taken in response to EHIAs.

g. Send the approved document to the Head of Corporate Governance for publication within **five working days** of approval by Board or Committee.

## 2.4 Corporate Governance

2.4.1 The Director of Corporate Governance is responsible for ensuring that the Health Board has arrangements in place to ensure effective development and management of key documents.

2.4.2 The Head of Corporate Governance is part of the Director of Corporate Governance's team. He/she undertakes the function of organisation wide "Policy Process Manager" and can provide advice and assistance on any aspect of document development and review. He/she can be contacted on 029 21836691 (Extension 36691).

2.4.3 He/she maintains a register of all documents which are centrally recorded and will be able to advise if a document already exists. All of these documents are also published on the intranet, and most documents are also published on the UHB Internet Site.

2.4.4 The Head of Corporate Governance will arrange for draft documents to be shared with the Community Health Council during the Engagement and Consultation phase. He/she will also arrange for approved documents and the accompanying EHIA (if applicable) to be published on the intranet/internet as appropriate within **ten working days** of receipt from the author or Committee Secretary.

## 3. Process for Drafting or Revising Key Documents

3.1 Each pan-Health Board policy and written control document will be sponsored by a lead Executive Director. At Clinical Board/Directorate level written control documents will be sponsored by the appropriate Director or Clinical Board Director (see Appendix 2).

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3.2 In accordance with the Equality Act 2010 (as may be amended), all strategies and policies will be subject to an EHIA (see Paragraph 6).

3.3 In the case of **employment policies**, (excluding those enforced from Welsh Government following national negotiations and other “All Wales policies”), staff representatives and management will jointly negotiate a draft policy for submission to the Resources and Delivery Committee (or another appropriate Committee if this is superseded) for approval. If there are any issues that cannot be resolved at Committee level, the Policy will be brought to the Board for final consideration and approval.

3.4 The development of policies and written control documents will be based on sound evidence, and take account of current legislation, mandatory requirements and national/professional guidance.

3.5 Sources of information used should be appropriately referenced or acknowledged.

<b>Table 1: Steps Involved in Document Creation/Amendment</b>			
<b>Stages</b>	<b>Lead</b>	<b>Action</b>	<b>Additional Information</b>
<b>Step 1</b>	Policy Author	<b>Identify the need for a new (or revised version of an existing) Policy or Key Document</b> by completing the Key Document Approval Form at Appendix 1.	Approval obtained from the Corporate Governance Team following submission of the Approval Form
<b>Step 2</b>	Policy Author	<b>Carry out an Equality &amp; Health Impact Assessment (EHIA)</b> The purpose of an EHIA is to identify and eliminate any negative effect that the key document may have upon groups, individuals or communities as a consequence of their race, gender, disability, religion or belief, sexual orientation, age, Welsh language, gender reassignment, pregnancy or maternity, marital or civil partnership status or human rights.	Support available from the Equality and Welsh Language Teams.  See ‘Definition of Terms’ for guidance on the EHIA requirements for each Key Document type

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		<p>EHIA should start at the beginning of key document making or review. This enables equality considerations to be taken into account throughout the design or review. Responsible officers must therefore carry out the EIA process and start by screening the document for relevance to equality. The EHIA Process should be used to carry out the screening (see Appendix 2).</p> <p>Responsibility for completing the EHIA lies with the officer(s) responsible for the key document, however the Equality &amp; Welsh Language Teams are able to support as required.</p>	
<b>Step 3</b>	Policy Author	<p><b>Understand Key Document Format and Template Requirements</b></p> <p>The drafted Key Document needs to comply with:</p> <ul style="list-style-type: none"> <li>• The Document Format at Paragraph 5.</li> <li>• The Template requirements at Paragraph 5.</li> <li>• As required the EHIA Format at Paragraph 6.</li> </ul>	Advice available from the Corporate Governance Team
<b>Step 4</b>	Policy Author	<p><b>Draft the Key Document</b></p>	Advice available from the Corporate Governance Team
<b>Step 5</b>	Policy Author	<p><b>Engagement and Consultation</b></p> <p>Engagement and consultation on all policies and written control documents should take place with the target audience including appropriate stakeholder, service user/carer, managerial, clinical and staff representation. Where appropriate, documents should</p>	<p>See Paragraph 7.</p> <p>Allow at least 28 working days</p>

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		be co-produced with that target audience.	
<b>Step 6</b>	Executive Lead/Author	<b>Obtain Approval</b> Lead Executive to discuss with Head of Corporate Governance the process to be adopted for draft document approval by Board, committee or other appropriate group.	See Appendix 2.
<b>Step 7</b>	Executive Lead/Author	<b>Approval</b> Following approval the author of the document is responsible for submitting the final document to the Corporate Governance Team for publication via SharePoint and the Internet.  In accordance with the Welsh Language Standards, some policies need to be made available in Welsh. This should take place once the final version is approved.	See Paragraph 4 for specific requirement
<b>Step 8</b>	Corporate Governance Team	<b>Publication</b> When the policy has been received from the Policy Author the Corporate Governance Team will update the master policy library and upload to intranet and internet as required.	
<b>Step 9</b>	Executive Lead/Author	<b>Review</b> Executive Leads/Authors are responsible for reviewing the key document in accordance with the review date set when published and/or changed circumstances requiring more immediate review.  The Corporate Governance Team operate a Written Control Documents Tracker and will send reminders when review date is overdue.	See Paragraph 8 for specific requirement.

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#### 4. Approval for Key Documents

4.1 Some “All Wales” policies are developed by the Welsh Government or by Health Boards and Trusts working together. The Health Board is often mandated to adopt these documents. Where this is the case they will be reported to the Board or a Board Committee so that there is a record of their adoption.

4.2 Where policies relate to equitable access to safe and sustainable, high quality specialised and tertiary services (Relevant Services), the Board will delegate approval to the Joint Welsh Health Specialised Services Committee (WHSSC).

4.3 All other strategies and policies will be approved in accordance with the guidance provided at Appendix 2. In accordance with Standing Orders the Health Board's top-level organisation structure and corporate policies require Board approval; Lead Executives/Authors who feel that their draft policy requires deviation from the guidance in Appendix 2 should discuss with the Head of Corporate Governance.

4.4 Where a document requires only a small amendment which is not material to the aims or objectives of the document, e.g. to reflect a change in working practice, content of supporting documents etc., an interim review may be undertaken. This will be agreed in advance with the Corporate Governance Directorate to ensure that the completion of an interim review does not expose the Health Board to an increased level of risk. The change will be reported to the next available meeting of the approving body. The Board will periodically receive an update on all controlled documents approved by committee or other appropriate group.

4.5 Once approved, documents will be published on the UHB Intranet and Internet sites. Under limited circumstances it may be necessary to redact information from a document prior to publication on the Internet e.g. direct dial telephone numbers within the Major Incident Plan. The Committee/ Group approving the document will determine if redaction is required. Where this has been agreed the reason and extent of redaction will be explained in the published document.

#### 5. Document Format

5.1 Document templates have been developed which contain the mandatory sections for inclusion in policies and written control documents (See Appendix 3).

5.2 This Template must be used for all Health Board wide, Clinical Board or multi-departmental documents. Where a document is only applicable within a

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single Department or, for example consists of a flow chart, an alternative format is acceptable and a “basic template” is also shown in Appendix 3. As a minimum the following principles must be followed:

- Document must have a clear heading.
- The scope and objectives must be defined.
- The status of the document must be clear e.g. guidance/mandatory requirement.
- Instructions/guidance must be logically recorded.
- Date of approval shown.
- Date for next review shown.
- Date of last review shown.
- Author’s details.
- Pages numbered.

5.3 The language used for all documents should be plain English, using short sentences and where possible avoiding technical terms. If technical terms are used, they should be explained using a glossary or footnotes.

5.4 Policies, procedures and other written control documents will not be routinely translated into other languages. However, where staff are aware that this may cause difficulty for patients or their families they will ensure that the content is explained to them by an interpreter, translated if necessary or available in accessible formats (e.g. e-readers for the visually impaired).

5.5 In accordance with the requirements of the Data Protection Act 2018 (as may be amended), the names of individuals will not be contained within policies and written control documents. Individuals with particular responsibilities will be identified by their job title only.

5.6 Certain key documents may require the collection and processing of personal data as defined and regulated by personal data legislation as applies in Wales and /or the UK (including, without limitation, the Data Protection Act 2018 and the UK General Data Protection Regulation (UK GDPR)). Authors and sponsoring Executive Directors must ensure that the proposed key documents complies with these requirements, liaising with The Digital and Information Technology Directorate as required.

5.7 If the Health Board is adopting an externally approved document (such an All-Wales Policy) it will not need reformatting providing it meets the standards set above. These documents will be given a reference number, recorded and uploaded as if they were a Health Board authored document.

## 6. Equality and Health Impact Assessments

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6.1 The Equality Act 2010 requires the undertaking of Equality and Health Impact Assessments and all Health Board policies will require the completion of such **before** the policy is consulted upon.

6.2 These assessments determine whether a 'policy' will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights. It also takes account of Welsh Language issues. It is designed to ensure that Cardiff and Vale University Health Board take into consideration the needs of all individuals who work for us and/or access our services.

6.3 Health Impact Assessment (HIA) is a process that considers how the health and well-being of a population may be affected by a proposed action, be it a policy, programme, plan, project or a change to the organisation or delivery of a particular public service. Some impacts of policies on health may be direct, obvious and/or intentional, whilst others may be indirect, difficult to identify and unintentional. HIA is a systematic, objective, flexible and practical way of assessing both the potential positive and negative impacts of a proposal on health and well-being and suggests ways in which opportunities for health gain can be maximised and risks to health minimised. HIA looks at health in its broadest sense, using the wider determinants of health as a framework.

6.4 Where a procedure or other written control document has been developed in support of a policy it may not be necessary to undertake a further EHIA. If an EHIA has not been completed the reason for this will be explained at the beginning of the document. Where an EHIA has been completed the impact will be included in the document.

6.5 EHIAs will be published as part of the consultation process and they will be available on our internet and intranet sites alongside the relevant policy or written control document. A generic EHIA for Administrative-Type Policies has also been produced and formally agreed and can be used in support of the review and development of such policy types. This is available on the Policies page of the Intranet.

## 7. Engagement and Consultation

7.1 Written control documents must not be written in isolation. Engagement and consultation on all key documents occur with the target audience including appropriate stakeholder, service user/carer, managerial, clinical and staff representation. Where appropriate, documents should be co-produced with that target audience.

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7.2 The Health Board is developing a range of mechanisms to involve patients, carers and members of the public in its work. This will strengthen the stakeholder involvement with the Health Board, demonstrate our commitment to working with the local community, and develop our services and policies jointly. If required, authors should contact the Assistant Director of Patient Experience and the Assistant Director of Planning for advice and assistance in identifying the appropriate groups/individuals for co-production and consultation.

7.3 When a final draft has been developed the formal consultation can start. The consultation period should be a minimum of **28 working days**.

7.4 The policy author should send the document and equality and health impact assessment (if applicable) to the Head of Corporate Governance who will arrange for the documents to be uploaded onto the Health Board's Written Control Documents Consultation Page on the Intranet. He/she will also make sure that they are brought to the attention of appropriate consultees on a weekly basis. This will include the Community Health Council in accordance with mutually agreed principles.

## 8. Key Document Review

8.1 When drafting or reviewing a document the author should consult with the sponsoring executive to determine the most appropriate date for the key document to be reviewed.

8.2 Such consideration should be cognisant of any specific requirements imposed by statutory, regulatory or professional bodies, and the likelihood of a rapidly changing context or background to the key document.

8.3 The maximum 'life' of a key document before review will be two years from the date of publication.

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## Appendix 1

### Key Document Approval Form

This form should be completed by the document author and sent to the Corporate Governance Department for approval before production of the document.

<b>1. Key Document Category:</b>	New	<input type="checkbox"/>	Existing	<input type="checkbox"/>
<b>2. Key Document Type:</b>	Choose an item.			
<b>3. What is the reason for developing a new key document?</b>				
• Improve or standardise organisational procedures				<input type="checkbox"/>
• In response to learning from a complaint, incident or claim				<input type="checkbox"/>
• In response to alerts, safety notifications, Welsh Health Circulars etc				<input type="checkbox"/>
• Re-organisation of a service/department				<input type="checkbox"/>
• New or amended legislation				<input type="checkbox"/>
• Other (please specify)				Click here to enter text.
<b>4. What is the reason for amending an existing key document?</b>				
• Routine review				<input type="checkbox"/>
• Improve or standardise organisational procedures				<input type="checkbox"/>
• In response to learning from a complaint, incident or claim				<input type="checkbox"/>
• In response to alerts, safety notifications, Welsh Health Circulars etc				<input type="checkbox"/>
• Re-organisation of a service/department				<input type="checkbox"/>
• New or amended legislation				<input type="checkbox"/>
• Other (please specify)				Click here to enter text.
What Key Document need replacement/update?		Click here to enter text.		
Review type required:	Full Review	<input type="checkbox"/>	Interim Review	<input type="checkbox"/>
<b>5. What will be/is the title of the key document?</b>			Click here to enter text.	
<b>6. What will be/is the aim of the document?</b>			Click here to enter text.	
<b>7. Which other key documents will be/are relevant to the document?</b>			Click here to enter text.	
<b>8. Please indicate which of the following will need to be considered/consulted when developing/reviewing this document:</b>				
• Consent				<input type="checkbox"/>
• Deprivation of Liberty Safeguards (DOLS)				<input type="checkbox"/>
• Mental Capacity Act				<input type="checkbox"/>
• Mental Health Act				<input type="checkbox"/>
• Data Protection/GDPR				<input type="checkbox"/>
• Safeguarding				<input type="checkbox"/>

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• Equality and Diversity	<input type="checkbox"/>
• Welsh Language	<input type="checkbox"/>
• Patient Safety and Concerns	<input type="checkbox"/>
• Health and Safety	<input type="checkbox"/>
• Risk and Regulation	<input type="checkbox"/>
• Workforce and Development	<input type="checkbox"/>
• Information Governance	<input type="checkbox"/>
• Financial	<input type="checkbox"/>
• Business Continuity/Emergency Planning/Major Incident	<input type="checkbox"/>
• Other:	Click here to enter text.
<b>9. Who will be/is the sponsoring Executive Lead for this key document?</b>	Click here to enter text.
<b>10. Lead Author Details:</b>	
Name:	Click here to enter text.
Job Title:	Click here to enter text.
Email Address	Click here to enter text.

For Use by Corporate Governance:			
a. Date Received by Corporate Governance	Click here to enter a date.		
b. Permission to develop key document given?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
c. Full or Interim Review approved:	Choose an item.		
d. If <b>NOT</b> permitted why? What actions must author take to gain permission?	Click here to enter text.		
e. Approved title and reference number for <b>NEW</b> Key Document	Click here to enter text.		
f. Identify any other external or UHB Key Documents to be signposted/referenced in the new/reviewed key document	Click here to enter text.		
g. General Advice and follow up actions:	Click here to enter text.		
Name of Approver:	Click here to enter text.		
Job Role:	Click here to enter text.	Date Approved:	Click here to enter a date.
Date that Approval Form Returned to Author:	Click here to enter a date.		

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**Appendix 2: Approving Committee/ Group**

<b>Strategy and Policies</b>		<b>Procedures and Guidelines</b>	
Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.			
<b>Subject Area</b>	<b>Approving Body</b>	<b>Sub-area where clearly defined</b>	<b>Approving Group/ Director</b>
Capital	Strategy and Delivery Committee	Depending on subject – also see Health and Safety and Audit Committee re: Financial Control Procedures	Capital Management Group
Clinical Governance/Patient Experience/Quality and Safety	Quality, Safety and Experience Committee	See specific category e.g. Infection Control	As required by the specific category
Consent to Examination or Treatment	Quality, Safety and Experience Committee	Depending on subject matter	Health System Management Board or Clinical Board Quality, Safety and Experience Sub Committee
Corporate Governance	Audit Committee		

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<b>Strategy and Policies</b>		<b>Procedures and Guidelines</b>	
		Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
<b>Subject Area</b>	<b>Approving Body</b>	<b>Sub-area where clearly defined</b>	<b>Approving Group/ Director</b>
Counter Fraud	Audit Committee	Depending on subject matter	Corporate Governance to advise.
Data Protection	Strategy and Delivery Committee	Supporting procedures	Information Technology & Governance Sub Committee*
Employee Wellbeing and Stress Management	Health and Safety Committee	Health promotion and other documents	Corporate Governance to advise.
Employment/Human Resources/Workforce and Organisational Development Policies	Remuneration and Terms of Service Committee	All staff	Employment Policy Sub Group*
		Medical and Dental Staff	Workforce Partnership Group*
Environmental Management	Health and Safety Committee	Waste Management	Waste Management Group
		Other environmental management issues	Corporate Governance to advise.

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<b>Strategy and Policies</b>		<b>Procedures and Guidelines</b>	
		Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
<b>Subject Area</b>	<b>Approving Body</b>	<b>Sub-area where clearly defined</b>	<b>Approving Group/ Director</b>
Equality, Diversity and Human Rights	Board	Employment related procedures – all staff  Employment related procedures – Medical and Dental staff only  Patient Experience	Employment Policy sub-Group*  Medical Director*  Health System Management Board
Financial Governance	Audit Committee or Finance Committee	Some Financial Control Procedures	Heads of Finance Group//Director of Finance
Fire Policy	Board	Fire procedures	Fire Safety Group
Food Safety and Hygiene	Health and Safety Committee	Implementation procedures	Operational Services Management Group
Freedom of Information	Strategy and Engagement Committee	Supporting procedures	Health System Management Board
Fundraising and Investment Policies	Board	Supporting policies or procedures	Charitable Funds Committee

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<b>Strategy and Policies</b>		<b>Procedures and Guidelines</b>	
		Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
<b>Subject Area</b>	<b>Approving Body</b>	<b>Sub-area where clearly defined</b>	<b>Approving Group/ Director</b>
Health and Safety Policy	Board	Supporting procedures	Health and Safety Committee
Infection Prevention and Control	Quality, Safety and Experience Committee	Supporting procedures	Health System Management Board
Information Governance	Strategy and Engagement Committee	Supporting procedures	Health System Management Board*
Information Management and Technology Policy	Digital Health and Intelligence Committee	Supporting procedures	Health System Management Board*
Intellectual Property/Commercialisation	Strategy and Engagement Committee	Supporting procedures	Health System Management Board*
Major Incident Plan	Board	Implementation procedures:  If impacting on UHB/Site wide  If only local impact at Clinical Board/Directorate	Health System Management Board*  Clinical Board Management Team*
Medicines Management	Quality, Safety and Experience Committee	Supporting procedures	Clinical Safety Group

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<b>Strategy and Policies</b>		<b>Procedures and Guidelines</b>	
		Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
<b>Subject Area</b>	<b>Approving Body</b>	<b>Sub-area where clearly defined</b>	<b>Approving Group/ Director</b>
Mental Capacity related policies	Mental Health and Capacity Legislation Committee	Implementation Procedures	Health System Management Board
Mental Health Act related policies	Mental Health and Capacity Legislation Committee	Procedures relating to implementation of the Mental Health Act	Mental Health and Mental Capacity Legislation Committee  or Mental Health Clinical Board Quality, Safety and Experience Sub Committee depending on scope
No Smoking Policy	Health and Safety Committee	Supporting procedures	Health System Management Board*
Nutrition and Catering	Quality, Safety and Experience Committee	Supporting procedures	Health System Management Board*

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<b>Strategy and Policies</b>		<b>Procedures and Guidelines</b>	
		Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
<b>Subject Area</b>	<b>Approving Body</b>	<b>Sub-area where clearly defined</b>	<b>Approving Group/ Director</b>
Clinical and Non-Clinical Operational Policies with impact on more than one Clinical Board or the UHB as a whole.	Health System Management Board	Supporting procedures	Health System Management Board
Clinical and Non-Clinical Operational Policies with impact on a single Clinical Board or Directorate	Health System Management Board	Supporting procedures	Clinical Board or Directorate
Patient and Public Information	Quality, Safety and Experience Committee	Supporting procedures	Health System Management Board
Patient Experience, Quality and Safety/Clinical Governance	Quality, Safety and Experience Committee	See specific category e.g. Infection Control	As required by the specific category
Performance and Delivery	Strategy and Delivery Committee	UHB wide/affecting more than one Clinical Board	Health System Management Board
		Clinical Board/Directorate specific	Clinical Board or Directorate Management Group
Personal Safety/Violence and Aggression	Health and Safety Committee	Personal Safety/Violence and Aggression/	Operational Health and Safety Group

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<b>Strategy and Policies</b>		<b>Procedures and Guidelines</b>	
		Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
<b>Subject Area</b>	<b>Approving Body</b>	<b>Sub-area where clearly defined</b>	<b>Approving Group/ Director</b>
Policies, Procedures and Other Written Control Documents Management Policy	Audit Committee	Written Control Documents Development and Approval Procedure	Health System Management Board
Public Engagement	Strategy and Delivery Committee	Supporting procedures	Health System Management Board*
Public Health including Interventions not Normally undertaken and Individual Funding Patient Requests	Quality, Safety and Experience Committee	Supporting procedures	Health System Management Board*
Quality and Safety/Patient Experience/Clinical Governance	Quality, Safety and Experience Committee	See specific category e.g. Infection Control	As required by the specific category
Research and Development	Quality, Safety and Experience Committee	Supporting procedures	Research Governance Group
Risk Management and Board Assurance Framework Strategy	Board	Risk Assessment and Risk Management Procedures	Audit Committee
Scheme of Delegation	Audit Committee	Minor Changes to Scheme of Delegation	Management Executive
Service Planning	Strategy and Delivery Committee	Supporting procedures	Health System Management Board

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<b>Strategy and Policies</b>		<b>Procedures and Guidelines</b>	
		Note: where a group/sub Committee is marked with an * the arrangements are still subject to the agreement of the relevant Committee/sub Committee.	
<b>Subject Area</b>	<b>Approving Body</b>	<b>Sub-area where clearly defined</b>	<b>Approving Group/ Director</b>
Standards of Behaviour	Board		
Standing Financial Instructions	Board		
Standing Orders	Board		
Violence and Aggression/Personal Safety	Health and Safety Committee	Violence and Aggression/Personal Safety	Operational Health and Safety Group

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### TEMPLATES FOR DOCUMENTS

The template is designed for use when developing policies, procedures and other written control documents. It may not be suitable for all documents but any deviation will be agreed with the Head of Corporate Risk and Governance. Documents should be formatted in line with Corporate Style as follows:

Electronic format	Development - Microsoft Word  Publishing - PDF Read only (this will be arranged by the Head of Corporate Risk and Governance after the reference number has been added).
Document Style	<a href="#">Corporate Policy Template</a>  <a href="#">Corporate Procedure Template</a>  <a href="#">Employment Policy Template</a>  <a href="#">Employment Procedure Template</a>
Audit trail	Record information regarding consultation during development.
Body text	Arial 12
Headings	Arial 12 (Lower Case)
Tables and charts	Arial (size as appropriate)
Flow charts	Use Standard Flow Chart Symbols where possible
Use of bold	Headings only or to emphasise text
Alignment	Left Justified
Line spacing	Paragraphs – Single
Paragraph spacing	One line between paragraphs and section headings
Underlining	None
Contents page Contents page if >3 pages	As template Use judgement - help reader to find relevant information more easily
Staff Names	Use titles rather than names
Logo	Use UHB logo as incorporated in corporate template

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Headers and footers	Arial 9
Margins	Top and bottom of page 2.54 cm, sides 3.17cm
Document Title	To be included in the header on every page after first page
Page numbering	To be included in the header on every page after first page. It will include the page number and total number of pages (page x of x)
Bullets	<ul style="list-style-type: none"> <li>• Use standard bullets only, as they do not always format across different systems</li> </ul>
Abbreviations	State in full in first usage with abbreviation in brackets
Printing	A4 / double sided
Hyperlinks	<p>Hyperlinks should be considered for use in key documents when this will reduce the volume of a document or in any other way improve the reader's experience and understanding.</p> <p>However, consideration should be given to the anticipated longevity of a link to a site external to C&amp;V UHB. If it is assessed that a link has reasonable potential to change it should not be used. All hyperlinks should be preceded or superseded with a full reference to the external information source to enable access if the hyperlink fails.</p> <p><b>Hyperlinks in Approved Documents:</b> Authors are responsible for ensuring the accuracy of hyperlinks to external sites when submitting approved documents to Corporate Governance for publishing. If hyperlinks to existing C&amp;V UHB published key documents are required these will be inserted by the Corporate Governance Team prior to publishing; authors should clearly indicate which key documents require this action.</p>
Referencing	All reference material should be listed in full at the end of every document in Harvard style.

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Glossary of terms	<p>All documents need to be user friendly. They will be read by staff and members of the public. Therefore all necessary abbreviations, technical terms, jargon and specific wording must be clearly explained to the reader.</p> <p>Where possible always use plain English. Information to help with this is available on the <a href="#">Plain English Campaign web site</a>.</p>
Version Control	<p>Reference Number will be provided by the Corporate Governance Department. Documents to state 'Draft' as watermark whilst in development together with version number of draft e.g. Draft 1.</p>

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## APPENDIX 4

### REFERENCES

Cardiff and Vale NHS Trust, 2006. *Policy for the Management of Policies, Procedures and All other Written Control Documents, Ref No 68*

Cwm Taf Morgannwg University Health Board, 2021. *Policy for the Development, Review and Approval of Organisational Wide Policies*

Welsh Health Specialised Services Committee, 2010. *Memorandum of Understanding – Relating to Joint Committee of Welsh Health Specialised Services Committee*

Betsi Cadwaladr University Health Board, 2010, *Equality Impact Assessment – Policy for the Management of Policies, Procedures and Other Written Control Documents*

Cornwall and Isles of Scilly Primary Care Trust, 2008, *Initial Equality Impact Assessment Proforma - Policy for the Development and Ratification of Corporate Documentation*

Cornwall and Isles of Scilly Primary Care Trust, 2008, *Policy for the Development and Ratification of Corporate Documentation*

North East London NHS Foundation Trust, 2011, *Policy for the Drafting and Implementation of Procedural Documents and Equality Impact Assessment*

Metropolitan Police Service, 2011, *The Management of Policy Development in the Metropolitan Police Service and Equality Impact Assessment*

Cumbria Partnership NHS Foundation Trust, January 2013, *Document Development Policy*

NHS Scotland, Scottish Capital Investment Manual Glossary  
<http://www.scim.scot.nhs.uk/Index.htm>

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# Recovery of Services and Delivery of the Annual Plan 2021 – 2022

## Final Internal Audit Report

June 2022

Cardiff & Vale University Health Board

## Contents

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Appendix B: Assurance opinion and action plan risk rating .....	11

Review reference:	CVU 2122-31
Report status:	Final Report
Fieldwork commencement:	8 <sup>th</sup> April 2022
Fieldwork completion:	25 <sup>th</sup> May 2022
Debrief meeting:	26 <sup>th</sup> May 2022
Draft report issued:	30 <sup>th</sup> May 2022
Management responses received:	8 <sup>th</sup> & 15 <sup>th</sup> June 2022
Final report issued:	16 <sup>th</sup> June 2022
Auditors:	Henry Wellesley, Audit Manager Wendy Wright-Davies, Deputy Head of Internal Audit
Executive sign-off:	Caroline Bird, Interim Chief Operating Officer Abigail Harris, Executive Director of Strategic Planning Nicola Foreman, Director of Corporate Governance
Distribution:	Hannah Evans, Recovery and Redesign Programmes Delivery Director
Committee:	Audit & Assurance Committee



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

### Acknowledgement

NHS Wales Audit 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 & 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 and Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

## Executive Summary

### Purpose

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to 'Recovery of Services and Delivery of the Annual Plan 2021/22'.

### Overview

We have issued an overall rating of substantial assurance on this area and are also able to provide substantial assurance for each of the individual objectives, as detailed within the Assurance Summary table.

Our report makes two low priority recommendations, which are forward looking given the review focused on 2021/22 arrangements. The recommendations can be taken forward to 2022/23 and relate to:

- The transparency of reprofiling recovery funding; and
- The timeliness of information contained within the Board Assurance Framework.

### Report Classification

Substantial



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

**Low impact** on residual risk exposure.

### Assurance summary<sup>1</sup>

Assurance objectives	Assurance
1 Appropriate governance arrangements have been established which provide effective oversight	Substantial
2 Deliverables outlined within the Addendum to the 2021/22 Annual Plan are regularly monitored	Substantial
3 The Board Assurance Framework adequately highlights the risk of delivery of the Annual Plan 2021/22	Substantial

<sup>1</sup>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

### Key Matters Arising

There are no key matters arising to report on this occasion.

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## 1. Introduction

- 1.1 The review of 'Recovery of Services and Delivery of the Annual Plan 2021-2022' was completed in line with the Cardiff and Vale University Health Board's (the 'Health Board') 2021/22 Internal Audit Plan.
- 1.2 The NHS Wales Annual Planning Framework 2021–22, which was published on 14 December 2020, noted that, *"This framework is by necessity different from previous versions in that it requires organisations to provide an annual plan that builds on the quarterly operational planning arrangements of 2020/21. It seeks to set out short, sharp requirements for the coming year but also provide a guide for some of the longer term objectives that NHS Wales and the Welsh Government have committed to, which must not be lost sight of as we seek to build back stronger as part of medium to longer term recovery and stabilisation."*<sup>1</sup>
- 1.3 The 2020/21 Internal Audit Plan included an audit of the 'Annual Planning Process 2021-22' (CVU 2021-08), the final audit report was published on 28 May 2021, which reported substantial assurance.
- 1.4 A Special Board Meeting took place on 24 June 2021, where the Annual Plan 2021-22 was resubmitted for approval, the report noted, *"WG required the HEALTH BOARD to submit a Board approved 'draft' plan in March with the expectation that a final plan was resubmitted by the 30 June 2021. Guidance received from WG in late May requested that a draft of the updated plan was submitted by the 11 June 2021."*
- 1.5 The resubmitted Plan incorporated an Addendum, 'Planning for Recovery and Redesign', which included five programmes, supported by a number of schemes: 1. Primary and Community Care, 2. Mental Health, 3. Planned Care, 4. Unscheduled Care, and 5. Diagnostics.
- 1.6 The joint executive leads for the review are the Interim Chief Operating Officer and Executive Director of Strategic Planning.

### Audit Risk

- 1.7 The Health Board had identified the following risk within the Board Assurance Framework, for which the Executive Director of Strategic Planning is the lead (March 2022):
  - Risk of Delivery of Annual Plan 2021/22 - The Health Board will not deliver the objectives set out in the Annual Plan due to the challenge around recovering the backlog of planned activity.

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<sup>1</sup> <https://gov.wales/nhs-wales-planning-framework-2021-2022>

### Limitation of scope

- 1.8 This audit did not review the scheme deliverables, rather the mechanisms for monitoring, reporting and actions taken in response to the monitoring process.

## 2. Detailed Audit Findings

### **Objective 1: Appropriate governance arrangements have been established which provide effective oversight of development and delivery of the recovery and redesign portfolio, ensuring that it is subject to scrutiny and review**

#### Development and context of the Recovery and Redesign Addendum

- 2.1 The Health Board had a short window of time to develop the 'Recovery and Redesign Addendum' (the Addendum) to the Annual Plan 2021/22, approved by the Board in June 2021 and submitted to Welsh Government. The Addendum details the five programmes which are underpinned by a number of schemes. The schemes in the Annual Plan represented both that had already received financial support plus new schemes for which the UHB was requesting additional funding from WG to support return to pre-covid activity levels in order to improve access and reduce waiting times.
- 2.2 At the time of developing the Addendum, the Health Board was aware that there would be funding for recovery schemes, but there was no certainty about the amount of funds which would be made available or which schemes would be supported, we noted these discussions in the Portfolio Board minutes.
- 2.3 We were informed by management that, in the knowledge that funding would become available but would likely have the requirement that it would have to be utilised by the end of March 2022, a decision was made via Management Executive (and through to the Strategy and Delivery Committee) to progress some of the schemes at risk with the acceptance that there was some uncertainty of the eventual level of funding and which schemes would be funded by the Welsh Government. Management confirmed that these decisions were communicated to Welsh Government.
- 2.4 The Welsh Government announced recovery funding in tranches. The first tranche of money was announced in May 2021 and totalled £13.662m. A further £11.536m was confirmed on 29 September 2021. A total of £25.198m. The total ask of the Recovery Plan (as per the Addendum) was £37.236m. In October 2021, a further £2.208m was issued by Welsh Government which could be allocated against some of the unfunded recovery schemes.

#### Governance of Recovery and Redesign

- 2.5 To oversee recovery efforts the Health Board set up a Recovery and Redesign Portfolio Board, which has responsibility for overseeing the development and implementation of the Recovery and Redesign Programmes. The Health Board

appointed a Recovery and Redesign Programmes Delivery Director to oversee the Portfolio, as Senior Responsible Officer and chair of the Portfolio Board. The Interim Chief Operating Officer is the executive sponsor for the Portfolio.

- 2.6 The Portfolio Board first met in September 2021, membership was designed to reflect both clinical and corporate teams with responsibility for ensuring progression and implementation of the recovery programmes, designed to drive the Health Board’s recovery from COVID-19 and to return to pre-Covid levels of activity.
- 2.7 The audit reviewed the documentation received by the Portfolio Board and was able to confirm that for each month the Board received Flash Reports (highlight reports), Dashboard Reports and Risks, Actions, Issues and Decisions (RAID) logs. Minutes were taken at each meeting and reviewed at the subsequent meeting. We were advised that in response to the winter pressures and the COVID Omicron variant, Portfolio Board meetings were stepped down at the start of 2022, but papers were still circulated.
- 2.8 We further confirmed that the Strategy and Delivery Committee was receiving copies of the Flash Reports and that the Committee through the Chair was providing updates to the Board.

Conclusion 1: Governance arrangements have been established which provide effective oversight of development and delivery of the Recovery and Redesign Portfolio. The Strategy and Delivery Committee are receiving updates from the Portfolio Board and provide a summary to the Board. (Substantial Assurance).

**Objective 2: Deliverables outlined within the Addendum to the 2021/22 Annual Plan are regularly monitored, with assurance provided to the Board and where performance issues are encountered, appropriate rectifying action is undertaken**

- 2.9 We note in paragraph 2.4 that funding for the schemes outlined in the Addendum were not confirmed in full until the end of September 2021. To ensure progress was made on the Recovery Programme schemes commenced before funding was confirmed, on the basis that some were at risk if funding was not received.
- 2.10 A sample of schemes were tested to confirm that monitoring and reporting to the Portfolio Board was taking place and that updates were provided to the Strategy and Delivery Committee. The schemes sampled are included below:

<b>Recovery &amp; Redesign Programme</b>	<b>Scheme</b>	<b>Description</b>
Primary & Community Care	MDT Clusters	Multidisciplinary Teams (MDT) approach to the care of complex patients at home through provision of hub teams.

<b>Recovery &amp; Redesign Programme</b>	<b>Scheme</b>	<b>Description</b>
	General dental services / Orthodontics	Additional capacity on weekends / evenings to address backlog.
	Oral Surgery – Transfer of extractions	Transfer of some extraction procedures from the acute hospital to community setting, to take pressure off secondary care.
	Eye Care Specialist Optometrists	Upskilling Optometrists with the Higher qualifications in Glaucoma, Medical Retina and Independent Prescribing. To assess outpatients with complex eye problems, thereby reducing pressures on secondary care.
Diagnostics	Endoscopy insourcing extension	Increase current insourcing contracts to increase provision.
	Mobile Theatre	A mobile endoscopy theatre based at UHL to provide additional capacity to deliver diagnostic and surveillance procedures and reduce the wait for patients.
Unscheduled Care	Same Day Emergency Care (SDEC)	The delivery of a comprehensive SDEC provides an alternative for emergency patients who would otherwise be admitted to hospital. Patients presenting with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward.
Planned Care	Gynaecology Treatment Room	Set up a gynaecology treatment pathway within current outpatient setting that will increase outpatient operating capacity and reduce waiting lists for treatment and diagnostics.

2.11 As schemes progressed it became apparent that delays in recruiting and procurement meant that the delivery of some schemes would slip. As an example, the drive to increase endoscopy activity, where the benefit was delayed due to delays in the contractor being able to deliver the mobile units, which meant that the benefit of the scheme was delayed into the 2022/23 financial year. We noted that some expenditure was reprofiled into areas such as increased insourcing where waiting lists were growing.

2.12 We reviewed all Dashboard and Flash reports which were produced from October 2021 to March 2022, and we are able to confirm the appropriate monitoring and reporting of the schemes. We interrogated the December to March reports to confirm that the expenditure was monitored and slippage within schemes was identified, so that the recovery funding could be utilised in other areas that would help increase activity to pre-COVID levels. The Portfolio Dashboard reports did not

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outline where the slippage expenditure was being redirected to, although we did find evidence that there was a procedure in place to redirect funds which could not be utilised within 2021/22 for the schemes which they were originally allocated.  
(Matter Arising 1 – Low Priority)

2.13 We reviewed the Strategy and Delivery and Committee papers from October to March and confirmed that the Committee was receiving updates on the Recovery Programme and the risks to the programme, which were as noted above around recruitment and procurement.

Conclusion 2: In the most part, we found that there were systems and controls operating effectively for the monitoring and reporting of recovery schemes, but an inclusion within the latter reports of where slippage expenditure was being redirected would have provided more detail and completeness to users of the reports. (Substantial Assurance)

**Objective 3: The Board Assurance Framework adequately highlights the risk of delivery of the Annual Plan 2021/22 and the associated controls and assurances, in addition to identifying the gaps in controls and assurances.**

2.14 The March 2022 Board Assurance Framework (BAF), Risk 7 - Risk of Delivery of Annual Plan 2021/22 identifies that; *"There is a risk that the Health Board will not deliver the objectives set out in the Annual Plan due to the challenge around recovering the backlog of planned activity ... not taking the opportunity to do things differently and the potential risk associated with the Medium Term Financial position all of which could impact upon delivery of the Annual Plan."*

2.15 We were able to confirm that the risk mitigation detailed in the BAF "Monitor implementation of Annual Plan and continue to report through Strategy and Delivery Committee and Welsh Government via monthly meeting", reflected the mitigation that we found to be in place during our testing of this area. However, we found that the 'Gaps in Assurances' was not entirely reflective of the position (as at March 2022), as it stated *"the Health Board is unsure on the timeliness of money being released from WG"*. This was no longer the case, at the end of September 2021 the Health Board was advised about the awarding of funding, and in November advised that funding would be recurrent for a further three years.  
(Matter Arising 2 – Low Priority)

Conclusion 3: In the most part, the BAF reflected the risk of delivery of the Annual Plan, however the 'Gaps in Assurances' required a refresh. (Substantial Assurance)

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## Appendix A: Management Action Plan

Matter Arising 1: Transparency of reprofiling recovery funding (Operation)		Impact
<p>We acknowledge that the Portfolio Board is no longer in place, as the Health Board transitions from COVID Recovery and Redesign to one holistic Operational Plan for 2022/23, with revised governance arrangements of the new Operational Plan Delivery Group. However, we did identify that there was opportunity for greater transparency of slippage of schemes and how funds were redirected to other recovery schemes. The Portfolio Dashboard reports did not outline where the slippage expenditure was being redirected, although we did find evidence that there was a procedure in place to redirect funds which could not be utilised within 2021/22 for the schemes for which they were originally allocated.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>A lack of transparency on the reallocation of funding.</li> </ul>
Recommendation 1		Priority
<p>Within the governance arrangements for 2022/23 onwards, where slippage requires funds to be redirected, that information on where the funds have been reallocated to is included in the reports to the appropriate governance group.</p>		<b>Low</b>
Agreed Management Action 1	Target Date	Responsible Officer
<p>In reporting against the 2022/23 plan, any financial under or overspend will be included. Where slippage is identified, plans for deployment of slippage will be agreed and reported through the Operational Plan Delivery Group and on to Management Executives.</p>	July 2022	Hannah Evans, Recovery and Redesign Programmes Delivery Director




Matter Arising 2: Updating the Board Assurance Framework (Operation)		Impact
<p>We reviewed the Board Assurance Framework (BAF), Risk 7 - Risk of Delivery of Annual Plan 2021/22 as at March 2022, and found that the 'Gaps in Assurances' had not been updated to reflect the position we found at the time of our review.</p> <p>The 'Gap in the Assurances' stated that <i>'the Health Board is unsure on the timeliness of money being released from WG'</i>. This was no longer the case by March 2022, in October 2021 the Health Board was advised about the awarding of funding and in November advised that funding would be recurrent for a further three years.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>The current level of risk is not reflected in the BAF.</li> </ul>
Recommendation 2		Priority
<p>It is acknowledged that the Board Assurance Framework (BAF) will be redrafted for 2022/23 and that the risk reviewed is no longer relevant. However, future reviews of the BAF should ensure that the 'Gaps in Assurances' are updated as the risks evolve to reflect an up to date position.</p>		<b>Low</b>
Agreed Management Action 2	Target Date	Responsible Officer
<p>Agreed - This question is always raised in each discussion with the Executive Lead therefore it will be important to ensure that Executive Leads reflect changes to the BAF in their discussion with the Director of Corporate Governance.</p>	<p>From 1<sup>st</sup> July throughout the year</p>	<p>Director of Corporate Governance with relevant Executive Lead for BAF Risk.</p>

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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:

	<b>Substantial assurance</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable assurance</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited assurance</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>No assurance</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Assurance not applicable</b>	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
<b>High</b>	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*
<b>Medium</b>	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
<b>Low</b>	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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# Risk Management

## Final Internal Audit Report

June 2022

Cardiff & Vale University Health Board



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Executive sign-off:	Nicola Foreman, Director of Corporate Governance
Distribution:	Aaron Fowler, Head of Risk and Regulation
Committee:	Audit & Assurance Committee



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

### Acknowledgement

NHS Wales Audit 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 & 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 and Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

# Executive Summary

## Purpose

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

## Overview



We have issued reasonable assurance on this area.

For three of the five objectives reviewed we have offered reasonable assurance, largely due to the continued efforts required by Clinical Boards and Corporate Departments to enhance their risk registers, as highlighted in the key matter arising below.

We also note that the tools available to management are lacking, in that risk registers are currently held in spreadsheets, which limits the visibility of risks and the ability to profile and aggregate risks across the Health Board. We make no recommendation in this area given an all-Wales solution is being developed but highlight the position, and the impact on the assurance we can offer against Objective 3.

Our report makes two further low priority recommendations, which are best practice in nature to support the Health Board’s risk maturity.

## Report Classification

		Trend
	<b>Reasonable</b> Some matters require management attention in control design or compliance.	 2020/21
<b>Low to moderate impact</b> on residual risk exposure until resolved.		

## Assurance summary<sup>1</sup>

Assurance objectives	Assurance
1 Up to date Risk Management Strategy and Procedures.	Substantial
2 Risks are managed effectively at Clinical Board/Corporate Department level.	Reasonable
3 Risks are profiled and aggregated where possible.	Reasonable
4 Risks are consistently captured, scored and mitigated (where applicable).	Reasonable
5 Progress with internal audit recommendations from 2020/21 Risk Management audit.	Substantial

<sup>1</sup>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matter Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
2 Enhancements required to Clinical Board and Corporate Department Risk Registers	2 & 4	Operation	Medium

## 1. Introduction

- 1.1 The review of Risk Management was completed in line with the 2021/22 Internal Audit Plan for the Cardiff and Vale University Health Board (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 Effective risk management is a key component of corporate and clinical governance, which is integral to the delivery of organisational objectives. *"The Board Assurance Framework provides the Board with information on the key Strategic Risks that could impact upon the delivery of the Health Board's Strategy 'Shaping our Future Wellbeing'. It provides information on the controls and assurances in place to manage and/mitigate the risks identified and any further actions which are required".*<sup>1</sup>
- 1.3 At the Board's meeting on 27 January 2022, the Corporate Risk Register (CRR) (item 8.1) and Board Assurance Framework (BAF) (item 7.1) were presented. The covering report accompanying the CRR noted, *"The Risk and Regulation Team continue to work alongside clinical boards and corporate departments to ensure that risks are clearly defined and appropriately scored in line with the Health Board's Risk Management Strategy and Procedure."*<sup>1</sup>
- 1.4 An internal audit of risk management is undertaken annually, with a change in focus year on year. The 2020/21 review of risk management (audit reference CVU-2021-02) reported Reasonable Assurance. The review had focused on the governance and leadership, particularly the Risk Management framework, Board Assurance Framework and Corporate Risk Register. In this review for 2021/22 greater emphasis was placed on the local arrangements within Clinical Boards and Corporate Departments.
- 1.5 The Director of Corporate Governance is the lead for this review.

### Audit Risks

- 1.6 The potential risks considered in this review are as follows:
  - Lack of awareness of the Risk Management Framework and supporting processes;
  - Risks are not managed in line with the Health Board's policy and procedure;
  - Risk management arrangements operate in silos and fail to provide a comprehensive risk profile of the Health Board;
  - Appropriate action is not taken because risks are not being escalated through the Health Board as appropriate; and
  - Exposure to reputational damages due to inadequate identification, assessment and inclusion of risk in the risk registers.

<sup>1</sup> <https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/27-1-22-final-boardbook-v9-pdf/>

## 2. Detailed Audit Findings

**Objective 1: An up to date, comprehensive Risk Management and Board Assurance Framework Strategy has been approved by the Board, and documented risk management procedures underpin and support the effective delivery of the strategy.**

2.1 The Health Board has developed a comprehensive 'Risk Management and Board Assurance Framework Strategy', which was most recently received by the Audit Committee<sup>2</sup>, and approved by the Board in July 2021<sup>3</sup>. Our review of the latest approved Strategy confirmed that the document comprehensively outlines the following:

- Responsibilities for strategic and operational risk management for the Board and staff throughout the Health Board;
- Describes the framework in place for identifying, analysing, evaluating and controlling risks to the delivery of strategic objectives;
- Defines the Health Board's approach to risk appetite;
- Sets out the training arrangements with respect to risk management; and
- Incorporates and references risk management best practice guidance.

2.2 The Health Board has documented Risk Management Procedures which underpin and support the effective delivery of the Risk Management and Board Assurance Framework Strategy. The Procedures were reviewed and approved at the same time as the Risk Management and Board Assurance Framework Strategy by the Board in July 2021.

2.3 It was noted that both the strategy and procedures had been reviewed and revised by the Risk and Regulation Team to incorporate risk management standards and best practice as recommended by us when we reviewed the risk management arrangements during 2020/21. We did note however, that the assurance approach taken by the Health Board in relation to the 'three lines of defence'<sup>4</sup> varied slightly from the best practice guidelines, which we will consider in further detail when we undertake a planned piece of work in 2022/23 relating to Assurance Mapping.

2.4 The risk management strategy and procedures are readily available to all staff and public via the Health Board's website.

**Conclusion 1: We can confirm that the Health Board has developed a comprehensive 'Risk Management Board Assurance Framework Strategy' and 'Risk Management Procedures', which are routinely reviewed and revised by the Risk and Regulation Team, and approved by the Board. (Substantial Assurance)**

<sup>2</sup> <https://cavuhb.nhs.wales/files/board-and-committees/audit-and-assurance-committee-2021-22/06-07-2021-audit-committee-papers-v1-pdf/> (Item 8.5)

<sup>3</sup> <https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/board-papers-29-07-2021-v3-pdf/> (Item 7.1)

<sup>4</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/866117/6.6266\\_HMT\\_Orange\\_Book\\_Update\\_v6\\_WEB.PDF](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/866117/6.6266_HMT_Orange_Book_Update_v6_WEB.PDF) (page 33 of 48)

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**Objective 2: In accordance with approved policy and procedure there are effective processes in place to manage risks within the Clinical Boards and Corporate Departments, which includes the escalation of risks.**

- 2.5 Meetings were held with risk owners/leads from the following sample of Clinical Boards and Corporate Departments to ascertain the risk management arrangements in place:
- Medicine Clinical Board;
  - Children and Women’s Clinical Board; and
  - Capital and Estates Corporate Department.
- 2.6 During 2021/22 we also undertook an advisory audit within the Mental Health Clinical Board (2122.28), which gave us a depth of understanding of processes and the risk registers held, which also informed this review.
- 2.7 Discussions with our sampled risk areas and a review of risk registers confirmed that there was an adequate understanding of the Health Board’s risk management framework and of the roles and responsibilities of staff in relation to managing risk. Appropriate mechanisms were confirmed as being in place to effectively identify and report on new or emerging risks. It was found that there are appropriate reporting channels to elevate the profile of risks identified and these include one to one meeting with line management, weekly/monthly operational team meetings and senior management meetings. We did identify issues when reviewing the risk information captured within Clinical Boards and Corporate Department risk registers, and this has been detailed under Objective 4 and referred to in Matter Arising 2.
- 2.8 Clinical Boards and Corporate Departments are responsible for reviewing their risk registers and selecting risks for escalation to the Corporate Risk Register for presentation to the Board on a quarterly basis. Health Board guidance states that these risks should either have a residual score of 20 and above, or should be risks which cannot be managed effectively at Clinical Board or Corporate Department level and thus the profile needs to be raised through the governance structure.
- 2.9 The escalation process has been in place for some time, however it was strengthened in 2021 by the Risk and Regulation Team. It had been considered that too many risks were being escalated to the Corporate Risk Register without having received the proper review and scrutiny and this was impacting the ability to maintain an accurate and up to date Corporate Risk Register. As such a ‘check and challenge’ process was introduced whereby Clinical Boards and Corporate Departments would provide candidate risks for escalation and these would be reviewed and assessed by the Risk and Regulation Team prior to inclusion to the Corporate Risk Register.
- 2.10 Following the check and challenge process, feedback is provided to the relevant areas by the Risk and Regulation Team. We were able to evidence the operation of the process. It was confirmed that the check and challenge process was in place

for January and March 2022, however the level of engagement by each area was not consistent throughout.

- 2.11 Whilst we note the clear improvements from the implementation of the check and challenge process, the effectiveness relies on the level of engagement by the relevant area and feedback. Identified areas of improvement are communicated individually to each area rather than being shared across the Health Board, which could be a missed opportunity for the Health Board to identify, share and enhance risk management practice consistently.
- 2.12 There are currently no risk management groups in operation, such as a network of risk champions or a steering group. We have observed in other public sector organisations that a Risk Management Steering Group has taken a key role in the agreement of escalation of risks to the Corporate Risk Register. The Health Board may wish to consider if there is value in creating such a group / network, to reduce some of the reliance currently placed on the Risk and Regulation Team. (*Matters Arising 1 - Low Priority*)

**Conclusion 2:** Whilst Clinical Boards and Corporate Departments are broadly adhering to the Risk Management Strategy and Procedures, there is still room for improvement within the risk registers held locally. Also, the arrangements to escalate risks from a Clinical Board or a Corporate Department were evident, but we have sighted alternative practices in other public sector organisations which the Health Board may want to consider. (Reasonable Assurance)

**Objective 3: Clinical Boards and Corporate Departments effectively profile their risks, and aggregate them where appropriate, in support of governance and decision making requirements.**

- 2.13 Whilst the Health Board has adequately documented the approach to risk profiling within the Risk Management Strategy and Procedures it was difficult to evidence this objective at a Clinical Board and Corporate Department. Currently, risk registers are held in spreadsheets and reside within each Clinical Board and Corporate Department, thus there is little visibility across the organisation and limited opportunity for risk aggregation. We acknowledge that management are aware of this issue, and it was also highlighted in the 2020/21 audit of Risk Management.
- 2.14 Currently, the Health Board is awaiting the rollout of an All-Wales web based risk management system, which is expected to aid the capturing and recording of risk management information, to facilitate risk profiling and aggregation. The risk solution falls within the 'Once for Wales Project', which the Head of Risk and Regulation, and Risk and Regulation Officer are members. The solution is expected to be rolled out through 2022/23, after a period of slippage.

**Conclusion 3:** Whilst we make no recommendations in this area, we are unable to offer substantial assurance given the lack of available tools to facilitate the effective profiling

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and aggregation of risks. The 'Once for Wales – risks management module' has the potential to enhance this area, once rolled out. (Reasonable Assurance)

**Objective 4: There are processes in place to ensure the consistency of capturing, scoring and mitigating risks.**

2.15 The Risk and Regulation team have developed a risk register template which is annexed to the Risk Management and Board Assurance Framework Strategy and Procedures. At the time of the audit, risk registers were requested from a sample of Clinical Boards and Corporate Departments and the content was reviewed. On the whole we found the registers to be in keeping with the template.

2.16 On review of the content of the sampled risk registers we identified a number of gaps, which were reoccurring across the sample of risk registers. As stated within the Risk Management Strategy and Procedures, risk owners are responsible for reviewing and updating information within their risk registers to inform decision making. This is an area for improvement for the Health Board. (*Matters Arising 2 - Medium Priority*)

2.17 Our findings from reviewing the sampled risk registers were consistent with the feedback being provided by the Risk and Regulation Team, as part of the check and challenge process. Whilst some of the issues identified are housekeeping matters, there is a need to continue educating and training staff to ensure that the risk registers are being updated accordingly. The Risk and Regulation Team have provided risk management training in the past and this must continue where it is deemed appropriate. (*Matters Arising 3 - Low Priority*)

Conclusion 4: Momentum needs to continue to enhance the risk registers currently held by the Clinical Boards and Corporate Departments, where onus lies locally, and continued training by the Risk and Regulation Team will support the improvement agenda. (Reasonable Assurance)

**Objective 5: The audit will identify the progress of implementing the internal audit recommendations raised in the 2020/21 audit of risk management**

2.18 The Audit Committee is provided with regular updates on the implementation of internal audit recommendations via the 'Internal Audit Tracking' Report.

2.19 The Head of Risk and Regulation also presented a 'Risk Management System' report to the Audit Committee in February 2022, setting out the progress of the five recommendations raised in the Risk Management audit 2020/21.

2.20 We are satisfied that the internal audit recommendations raised in the 2020/21 audit of risk management have been implemented.

Conclusion 5: The Health Board has progressed with the implementation of the recommendations raised in the 2020/21 audit of risk management, improvements are noted throughout this report. (Substantial Assurance)

## Appendix A: Management Action Plan

Matter Arising 1: Facilitation of risk escalation to the Corporate Risk Register (Operation)		Impact
<p>The means of Clinical Board and Corporate Department risks being escalated onto the Corporate Risk Register is facilitated by the check and challenge process instigated by the Risk and Regulation Team, which is a noted improvement in the past year, but places the Team as gate keepers to the Corporate Risk Register.</p> <p>In other organisations we have witnessed this being undertaken by a risk management steering group, with a mix of senior individuals and input from an independent member of the Board.</p>		<p>Poor visibility of new and emerging high-profile risks impacting the Health Board's ability to manage these appropriately.</p>
Recommendation 1		Priority
<p>Consideration should be given to the roles and responsibilities associated with the 'check and challenge' process of proposed corporate risks, beyond the Risk and Regulation Team, and whether there would be value in holding a risk management steering group.</p>		<p><b>Low</b></p>
Agreed Management Action 1	Target Date	Responsible Officer
<p>It is agreed that consideration will be given to this recommendation albeit the ability to achieve this recommendation will, to a large degree be dependent on the availability of risk leads to meet to discuss and review their risks at an agreeable and consistent time.</p>	<p>31.12.2022</p>	<p>Head of Risk and Regulation</p>

<b>Matter Arising 2: Enhancements required to Clinical Board and Corporate Department Risk Registers (Operation)</b>	<b>Impact</b>
<p>Gaps were noted when reviewing the content of risk registers for the sampled Clinical Boards and Corporate Departments. As stated within the Risk Management Strategy and Procedures, risk owners are responsible for reviewing and updating information within their risk registers to inform decision making. A summary of the issues found during our testing has been detailed below:</p> <ul style="list-style-type: none"> <li>• Some risk registers adopted individual layouts which were not consistent with the approved risk register template;</li> <li>• A number of risk registers omitted target dates and information on risk ownership for improvement actions relating to risks;</li> <li>• Target dates for improvement actions had lapsed and there was no information to suggest that these had been reviewed in a timely manner;</li> <li>• A number of risk descriptions suggested that the risk had already materialised and was in fact an issue rather than a potential risk which may or may not occur; and</li> <li>• Other gaps were noted such as no link to the strategic objectives, no assignment of risk owners and gaps in mitigating actions.</li> </ul>	<p>Poor decision making as risk management information is missing and/or not up to date.</p>
<b>Recommendation 2</b>	<b>Priority</b>
<p>Risk owners should be reminded of their roles and responsibilities to ensure that the risk management information held within the risk registers is complete and regularly reviewed and updated.</p>	<p style="text-align: center;"><b>Medium</b></p>

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Agreed Management Action 2	Target Date	Responsible Officer
Recommendation Agreed – Feedback on Risk Registers will continue to be provided to Risk Leads. Such feedback will, moving forward, incorporate the detail referred to in this recommendation.	30.09.2022	Head of Risk and Regulation

Matter Arising 3: Risk Management Training	Impact	
<p>Matter Arising 2 identifies gaps within Clinical Board and Corporate Department risk registers, highlighting that there is a need to continue educating and training staff to ensure that the risk registers are being updated accordingly.</p> <p>We note that the delivery of training has been a challenge through the COVID-19 pandemic.</p>	Limited risk management maturity and risk management culture within the organisation.	
Recommendation 3	Priority	
Continued efforts should be made to provide risk management training to risk owners, to maintain momentum of risk management maturity within the Health Board.	<b>Low</b>	
Agreed Management Action 3	Target Date	Responsible Officer
Recommendation Agreed – Training will continue to be provided to staff both proactively through offers for training, and reactively in response to specific requests.	01.07.2022	Head of Risk and Regulation

## 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:

	<b>Substantial assurance</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable assurance</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited assurance</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>No assurance</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Assurance not applicable</b>	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
<b>High</b>	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*
<b>Medium</b>	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
<b>Low</b>	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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# Performance Reporting (Data Quality)

## Final Internal Audit Report

June 2022

Cardiff & Vale University Health Board



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Auditors:	Olubanke Ajayi-Olaoye, Principal Auditor Wendy Wright-Davies, Deputy Head of Internal Audit
Executive sign-off:	David Thomas, Director of Digital and Health Intelligence
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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 Institute of Internal Auditors.

### Acknowledgement

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

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## Executive Summary

### Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to Performance Reporting (Data Quality).

The review specifically focused on the 'Integrated Performance Report' and the processes in place for its production and reporting.

### Overview

We have issued reasonable assurance on this area.

We have made two medium priority recommendations which require management attention, both fall within objective two of this review and focus on the robustness of systems and processes to capture and validate the data within the Integrated Performance Report, specifically the Balanced Scorecard.

Whilst we found no fundamental data quality issues within our sample, we did note the absence of data completely for one indicator. The recommendations proposed, once implemented would enhance the clarity and completeness of the report.

Other low priority recommendations are within the detail of the report.

### Report Classification

Reasonable



Some matters require management attention in control design or compliance.

**Low to moderate** impact on residual risk exposure until resolved.

### Assurance summary<sup>1</sup>

Assurance objectives	Assurance
1 Appropriate governance arrangements for effective reporting of the Integrated Performance Report	Substantial
2 Robustness of systems and processes to capture and validate the data required to produce the Integrated Performance Report	Reasonable
3 Timely compilation of the Integrated Performance Report	Substantial

<sup>1</sup>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

### Key Matters Arising

	Assurance Objective	Control Design or Operation	Recommendation Priority
2	Data accuracy and completeness of the Balanced Scorecard	Operation	Medium
4	Further enhancements to develop the Balanced Scorecard	Operation	Medium

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## 1. Introduction

- 1.1 The review of Performance Reporting (Data Quality) was completed in line with the 2021/22 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').
- 1.2 Effective performance reporting is integral to the Health Board's overall management and assurance arrangements. Performance reporting should focus on continuous improvement and delivering improved outcomes, highlighting when action is required to meet expected outcomes aligned to overall strategy and ministerial priorities.
- 1.3 Through 2020/21 the Health Board has been developing an Integrated Performance Report, which was first presented in the public session of the Board in November 2021, previous performance reporting was disaggregated. The new report includes an emerging Balanced Scorecard, with indicators that bring together Quality and Safety, Finance, Workforce, Performance and Population Health for the Health Board.
- 1.4 As noted in the Integrated Performance Report presented to the Board on 27 January 2022, *"This report provides the Board with a summary of performance against a number of key quality and performance indicators. This will include areas where the organisation has made significant improvements or has particular challenges including the impact of COVID-19, together with areas where the Health Board is under formal escalation measures from the Welsh Government and/or where local progress is being monitored."*<sup>1</sup>
- 1.5 Audit Wales, through their Structured Assessment 2021 (phase two) reported on the Integrated Performance Report, *"The Board has started to receive and consider the Integrated Performance Report in public since November 2021. Whilst this is a positive development, there is scope to enhance the report by aligning the indicators to the four harms associated with COVID-19, as well providing stronger assurances to the Board on the actions being taken to sustain or improve performance."*<sup>2</sup>
- 1.6 The focus of our current review was to evaluate the processes for ensuring the quality of the data within the report, and not how the Health Board is utilising the report to address performance issues or drive improvements.
- 1.7 The Director of Digital and Health Intelligence is the lead for this review.

<sup>1</sup> <https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/27-1-22-final-boardbook-v9-pdf/>

<sup>2</sup> <https://cavuhb.nhs.wales/files/board-and-committees/audit-and-assurance-committee-2021-22/audit-080222-final-boardbook-v7-0-pdf/>

## Audit Risks

- 1.8 The potential risks considered in this review are as follows:
- Inaccurate and incomplete performance information;
  - Health Board's exposure to reputational damages; and
  - The service does not meet performance measures due to ineffective monitoring and governance arrangements.

## 2. Detailed Audit Findings

### **Objective 1: Appropriate governance arrangements are in place to ensure effective reporting and oversight of the Health Board's Integrated Performance Report**

- 2.1 The Director of Digital and Health Intelligence takes the lead on compiling the Integrated Performance Report, with information provided from key areas including, Quality and Safety, Finance, Workforce, Performance and Public Health.
- 2.2 The executive leads for the report, as listed in the cover reports to the Board include the Executive Director Nursing, Interim Chief Operating Officer, Executive Director People and Culture, and Executive Finance Director.
- 2.3 In advance of the Integrated Performance Report being presented to the Board, the Executive Management Team receive the report, as evidenced on 7 March 2022. Minutes of the meeting confirmed that it had previously been agreed that the draft report would be received by the Management Executive in advance of presentation at the Board. The minutes further confirmed that the report remains a 'living and developing' document. It was resolved at the meeting that the report would be taken to the Board and that further amendments would be made for future Board meetings.
- 2.4 A review of the Board papers highlighted that the Board have received the Integrated Performance Report on 25 November 2021, 27 January 2021 and 31 March, which included the emerging Balanced Scorecard.

**Conclusion 1:** The Integrated Performance Report remains under development, but we were able to evidence the oversight by the Management Executive Team and the reporting to the Board. (Substantial Assurance)

### **Objective 2: The robustness of systems and processes to capture and validate the data required to produce the Integrated Performance Report and the balanced scorecard**

#### Guidance to support the compilation of the Integrated Performance Report

- 2.5 At the commencement of the review the Information Manager (Analytics Team) provided a copy of the draft 'Procedure to compile the Cardiff and Vale Integrated Performance Report for Executive Management Team and Public Board Meeting',

which has been under development through 2021/22, in tandem with the development of the Integrated Performance Report. We support the continued development and finalisation of the guidance to support key processes and to facilitate resilience. *(Matter Arising 1- Low Priority)*

#### Collation and submission of the Integrated Performance Report

- 2.6 We were advised that the Information Manager works with the respective thematic leads to collate the information to inform the Integrated Performance Report. We noted that the Quality and Safety section of the report involves input from a number of sources, and this was being streamlined at the time of our review, the Assistant Director of Patient Experience confirmed the revised approach.
- 2.7 There is a standardised Integrated Performance Report template in place. To minimise the risk of error and avoid transposition errors, we were advised that the Information Manager 'cuts and pastes' information received as opposed to typing into the template.
- 2.8 The Integrated Performance Report once collated is submitted to the Corporate Governance team for presentation at the Executive Management Team by the Director of Digital and Health Intelligence. The Information Manager incorporates any proposed amendments by the Executive Management Team in advance of preparing for submission to the Board.

#### Data validation of the Integrated Performance Report

- 2.9 Our audit testing to validate the data within the Integrated Performance Report was measured against the report presented to the Board on 31<sup>st</sup> March 2022.<sup>3</sup> Our sample extended across four of the five themes. We did not take a sample from the Population theme whilst this review was progressing, since we were also undertaking a review of 'COVID-19 Vaccination Programme - Phase 3 delivery (2122.10)', which the Public Health team were already actively contributing to.
- 2.10 We selected a sample of measures from the Balanced Scorecard contained within the Integrated Performance Report, as outlined below:

<b>Scorecard Theme</b>	<b>Audit Sample</b>
Finance	Deliver 2021/22 Draft Financial Plan
	Creditor payments compliance 30-day Non-NHS (Cumulative)
Performance	A&E 12 hour waiting times
	Mental Health 1a
Quality & Safety	Patient Satisfaction: 30 day complaints response compliance %

<sup>3</sup> <https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/2022-03-31-public-board-papers-v14-pdf/> (item 6.11)

	Patient Experience: Mass Vaccination Centres and Other Hospital Environments
	Mortality: Risk Adjusted Mortality Index (RAMI)
	Mortality: Number of still births
Workforce	Staff Turnover Rate
	Achieve annual local sickness and absence workforce target (rolling 12 month)

2.11 Overall, for the measures sampled we were able to substantiate the accuracy of the data presented in the Balanced Scorecard. Although, we identified two instances from the 10 that were impacted by rounding / transposition anomalies, and one of the indicators could not be validated due to the absence of data. (*Matter Arising 2 – Medium Priority*)

2.12 We also observed from our audit sample that the data quality risks associated with the indicators are not all equal, some are at greater risk of error because of manual intervention. (*Matter Arising 3 – Low Priority*)

#### General observations outside of the audit sample

2.13 We undertook a general review of the Balanced Scorecard, beyond the audit sample and have identified points for consideration and enhancement to support the ongoing development of the report. (*Matter Arising 4 – Medium Priority*)

Conclusion 2: The Integrated Performance Report has been under development through 2021/22. Whilst acknowledging this, our recommendations made under this objective will support the future development of the report, and enhance the systems and processes in place to capture and validate the data, which feeds into the report. (Reasonable Assurance)

### **Objective 3: The timely compilation of the Integrated Performance Report for reporting to the relevant governance fora**

2.14 There is a timetable in place for compiling the Integrated Performance Report for presentation at the Executive Management Team and Board, which covers the Board meetings through 2022/23. The timeline details the following:

- Digital and Health Intelligence team's start date for collation of Integrated Performance Report cycle;
- Deadline date of Integrated Performance Report submission to Corporate Governance for Executive Management meeting;
- Date of the Executive Management Meeting;
- Deadline date of Integrated Performance Report submission to Corporate Governance for the Board meeting (papers deadline); and
- Date of Board Meeting.

- 2.15 We were able to evidence the communication with key leads to confirm the timeline and any noted changes, such as the impact of bank holidays. Clear requests are made for statistics, graphs and full commentary for the required areas.
- 2.16 For the sample of indicators we selected for testing, we were able to confirm the timely submission to the Information Manager (Analytics Team), with the exception of one indicator which was not populated in the report, referred to in Appendix A, Matter Arising 2.

Conclusion 3: We were satisfied with the arrangements in place to ensure the timely compilation of the Integrated Performance Report for reporting to the relevant governance fora. (Substantial Assurance)

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## Appendix A: Management Action Plan

Matter Arising 1: Guidance to support the compilation of the Integrated Performance Report (Operation)		Impact
<p>The draft 'Procedure to compile the Cardiff and Vale Integrated Performance Report for Executive Management Team and Public Board Meeting', was in development at the time of the review and was close to completion, but was yet to be approved and published.</p> <p>Once finalised the document will direct and provide resilience to the compilation process of the Integrated Performance Report.</p>		<p>Potential risks of:</p> <ul style="list-style-type: none"> <li>Inaccurate and incomplete performance information.</li> </ul>
Recommendation 1		Priority
<p>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'.</p>		<b>Low</b>
Agreed Management Action 1	Target Date	Responsible Officer
<p>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.</p>	30-Sept-2022	David Thomas, Director of Digital & Health Intelligence

Matter Arising 2: Data accuracy and completeness of the Balanced Scorecard (Operation)			Impact												
<p>We selected a sample of indicators from the Balanced Scorecard held within the Integrated Performance Report presented to the Board on 31<sup>st</sup> March 2022. We attempted to verify the accuracy of the reported figures and we make the following observations from our sample of 10 indicators:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Scorecard Theme and Indicator</th> <th style="text-align: center;">Board Report</th> <th style="text-align: center;">Source documentation</th> </tr> </thead> <tbody> <tr> <td>Quality and Safety – Mortality Number of still births</td> <td style="text-align: center;">Blank – no data reported against the indicator</td> <td style="text-align: center;">No available information</td> </tr> <tr> <td>Quality and Safety - Patient satisfaction 30 day complaints response compliance %</td> <td style="text-align: center;">77%</td> <td style="text-align: center;">76% (76.23%)</td> </tr> <tr> <td>Workforce Achieve annual local sickness and absence workforce target (rolling 12 months)</td> <td style="text-align: center;">6.70%</td> <td style="text-align: center;">6.68%</td> </tr> </tbody> </table> <p>We did observe the meeting of the Board on 31 March 2022 and the absence of data for the 'Number of still births' was highlighted, with the intention of being addressed going forward. The further two observations are minor in nature.</p>			Scorecard Theme and Indicator	Board Report	Source documentation	Quality and Safety – Mortality Number of still births	Blank – no data reported against the indicator	No available information	Quality and Safety - Patient satisfaction 30 day complaints response compliance %	77%	76% (76.23%)	Workforce Achieve annual local sickness and absence workforce target (rolling 12 months)	6.70%	6.68%	<p>Potential risks of:</p> <ul style="list-style-type: none"> <li>Inaccurate and incomplete performance information.</li> </ul>
Scorecard Theme and Indicator	Board Report	Source documentation													
Quality and Safety – Mortality Number of still births	Blank – no data reported against the indicator	No available information													
Quality and Safety - Patient satisfaction 30 day complaints response compliance %	77%	76% (76.23%)													
Workforce Achieve annual local sickness and absence workforce target (rolling 12 months)	6.70%	6.68%													
Recommendation 2			Priority												
<p>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.</p>			<b>Medium</b>												

Agreed Management Action 2	Target Date	Responsible Officer
<p>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.</p>	<p>30-June-2022</p>	<p>Gary Williams, Information Manager</p>

Matter Arising 3: Risks associated with defined indicators (Operation)	Impact
<p>The sample of indicators we reviewed highlighted the various processes and systems in place to extract the required information to inform the Balanced Scorecard. Some figures were easily selected from system generated reports, in contrast others required adjustments such as adding figures from a number of reports and apportioning figures to a total population, for example the 'Mental Health Part 1a' indicator, and the 'Patient Satisfaction' indicator. Although we note the manual compilation of the Patient Satisfaction indicator is a temporary process, as a result of the upgrade of the Datix system.</p> <p>We acknowledge that there will be varying methods to determine the results reported in the Balanced Scorecard, but there is opportunity whilst the report is underdevelopment to flag the indicators most at risk and prone to error.</p>	<p>Potential risks of:</p> <ul style="list-style-type: none"> <li>Inaccurate and incomplete performance information.</li> </ul>

Recommendation 3	Priority
<p>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.</p>	<p style="text-align: center;"><b>Low</b></p>

Agreed Management Action 3	Target Date	Responsible Officer
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.	30-June-2022	Gary Williams, Information Manager

Matter Arising 4: Further enhancements to develop the Balanced Scorecard (Operation)	Impact
<p>Following a review of a sample of indicators, we also undertook a wider review of the Balanced Scorecard presented to the Board on 31 March 2022 and noted the following, which if addressed would enhance the clarity and completeness of the report:</p> <ul style="list-style-type: none"> <li>• Labelling of indicators - There was an error in the period title (Dec-21) within the finance section, which should have noted 'Jan-22'.</li> <li>• On review of finance source data we noted that the 'Remain within capital resource limits' indicator had a target limit of £59.239m, but the scorecard notes a lower target of £55.865m.</li> <li>• No target / RAG rating - There were a number of indicators which have no set target and therefore no associated RAG rating. The target field was blank, which appeared incomplete.</li> <li>• Clarity of description - Given the scorecard is within the public domain there are a number of indicators listed which would not resonate with a member of the public or lay person, for example 'Mental Health Part 1a or 1b' and the report is not accompanied by definitions or a key.</li> <li>• RAG ratings - there is a lack of clarity of the tolerances associated with the RAG ratings listed.</li> </ul>	<p>Potential risks of:</p> <ul style="list-style-type: none"> <li>• Inaccurate and incomplete performance information.</li> </ul>

Recommendation 4		Priority
<p>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.</p>		<p><b>Medium</b></p>
Agreed Management Action 4	Target Date	Responsible Officer
<p>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.</p>	<p>30-June-2022</p>	<p>Gary Williams, Information Manager</p>

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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:

	<b>Substantial assurance</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable assurance</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited assurance</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>No assurance</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Assurance not applicable</b>	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
<b>High</b>	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*
<b>Medium</b>	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
<b>Low</b>	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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# ChemoCare IT System Final Internal Audit Report

May 2022

Cardiff & Vale University Health Board



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Cardiff and Vale  
University Health Board



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Auditors:	Syed Shah, Bank Principal Auditor Martyn Lewis, IT Audit Manager
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Distribution:	David Trigg, Lead for Implementation of ChemoCare (Adult) Kerry Crompton, Lead for Implementation of ChemoCare (Paediatric) Sandra Whitney, IT Programme Manager
Committee:	Audit & Assurance Committee



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## Executive Summary

### Purpose

To provide assurance that data held within the ChemoCare IT System is accurate, secure from unauthorised access and loss, and that the system is used fully.

### Overview

There is a framework for control over the ChemoCare system and there were areas of good practice. However, the controls have not been fully enacted. The significant matters which require management attention include:

- Out of date versions of Windows server and SQL Server database in use.
- Generic accounts exist with system administrator privileges.
- Lack of formal supplier's performance monitoring mechanism.
- Weaknesses within the Business Continuity Plan and Hosting and Backup arrangements.
- Weaknesses in password policy and current configuration settings.
- No automatic alerts configured to notify in the event of interface failures.

Additional recommendations are also made which can be found within the detail of the report.

### Report Classification

Limited



More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

### Assurance summary<sup>1</sup>

Assurance objectives	Assurance
1 Governance Process	Reasonable
2 Database Control	None
3 Input Controls	Substantial
4 Application Access	Limited
5 Outputs and Interfaces	Reasonable
6 Audit Log	Substantial
7 Continuity	Limited

<sup>1</sup>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

### Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Performance Monitoring Mechanism.	1	Design	Medium
2	Database Security	2	Operation	High
4	User Management	4	Operation	Medium
5	Password Controls	4	Operation	Medium
6	Interface Failure Alerts	5	Design	Medium
7	Hosting and Backup Agreements	7	Operation	Medium
8	Business Continuity	7	Operation	Medium

## 1. Introduction

- 1.1 In line with the 2021/22 Internal Audit Plan for Cardiff & Vale University Health Board (the Health Board) a review of the ChemoCare IT system was undertaken.
- 1.2 The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of the ChemoCare IT System, to provide assurance to the Health Board Audit Committee that risks material to the achievement of system objectives are managed appropriately.
- 1.3 The ChemoCare system provides an integrated prescribing solution for Paediatric Oncology and Adult Haematology patients within Cardiff & Vale UHB, Cwm Taf Morgannwg UHB and Aneurin Bevan UHB.
- 1.4 The potential risks considered in this review were as follows:
  - 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 At the time of our audit, management is in the process of upgrading the system from version 5 to the new version 6.

## 2. Detailed Audit Findings

### **Objective 1: an appropriate governance process is in place for the system.**

- 2.1 The ChemoCare system was bought from CIS in 2018 and a contract is in place for the provision of the system. The system was implemented in different phases. Currently version 5 is being used and the plan is to move to version 6 within six months, for which necessary administration work is being done. All the maintenance support is provided by CIS Oncology (Via accounts managed by Boxxe), with an appropriate contract in place.
- 2.2 The contract provides a clear requirement and specification for the system, and also covers confidentiality, data protection, intellectual property, indemnity, limitation of liability, dispute resolution, force majeure, records retention and right of audits.
- 2.3 There is an agreed SLA with the service provider, which states different incident severity levels and the vendor's response and fixing time. In addition, the service agreement also requires a periodic review meeting to assess the performance of the supplier. We also note that the NWSSP Procurement manual also requires monitoring of the contracted Key Performance Indicators and requires that the contract owner should keep the procurement services advised on supplier performance.

- 2.4 However, we note that the system administrators for ChemoCare were not aware of the agreed SLAs and requirement for supplier performance review. Hence there is no mechanism in place for performance monitoring for ChemoCare and no process to record the supplier's compliance with the agreed SLAs or to carry-out a periodic performance assessment to highlight any significant or frequent breaches (if any). **(Matter Arising 1)**.
- 2.5 In addition, we note that there are no agreed penalty clauses in the contract to protect and compensate the NHS in the event of the supplier frequently breaching the agreed SLA.
- 2.6 We further note however, that from discussion with the system administrators, the supplier's performance in providing system support is satisfactory and there have been no major performance issues.
- 2.7 There are named system administrators in place for both South East Wales Haematology (SEWHN) and Paediatrics with good knowledge of the system and of the role. We note that the role of the system administrator has been defined within a document.
- 2.8 User groups are in place within both SEWHN and Paediatrics for users to feed their concerns into, although we note that the pandemic has impacted on the operation of these. However, both the system administrators are based within the respective departments and are therefore accessible.

#### Conclusion:

- 2.9 There is a governance process in place for the system, with named system administrators who understand the role and the system, and a contract is in place for maintenance and support, although we note that the performance is not currently being monitored. Accordingly, we have provided reasonable assurance over this objective.

#### Objective 2: appropriate control is maintained over the database.

- 2.10 The current version of Chemocare is installed on Windows Server 2008, support for which ended in 2020 and which contains vulnerabilities, including some significant vulnerabilities. The current system is based on SQL Server 2008, support for which ended in 2019. The use of these out-of-date components leads to an increased security risk for the Health Board. **(Matter Arising 2)**
- 2.11 We do note the ongoing work to move to a later version of ChemoCare and that this is based on more up to date versions of server and SQL server.
- 2.12 The system is securely hosted by IT, however our review of the access controls over the database identified further security weaknesses: **(Matter Arising 2)**
- database access is via SQL authentication and not windows, which is a less secure methodology;
  - application users access the database using a single database user with the database Owner role. This role provides complete access to the database and so introduces a security risk; and

- user passwords are stored in clear text within the database and are not encrypted.

2.13 We further note that there is no process to ensure ongoing database management actions such as integrity checks or table optimisation is undertaken. Testing of the database noted that the errors table had a very large number of errors logged within it. These are not reviewed and the table is not periodically cleared out. **(Matter Arising 2)**

#### Conclusion:

2.14 Although the system is securely hosted, it is based on out-of-date components for which vulnerabilities exist. In addition, security is weakened by the authentication method, lack of encryption and provision of database owner to all users. There is no established process for database maintenance and there are a significant number of errors within the database errors table. Accordingly, we have provided no assurance against this objective.

#### **Objective 3: all input is authorised, complete, accurate, timely and input once only.**

2.15 Data entry into the Chemocare system is by a mixture of free text and selecting from drop down menus.

2.16 The standing data which supports the drop down lists within Chemocare was defined during the system set up of the system, with different values in place for adults and paediatrics. There was a structured process in place for this with a peer review process to ensure that all minor and major changes in the input parameters were independently reviewed by another member of staff and the results are archived to retain a record.

2.17 We tested a sample of entry fields within the system to establish if there were controls in place to enforce data quality on entry. This testing demonstrated that there are input controls in place and they are being managed, for example:

- There are established ranges for adult and paediatric patients. The age limit has been set as > 18 = Adult and < 12 as Paediatric, with the option to treat as either if aged between these;
- There is a warning triggered if abnormal weight is entered for a patient to ensure the user checks the entry values;
- The format is enforced for Adult GFR and Paediatric Calculation; and
- There are restrictions in place to prevent users modifying a prescription, with the system only allowing modification to drugs i.e. changes within agreed set parameters set in the drug file.

2.18 There is a user guide available for users in the form of a quick reference guide, there are also a comprehensive set of Standard Operating Procedures (SOPs) in place and a basic task guide is also available for nursing staff. We note that the user guide was last updated in 2013, and there is an intent to review and update after the move to version 6.

2.19 Training is provided to users prior to them being granted full access to the system to ensure that they understand how to use the system. We did note however that within Adult Haematology individual training logs are not signed off and archived for the records purpose. In addition, there is no centralised training record maintained to track whether training has been provided to all users. We have been informed that this is being currently worked on and will be completed before the launch of version 6. (**Matter Arising 3**)

#### Conclusion:

2.20 There is extensive use of drop-down lists, the maintenance of these is controlled. There are data input restrictions in place and a set of user guides for staff to ensure they understand how to use the system. Accordingly, we have provided substantial assurance against this objective.

#### Objective 4: proper control is exercised over access to application systems.

2.21 User access is managed by the system administrators for both Adult and Paediatrics. Access to users is based on roles and our testing confirmed that the concept of least privilege is being maintained and that the roles given to users were appropriate. We also note that there are a number of staff with read only access to the system that facilitates the sharing of information without a risk of erroneous data entry.

2.22 There is a SOP that sets out the process for providing access to new users and is accompanied by a new user request form to enable approval and tracking of user creation. We note however that this is not generally followed. User access is mostly granted by an email (or sometimes) verbal request and not the form provided. In addition, we note that the user request form is not up to date and does not include all the current roles in use within the system. (**Matter Arising 4**)

2.23 Users are given usernames for individual access to ensure that actions can be tracked within the system. However, there are generic accounts within both Adult Haematology and Paediatric Services. These include system manager level access and so remove accountability and traceability for actions undertaken using these accounts.

2.24 Our testing identified staff who have left the Health Board, or who have transferred and whose accounts were still active. We note that accounts are automatically archived if not used for 180 days, however this does not fully manage the risk associated with inappropriate access. (**Matter Arising 4**)

2.25 Access to the system is controlled via username and password and the SOP sets out the requirements for the password. We note however, that the SOP governing password setting is outdated and does not reflect the Health Board the IT Security policy. In addition, there were variations in practice between the services. (**Matter Arising 5**)

- There are different length requirements for passwords between the systems. For adult it is 8 and Paediatric it is only 6: and

- There are differences in the password re-use times between systems. Passwords are archived for 365 days in Adult Haematology; however, it is archived for only 200 days in paediatric.
- 2.26 We further note that there are weaknesses in password management, with no forced requirement for passwords to contain a mixture of uppercase, lowercase and numbers despite the SOP stating this. Furthermore, the current version in use (v5) does not have the ability to lock-out an account after a set number of attempts using an incorrect password. **(Matter Arising 5)**
- 2.27 Our testing also identified that there are few user accounts (including system admin) where the password change policy is different from the current practice and SOP. For instance, on 3rd March 2022 next password due for System Manager accounts were appearing as 10<sup>th</sup> March 2027 and 5<sup>th</sup> September 2024. **(Matter Arising 5)**

#### Conclusion:

- 2.28 Although there is an SOP that sets out the requirements for the provision of user access, this is not always complied with and there are both generic users and leavers still active within the system. In addition, the password controls are not currently set at the level required by the security policy. Accordingly, we have provided limited assurance against this objective.

#### **Objective 5: controls ensure the accuracy, completeness, confidentiality and timeliness of output, reports, and interfaces.**

- 2.29 There is a reporting module and reports are created through Crystal (Licensed), with a set of reports in place which were created by the system administrator. We note that the Health Board has paid for the auto reporting module, through a grant provided by the Welsh Cancer Network who are provided with updates. However this is not currently active and so reports are manually produced. However, we were informed that work is ongoing to enable the automation functionality.
- 2.30 There are inbound real time interfaces for Paediatric services with LIMS and RPMS and for Haematology Adults with LIMS and EMPI to enable the transfer of patient demographics and of results. However, there is no auto alert mechanism to notify the system administrators for the failure in the interfaces with reliance currently placed on end-users identifying missing information, or pathology daily checks identifying failed delivery, these are then escalated to CIS oncology and relevant internal forums.
- 2.31 On our inquiry, the CIS project manager explained that ChemoCare can email warnings should errors grow or no inbound messages be received in certain minutes, but access to SMTP server is required to enable this functionality. **(Matter Arising 6)**
- 2.32 Conversely, we note that outbound interfaces generate errors when not successful. This is displayed to the users who will then report it to system administrators who then escalate the matter to the CIS help desk.

2.33 There are restrictions in place to prevent loss of data via USB transfer, with the USB ports having been locked down within the Health Board. We further noted during our access management testing that separate profiles for Read Only - With Printing has been created for a few users having service printing requirement. This also prevents data loss as normal Read Only users don't have printing rights.

**Conclusion:**

2.34 Reports are in place and the creation of these are controlled by the system administrator, although we note the current lack of the automation functionality. There are interfaces in place, although failure notification is not automatic and relies on users. There are restrictions in place to prevent data loss through USB and unauthorised printing. Accordingly, we have provided reasonable assurance against this objective.

**Objective 6: a complete audit log is maintained which enables data items item to be tracked**

2.35 Audit logging is available within the system, although we note that the current functionality is limited in version 5, with the full functionality available in Version 6.

2.36 The system does track creation, deletion and changes to data items and the system administrators have access to limited log records. For example, front-end user activities are logged and accessible to the system administrators such as for day-to-day patient treatment they can see modification to a treatment, or to particular patient records.

2.37 We note however that more detailed audit log records can be accessed by the supplier and they will provide these when asked if it is necessary.

2.38 Security log information such as logins and failed logins are recorded and stored within the database, although as there is no active database management as noted previously, there is no review of this information.

**Conclusion:**

2.39 Audit logging is available within the system. We note the current limited access, However, as the system will be upgraded to version 6 by summer, which will provide full audit functionality, and as the current version is meeting the service requirements for day-to-day user activities, we have provided substantial assurance over this objective.

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

2.40 The ChemoCare system has a resilient architecture and is installed on virtual servers with the physical servers hosted within the Health Boards SAC. The hosting is within the Digital Directorate and so is protected to the same level as other core Health Board systems.

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- 2.41 The hosting arrangement is set out with Hosting and Backup Agreements (HBAs) which set out the responsibilities and the systems covered, together with the backup regimen. However, we note that the HBAs are in draft stage and have not been signed by the system owners since March 2018. Moreover, 7 out of 12 servers in place are not included in the draft HBAs. (**Matter Arising 7**)
- 2.42 The HBAs state that regular backups will be taken and monthly backup reports provided to the service, however the system administrators have not been provided with these reports, and despite several reminders the information relating to confirmation of backups (logs) and testing of these for validity was not made available during our fieldwork. As such we could not confirm the successful backup for ChemoCare. In addition, information related to a Disaster Recovery (DR) plan and its periodic testing was also not shared during our fieldwork. (**Matter Arising 7**)
- 2.43 There is a Business Continuity Plan (BCP) in place for the ChemoCare system to enable patient care to continue in the event of a system interruption and this was prepared in the year 2016.
- 2.44 We noted that the current BCP is not periodically tested and has not been updated for a substantial time. We were informed by the system administrators that the current BCP will be updated once the version 6 goes live. In addition, we also noted that the criticality of the system and reliance on other systems and key IT infrastructure have not been formally established. Also, there is no evidence that a Business Impact Analysis was performed to assess the extent of losses in the event of any failure (**Matter Arising 8**).

#### Conclusion:

- 2.45 The system is resiliently hosted and there is a departmental continuity plan in place, although we note that this does contain weaknesses. There is a backup regimen in place, which is the Health Board standard process. However, we were not able to confirm the operation of this or the testing of backups and disaster recovery. Accordingly, we have provided limited assurance over this objective.

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## Appendix A: Management Action Plan

Matter Arising 1: Performance Monitoring mechanism (Design)	Impact
<p>The system administrators for ChemoCare were not aware of the agreed SLAs and requirement for supplier performance review. Hence there is no mechanism in place for performance monitoring for ChemoCare and no process to record the supplier’s compliance with the agreed SLAs or to carry-out a periodic performance assessment to highlight any significant or frequent breeches (if any).</p> <p>In addition, we note that there are no agreed penalty clauses in the contract to protect and compensate the NHS in the event of the supplier frequently breaching the agreed SLA.</p>	<p>Absence of formal supplier performance mechanism could lead to unidentified breeches of agreed SLA.</p>
Recommendations	Priority
<p>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 breeches of SLA.</p> <p>1.2 Outcome of the performance review should be periodically shared with the Shared Services Procurement team, as required by the procurement manual.</p> <p>1.3 If possible, penalty clauses should be agreed with the supplier during the subsequent contract renewal process.</p>	<p>Medium</p>

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Agreed Management Action	Target Date	Responsible Officer
<p>1.1 Create SLA breach log with annual review of this.</p> <p>1.2 Annual review can be shared with Shared Services Procurement team. Will commence post-implementation of Version 6.</p> <p>1.3 Penalty clauses will be discussed at next contract renewal (there is a national procurement process underway)</p>	<p>Start log July 2022 with first annual review July 2023</p>	<p>Kerry Crompton (Paeds)</p>

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Matter Arising 2: Database (operation)	Impact
<p>We noted weaknesses in the control and security over the database:</p> <ul style="list-style-type: none"> <li>• The current version of ChemoCare is installed on Windows Server 2008, support for which ended in 2020 and which contains vulnerabilities, including some significant vulnerabilities. The current system is based on SQL Server 2008, support for which ended in 2019. The use of these out-of-date components leads to an increase security risk for the Health Board;</li> <li>• User access is via SQL authentication and not windows, which is less secure;</li> <li>• Application users access the database using a single database user with the dbo role. This role provides complete access to the database and so introduces a security risk;</li> <li>• User passwords are stored in clear text within the database and are not encrypted. This introduced a security risk;</li> <li>• There is no process to ensure ongoing database management actions such as integrity checks or table optimisation is undertaken; and</li> <li>• Testing of the database noted that the errors table had a very large number of errors logged within it. These are not reviewed and the table is not periodically cleared out.</li> </ul>	<p>There is a cyber security risk of inappropriate access and loss of data.</p>
Recommendations	Priority
<p>2.1 Windows servers should be upgraded to versions for which support is available;</p> <p>2.2 SQL Server 2008 R2 should also be replaced with new versions for which support is available;</p> <p>2.3 Database authentication should be moved to Windows authentication;</p>	<p>High</p>

- 2.4 User passwords should be encrypted within the database;
- 2.5 The core user account should have the dba role removed and a more appropriate user access role defined; and
- 2.6 Database management tasks should be defined and regularly undertaken, this should include review and clear out of the error table.



Agreed Management Action	Target Date	Responsible Officer
2.1 As part of the chemocare upgrade to version 6 Windows servers OSrs have been replaced with a version which is supported i.e Windows 2016	Complete in UAT go live July 2022	Gareth Richards (Server Manager)
2.2 As part of the Chemocare upgrade to version 6, SQL Server 2008R2 has been replaced with a version which is supported. i.e. SQL Server 2019.	Complete in UAT go live July 2022	Gareth Richards (Server Manager)
2.3 Discussion with the supplier and service will take place post upgrade to understand if this is doable.	September 2022	Kerry Crompton, David Trigg / CIS
2.4 Not required if using Windows Authentication (as suggested in 2.3).		
2.5 Discussion required with the service and supplier.	September 2022	Kerry Crompton, David Trigg / CIS
2.6 Discussion required with the service and supplier.	September 2022	Kerry Crompton, David Trigg / CIS

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<b>Matter Arising 3: User Training Logs (Operations)</b>		<b>Impact</b>
<p>The SOP governing the new Chemo Care user account requires that nursing lead or system manager should contact the new user to organise a date for training. Once the new user has received training and is signed off to use the system, their access should be upgraded to their agreed level.</p> <p>On our inquiry, the Lead for Implementation of Chemo care (Adult Haematology) has informed that training is provided to every new user however, individual training logs are not signed off and archived for the record purpose.</p> <p>In addition, there is no centralised training record maintained to track whether training has been provided to all users. We have been informed that this is being currently worked on and will be completed before the launch of version 6.</p>		<p>In absence of a proper training record there is a probability the few users might not get the training.</p>
<b>Recommendations</b>		<b>Priority</b>
<p>3.1 Individual user training logs should be signed off and archived for record purpose.</p>		<p>Low</p>
<b>Agreed Management Action</b>	<b>Target Date</b>	<b>Responsible Officer</b>
<p>3.1 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.</p> <p>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.</p>	<p>July 2022 (Allowing 2 months of user groups to discuss, agree and implement)</p>	<p>David Trigg (Adult Haematology)</p>

<b>Matter Arising 4: User Management (operations)</b>	<b>Impact</b>
<p>There are weaknesses in the processes for user management:</p> <ul style="list-style-type: none"> <li>• Although there is a SOP that sets out the process for providing access to new users, this is not generally followed. User access is mostly granted by an email (or sometimes) verbal request and not the form provided. In addition, we note that the user request form is not up to date and does not include all the current roles;</li> <li>• There are generic accounts within both Adult Haematology and Paediatric Services. These include system manager level access; and</li> <li>• Our testing identified staff who have left the Health Board, or who have transferred and whose accounts were still active. We note that accounts are automatically archived if not used for 180 days, however this does not fully manage the risk associated with inappropriate access.</li> </ul>	<p>There is a risk of inappropriate access to the system / data.</p>
<b>Recommendations</b>	<b>Priority</b>
<p>4.1 The new user form should be updated to reflect the current roles, and the process as set out in the SOP should be followed for new user accounts;</p> <p>4.2 Generic accounts must not be used and identified accounts must be replaced with unique users. If any account is not required, then it should be deleted; and</p> <p>4.3 A process for periodic reconciliation of staff leavers to users should be established to ensure that accounts are deactivated on a timely basis.</p>	<p>Medium</p>

Agreed Management Action	Target Date	Responsible Officer
4.1 Update SOP to reflect all current roles. This will need to be done separately for adults and paediatrics as the roles differ slightly.	May 2022	Kerry Crompton (for paediatric system)
4.2 All generic accounts archived on the paediatric system.	April 2022	David Trigg (Adult Haematology)
4.2 Time to archive user accounts will be reduced from 180 days to 90 days within the paediatric system to reduce the risk of staff who have moved on still having access to the system.	April 2022	

Matter Arising 5: Password Controls (Operation)	Impact
<p>There were weaknesses in user access controls:</p> <ul style="list-style-type: none"> <li>• There is no forced requirement for passwords to contain a mixture of uppercase, lowercase and numbers;</li> <li>• There are different length requirements for passwords between the systems. For adult it is 8 and Paediatric it is only 6;</li> <li>• There are different account archive settings in both Adult Haematology and Paeds systems that is, 365 days and 200 days respectively. In case any account is not active for the defined number of days than the account is automatically archived and become inactive;</li> </ul>	<p>There is a risk of inappropriate access to the system / data.</p>

- The password change settings in both Adult Haematology and Paeds systems are 90 days;
- There are a few user accounts (including system admin) where the password change policy is different from the current practice and SOP. For instance, on 3rd March 2022 the next password due for the System Manager accounts were appearing as 10<sup>th</sup> March 2027 and 5<sup>th</sup> September 2024; and
- The current version in use (v5) does not has the ability to lock-out an account after a set number of attempts using an incorrect password.

In addition, the new user form contains out of date information relating to password length and change requirements.

Recommendations		Priority
5.1 Password controls should be set to enforce a level of complexity, with a minimum length of 8 and with a standard use and re-use time.		Medium
Agreed Management Action	Target Date	Responsible Officer
5.1 Paediatric system updated to reflect practice of adult system. Minimum of 8 characters.	April 2022	Kerry Crompton (for paediatric system)

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<b>Matter Arising 6: Interface Failure Alerts (design)</b>		<b>Impact</b>
<p>There are inbound real time interfaces for Paediatric services with LIMS and RPMS and Haematology Adults with LIMS and EMPI. However, there is no auto alert mechanism to notify the system administrators for any failure in the interfaces. Currently reliance is on the feedback received from end-users which is then escalated to CIS oncology and relevant internal forums.</p> <p>On our inquiry, the CIS project manager has informed that ChemoCare can email warnings should errors grow or no inbound messages be received in certain minutes but access to SMTP server is required to enable this functionality.</p>		Frequent interface failures might not be identified leading to service disruptions and manual work for the staff.
<b>Recommendations</b>		<b>Priority</b>
6.1 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
<b>Agreed Management Action</b>	<b>Target Date</b>	<b>Responsible Officer</b>
6.1 Will look at this as part of the V6 upgrade and ensure an auto alert system is in place.	July 2022	Kerry Crompton (paeds system) David Trigg (Adult Haematology)

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Matter Arising 7: Hosting and Back-up Agreements (Operations)		Impact
<p>We reviewed the Hosting and Back-up agreements (HBA) for both Adult Haematology and Paediatric Services and noted the below weaknesses:</p> <ul style="list-style-type: none"> <li>Both HBAs are in draft stage and have not been signed by the system owners since March 2018;</li> <li>7 out of 12 servers are not included in the HBAs; and</li> <li>As per the HBA, IM&amp;T is required to provide monthly backup reports to the Dept/Directorate however, we were informed by the Lead for Implementation of Chemo care (Adult Haematology) he has not received any such monthly reports in past.</li> </ul> <p><b>Scope Limitation:</b> Backup logs and evidence to confirm the backup testing were requested from the IM&amp;T Department however, despite several reminders the information was not made available during our fieldwork.</p>	<p>Absence of correct information related to servers could result in omitting such servers during the back-up process.</p>	
Recommendations		Priority
<p>7.1 HBAs should be updated and signed by the relevant department. Also, monthly back-up report should be sent to the relevant department; and</p> <p>7.2 A schedule for testing the backups to restore should be established.</p>	<p>Medium</p>	
Agreed Management Action	Target Date	Responsible Officer
<p>7.1 BCP will be reviewed as recommended. As part of the ChemoCare upgrade all HBAs will be updated to reflect the new infrastructure and signed by all relevant parties.</p> <p>7.2 As part of the HBAs review, a backup regime will be agreed and a plan to restore agreed.</p>	<p>July 2022</p> <p>July 2022</p>	<p>Gareth Richards (Server Manager)</p> <p>Gareth Richards (Server Manager)</p>

<b>Matter Arising 8: Business Continuity Plan (Operation)</b>		<b>Impact</b>
<p>While reviewing the Business Continuity plan for the Chemo Care system, the below weaknesses were noted:</p> <ul style="list-style-type: none"> <li>• The BCP is not periodically tested and has not been updated for a substantial time. As per the system owner the BCP will be updated once the version 6 goes live;</li> <li>• Criticality of the Chemo Care system has not been formally established;</li> <li>• There is no evidence that a formal risk assessment was carried-out to identify all significant events or vulnerabilities to the system;</li> <li>• The document does not outline dependencies on any other application, information system / IT infrastructure; and</li> <li>• No Business Impact Analysis were performed to assess the extent of losses in the event of any failure.</li> </ul>	<p>Noncomprehensive BCP can limit the ability to continue the business in case of system unavailability due to any adverse event.</p>	
<b>Recommendations</b>		<b>Priority</b>
<p>8.1 The identified gaps should be taken into consideration at the time of the next BCP update once the version 6 goes live.</p>		<p>Medium</p>
<b>Agreed Management Action</b>	<b>Target Date</b>	<b>Responsible Officer</b>
<p>8.1 BCP will be reviewed as recommended.</p>	<p>August 2022</p>	<p>Kerry Crompton (paeds system) David Trigg (Adult Haematology)</p>

## 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:

	<b>Substantial assurance</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable assurance</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited assurance</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>No assurance</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Assurance not applicable</b>	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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