Public Audit & Assurance Committee Meeting

Tue 05 November 2024, 09:00 - 10:30

Microsoft Teams

Agenda

09:00 - 09:10
10 min

1. Preliminaries (09:00 – 09:10)

1.1. Welcome & Introductions

Rhian Thomas

1.2. Apologies for Absence

Rhian Thomas

1.3. Declarations of Interest

Rhian Thomas

1.4. Minutes of the Committee meeting held: 03.09.2024

Rhian Thomas

- 1.4 Public Audit Committee Minutes 03.09.2024.pdf (10 pages)

1.5. Actions following meeting held: 03.09.2024

Rhian Thomas

- 1.5 Action Log - Public Audit & Assurance (5).pdf (1 pages)

1.6. Any Other Urgent Business

Rhian Thomas

09:10 - 10:25
75 min

2. Items for Review & Assurance (09:10 – 10:25)

2.1. Internal Audit Progress Report including: (20 MINUTES)

Ian Virgil

Maternity Care Draft Internal Audit Report

Safeguarding Final Internal Audit Report

Specialist Clinical Board Governance Arrangements Final Internal Audit Report

- 2.1 A&A Progress Report November 24 cover.pdf (2 pages)
- 2.1a A&A Progress Report November 24.pdf (15 pages)
- 2.1b Maternity Care Draft Internal Audit Report.pdf (14 pages)
- 2.1c Safeguarding Final Internal Audit Report.pdf (16 pages)
- 2.1d Specialist CB Governance Arrangements Final Internal Audit Report.pdf (17 pages)

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2.2. Audit Wales Update (15 MINUTES)

Wales Audit

2.2 - CVUHB Audit Committee Update (November 2024).pdf (12 pages)

2.3. Medical Records Tracking Verbal Update (10 MINUTES)

Sarah Lloyd

2.4. Procurement Compliance Report / Single Tender Actions / No PO No Pay (10 MINUTES)

Catherine Phillips

2.4 Procurement Audit Committee Board Report - Nov 2024 v1.pdf (7 pages)

2.5. Policies Update – Verbal Update (10 MINUTES)

Matt Phillips

2.6. Internal Audit Tracker Update Report (10 MINUTES)

Matt Phillips

2.6.1 - Internal Audit Tracker Update Report - November 2024 (1) (1).pdf (3 pages)
2.6.2 - Appendix 1 - All Internal Audit Actions (1).pdf (75 pages)
2.6.3 - Appendix 2 - Overdue Internal Audit Actions (1).pdf (26 pages)

10:25 - 10:25
0 min

3. Items for Approval/Ratification (10:25 – 10:25)

No items

10:25 - 10:25
0 min

4. Items for Noting & Information

4.1. Counter Fraud Progress Update

Henry Bales

4.1 COUNTER FRAUD PROGRESS _ PUBLIC _ COVER SHEET P3.pdf (2 pages)
4.1a COUNTER FRAUD PROGRESS REPORT - CAVUHB PUBLIC P3.pdf (8 pages)

10:25 - 10:25
0 min

5. Agenda for Private Audit and Assurance Committee

i) Approval of Private Minutes from previous meeting

ii) Counter Fraud Progress Update (Confidential – ongoing investigations

iii) Health Board Salaries Overpayment Update

10:25 - 10:25
0 min

6. Any Other Business

10:25 - 10:25
0 min

7. Review & Final Closure

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7.1. Items to defer to the Board / Committees & Review of Future Actions

7.2. Date and Time of the next Committee meeting:

14 January 2025 via MS Teams

7.3. 10-minute break prior to the Private Meeting

7.4. 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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Minutes of the Public Audit & Assurance Committee Meeting
Held On 03 September 2024 at 9:00am
Via MS Teams

View the full meeting here: https://www.youtube.com/watch?v=0perL4y2pnE
Please note that each item has been linked below so that it will start playing from that point. If you are unable to view sections, please copy and paste the link into your preferred internet browser.

Chair:		
Rhian Thomas	RT	Independent Member for Capital and Estates and Committee Chair (CC)
Present:		
David Edwards	DE	Independent Member for ICT
Mike Jones	MJ	Independent Member for Trade Union
Ceri Phillips	CP	Vice Chair of the Health Board
John Union	JU	Independent Member for Finance
In Attendance:		
Henry Bales	HB	Lead Local Counter Fraud Specialist (LLCFS)
Rachel Gidman	RG	Executive Director of People and Culture
Lucy Jugessur	LJ	Deputy Head of Internal Audit (IDHIA)
Amanda Legge	AL	All Wales Post Payment Verification Manager
Gareth Lucey	GL	Director – Audit Wales
Robert Mahoney	RM	Deputy Director of Finance
Urvisha Perez	UP	Audit Lead - Audit Wales
Catherine Phillips	CP	Executive Director of Finance (EDF)
Matt Phillips	MP	Director of Corporate Governance (DCG)
Andrew Partridge	AP	Corporate Archivist & Records Management Manager
Frankie Thomas	FT	Head of Corporate Governance
Ian Virgil	IV	Head of Internal Audit (HIA)
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Marie Davies	MD	Interim Executive Director of Strategic Planning

Item No	Agenda Item	Action
AAC 24/08/001	**Welcome & Introduction (click to view)** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 24/08/002	**Apologies for Absence (click to view)** Apologies for absence were received. **The Committee resolved that:** a) Apologies were noted.	

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AAC 24/08/003	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	
AAC 24/08/004	**Minutes of the Committee meeting held: 02.07.2024 & 11.07.2024 (click to view)** The Minutes of the Meeting Held on the 02.07.2024 & 11.07.2024 were received. A missing sentence from page 11 of the minutes of the meeting held on 11.07.2024 was noted and the Senior Corporate Governance Officer (SCGO) agreed to amend the minute. **The Committee resolved that:** a) The draft minutes of the meetings held on 02.07.2024 and 11.07.2024, were held to be a true and accurate record of the meeting pending the one amendment.	
AAC 24/08/005	**Actions following meeting held: 02.07.2024 (click to view)** The Actions were received. It was noted that the action to take the Medical Records Tracking (CD&T CB) Internal Audit Progress Report to the QSE Committee had not happened due to the QSE Committee meeting being cancelled in August 2024. The Vice Chair of the Health Board (VC) advised the Committee that the papers for that cancelled meeting had been published and so the public and Committee members were able to view the Medical Records Tracking (CD&T CB) Internal Audit Progress Report and noted that a verbal update would be provided at the next QSE meeting in October 2024. **The Committee resolved that:** a) The Actions were discussed and noted.	
AAC 24/08/006	**Internal Audit Progress Report including: (click to view)** The Internal Audit Progress Report was received. The Head of Internal Audit (HIA) advised the Committee that he would take the report as read and highlight key areas which included: • Section 2 of the report which outlined that 5 audits that had been scheduled to be received by the Committee but were delayed and not finalised in time for the meeting and the reasons for that.	

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The HIA noted that learning had been taken on the ambition on the number of audits/reports performed and around the availability of Health Board staff and Internal Audit staff during the summer holiday period.

- Section 3 gives of the report outlined the outcomes for the 4 audits that were being received by the Committee and it was noted that the first 2 reports were the final reports from the 2023/24 plan and fed into the 2023/24 opinion whilst the final 2 reports would feed into the 2024/25 plan.

- Section 4 gave a quick overall update with delivery of the Internal Audit plan for 2024/25 and confirmed that there were 37 reviews within that plan.

  The HIA advised the Committee that at the current point in time, one report had been finalised, one was at draft report stage, seven were a work in progress and ten were at planning stage and so Internal Audit had made good progress with the work and the plan which would be updated through the Committee as the year progressed.

- Section 5 of the report confirmed a couple of proposed changes to the plan

  It was noted that the planned audit of ‘Concerns / Complaints/ Putting Things Right’ would be removed from the plan, as an audit had recently been completed by the Welsh Risk Pool and the Health Board was awaiting the reported results.

  The HIA added that The Executive Director of Finance (EDF) and Chief Operating Officer (COO) had requested an additional advisory audit of the revenue investment made by the Health Board into the Endoscopy Unit and that it was proposed that the days allocated for the ‘Concerns / Complaints / Putting Things Right’ audit would be utilised to carry out that additional audit.

- Section 6 outlined the Executive Summaries of the 4 finalised Audit reports:

  - Implementation of the People & Culture Plan (Substantial Assurance rating received) – it was noted that only 1 low finding had been identified that required management attention.

  - Medical Staff Additional Sessions (Reasonable Assurance rating received) – it was noted that Clinical Boards were effectively utilising the new Additional Duty Hours rate card and the system of identifying and managing escalated shifts was also being used effectively but there were matters that required urgent management attention which included actions around the Waiting List Initiative (WLI) forms.

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	The Executive Director of People & Culture advised the Committee that work was being undertaken with the Executive Medical Director to mitigate those risks. - Performance Reporting (Reasonable Assurance rating received) – it was noted that there were 4 matters that required management attention. The CC asked if any of the work undertaken by Internal Audit every crossed over with the work undertaken by Audit Wales. The HIA responded that there was a potential for the work to crossover especially around the structured assessment undertaken by Audit Wales but noted that Internal Audit had regular meetings with Audit Wales to discuss audits and try to ensure that duplication was not happening. The Audit Lead - Audit Wales (ALAW) added that Audit Wales use the Internal Audit reports to reference their review and the structured assessment. - Health & Safety (Reasonable Assurance rating received) – it was noted that the objective of the audit was to review the current progress in delivery against the action plan that was developed following an external review of the Health & Safety arrangements in 2021. It was noted that there was 1 recommendation that covered the 3 objectives outlined. The Director of Corporate Governance (DCG) asked the HIA to set out the process the Health Board need to go through when a limited assurance report (or worse) was received. The HIA responded that all actions were added to the Health Boards tracker which was received by the Committee at every other meeting but noted that actions from the reports with limited assurance had more specific recommendations which were added to the tracker and a detailed follow up plan would be initiated to ensure progress was being made. **The Committee resolved that:** a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports was considered. b) The proposed adjustments to the 2024/25 plan were approved.	
AAC 24/08/007	**Audit Wales Update (click to view)** The Audit Wales Update was received.	

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The ALAW advised the Committee that exhibit 2 of the report summarised the status of Audit Wales' current and planned performance audit work and noted she would take the report as read.

Key points included:

- Fieldwork was underway on the structured assessment for 2024.
- The review of Unscheduled Care, discharge planning review was going through the Audit Wales quality assurance process and would be ready to issues shortly.
- The review of managing urgent and emergency care demand was in the latter stages of fieldwork.
- The review of cost saving arrangements was also in the latter stages of reporting and field work was underway for the planned care review.
- Following on from the report on orthopaedic services in 2023/24, Audit Wales would review the Health Boards Eye Care Services as it had the highest number of waits.
- The 2024 Deep Dive Review of investment in digital systems was ongoing.

The ALAW advised the Committee that exhibit 3 of the report provided information on other relevant examinations and studies published by the Auditor General in the last six months and the links to those.

The Director – Audit Wales (DAW) provided the Committee with an update on the Financial Audit and noted:

- Exhibit 1 summarised the report from an accounts audit perspective with the main work from the Health Boards 2023/24 accounts having been completed, certified and laid.
- Attention would now focus on the Health Boards Charitable Funds accounts and would start around November 2024 with the aim to certify the accounts prior to the Charity Commission deadline of 31st January 2025.

Addendum Report:

The DAW advised the Committee that the addendum report received was an addendum to the Audit of Accounts Report that were presented to the Audit and Risk Committee on 11 July 2024 and set out the recommendations arising from Audit Wales' audit of the 2023-24 annual report and accounts.

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	He added that it provided an update on the progress the Health Board had made against the previous year's recommendations and noted that he would take the report as read. It was noted that the 5 recommendations had been accepted by the Health Board and were in the Health Board's gift to look at, however, item 2 or the report which looked at derecognition of assets being replaced was more complex and required a look from an accounting perspective. **The Committee resolved that:** a) The Audit Wales update including the addendum report was noted.	
AAC 24/08/008	**Post Payment Verification End of Year report 2023/2024** **(click to view)** The Post Payment Verification (PPV) End of Year report 2023/2024. The EDF advised the Committee the report was received annually and provided by Shared Services. The All Wales Post Payment Verification Manager (AWPPVM) advised the Committee that the PPV team had had a busy year and noted that a number of revisits to areas had not been undertaken. She added that in 2023/24, PPV began recovering from the backlog of work. • General Ophthalmic Services (GOS) – it was noted that the visit plan for GOS 2023-2024 were not finalised after explaining to Health Boards that thee visits were subject to change due to a new way of verifying claims. It was noted that PPV began remote access options having full support from Optometry Wales and carried out a small percentage of virtual visits via Microsoft TEAMS, which proved successful but was more gradual than anticipated due to the lack of electronic patient records, with 16 visits completed for Cardiff & Vale University Health Board. The AWPPVM added that future visits would be included in the 2024-2025 visit plan and would incorporate physical visits to carry PPV through the transition period of electronic patient records, which was being encouraged by Welsh Government. • General Pharmacy Services (GPS) – it was noted that in 2023/2024 NWSSP/PPV introduced a new service check after a successful pilot, which was the Quality and Safety Scheme and completed all visits planned. It was noted that PPV had also begun the Collaborative Working Scheme verification for the upcoming financial year 2024-2025 and	

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could verify both those services remotely but that it did not affect the Health Board at this time.

- Additional Services – it was noted that Clinical Waste Self Assessments were piloted for GMS and had been live over the last year to ensure compliance with legislation.

  It was noted that PPV were planning to conduct a pilot with the Self Assessments for Pharmacies in the next few months in 2024-2025.

The AWPPVM advised the Committee that quarterly meetings were scheduled with the Head of Primary Care, Primary Care Managers, Finance Lead, PPV Team and local Counter Fraud team to regularly review the progress report and to discuss themes, recommendations, and any risks.

She added that PPV were also investigating other avenues of savings from the provision of Clinical Waste services and now produced a 'non-collection' 6 monthly report to all Health Boards.

It was noted that there were bi-monthly National GMS, GOS Working Group meetings with Primary Care Managers and PPV to discuss and agree any issues regarding the National application of the programme.

The Committee was advised that PPV training events and roadshows to Practice Managers had been delivered locally and were recorded in advance, based on trend data analysis which was in addition to facilitating one-on-one training requirements, particularly for new practice managers, a training video was recorded as a guide for both GOS and GMS.

The CC noted that the paper stated that the purpose of the PPV process was to provide assurance to Health Boards that the claims for payment made by primary care contractors were appropriate and asked the AWPPVM what her take was on if that was the case.

AWPPVM responded that every service PPV checked had to align with the service specification and provided an example:

- GMS – PPV would go into the Patient Journal and check that everything that was stated in relation to payments was recorded correctly in that journal.

  It was noted that if there were gaps, which could result in financial recoveries, PPV would go back to the practice and request evidence (if available) and if there was no evidence of anything suspicious, PPV would go to the practice and then the Health Board.

The CC asked if the incidents of issues were low, medium or high.

The AWPPVM responded that at the moment, if a new specification came out and a new service was needed, PPV do a roadshow and look at trend data and noted that incidents went up and down with various trends.

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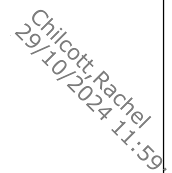
	The Independent Member – Finance (IMF) asked if there was a particular concern with a practice, how would it be raised. The AWPPVM responded that every practice had a routine visit every 3 years (noting it could be anywhere within the 3-year cycle) and that if any service had a 10% or over error rate, a revisit would occur. She added that 100% of claims were checked. The EDF advised the Committee that a number of reports being received by the Board and Committees of the Board now included trend lines and asked the AWPPVM is they could be included in future reports. The AWPPVM responded that there was a business information team within PPV that were working on a new report template which would be sent to the EDF once completed. **The Committee resolved that:** a) The content of the report was noted.	
AAC 24/08/009 	**Procurement Compliance Report / Single Tender Actions (click to view)** The Procurement Compliance Report / Single Tender Actions report was received. The EDF advised the Committee that 2 reports had been received. The standard routine report on Procurement Compliance and the Chair's Action Review. She added that the Head of Procurement would bring a report to the next Audit and Assurance Committee on No PO/No Pay. The EDF advised the Committee that it was pleasing to note that the amount of breaches on non-compliant activity was reducing. The CC asked why the Greenhouse Gas Emissions Trading Scheme Civil Penalty Notice for 2018, 2019, 2020 and 2021 was subject to procurement activity. The EDF responded that the example was part of the issues being identified because there were some areas that a full procurement was not required and whilst the team worked with estates, a number of those areas were being identified. She added capturing of the data correctly was important and making sure that relevant payment processes were in place rather than the robust procurement you'd observe in the majority of spend.	

	The CC noted that a lot of the statuses within the report denoted that dealing with the non-compliance was "in progress" and "client contract being put in place". She added that if a contract was being prepared retrospectively, that was great as it ensured proper terms of business to go with the spend, however it was difficult to negotiate terms of business when mid-way through delivery of a contract and asked how successful the Health Board were at retrospectively implementing contract terms that were as favourable to the Health Board as they would have been had they been put in place at the start. The EDF responded that as those areas were identified, a short-term contract was put in place whilst a robust procurement was undertaken and added that the question would be given to the Head of Procurement for further information. **The Committee resolved that:** a) The content of the reports was noted. b) The content of the reports was agreed.	
AAC 24/08/010	**Written Controlled Documents Policy & Procedure (click to view)** The Written Controlled Documents Policy & Procedure was received. The DCG thanked the Corporate Archivist & Records Management Manager for the work undertaken on the policy and procedure. He added that upon received limited assurance on policy management from Internal Audit, amendments to UHB 001 and UHB 242 documents were a necessary step in the improvement of that controlled document management and were consistent with recommendations made in the original audit against Policy Management. It was noted that the policy and procedure required a little bit more work around spelling and formatting but that due to the minor amendments required, the Committee would approve as requested. **The Committee resolved that:** a) The updated Written Controlled Documents Policy (UHB 001) & Procedure (UHB 242) attached as appendix 1 & 2 to the report were approved.	
AAC 24/08/011	**Counter Fraud Progress Update (click to view)** The Counter Fraud Progress Update was received. The Lead Local Counter Fraud Specialist (LLCFS) introduced themselves as they had recently taken up the post.	

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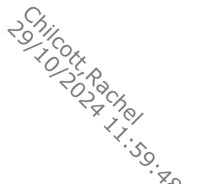
	He added that the report received covered the period from 18th June until 16th August and outlined ongoing investigations. It was noted that during the reporting period there had been a total of 21 referrals made to the team. 15 of those referrals had been investigated and informally resolved with 6 promoted to formal investigation as outlined in the report. **The Committee resolved that:** a) The Counter Fraud Progress report was noted.	
AAC 24/08/012	**Agenda for Private Audit and Assurance Committee** *i. Counter Fraud Progress Update (Confidential – ongoing investigations* *ii. Health Board Salaries Overpayment Update*	
AAC 24/08/013	**Any Other Business** No Other Business was discussed.	
AAC 24/08/014	**Items to be deferred to Board / Committee** The CC advised the Committee that there was an open invitation to contact the DCG, Senior Corporate Governance Officer or herself if anything needed to be added to future Audit & Assurance Committee meetings.	
	Date and time of next committee meeting 5 November 2024 via MS Teams	



Public Action Log
Following Audit & Assurance Committee Meeting
03 September 2024
(Updated for the meeting being held 05 November 2024)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Actions					
AAC 24/08/009	Procurement Compliance Report / Single Tender Actions	Committee to receive report on 'No PO/No Pay' at the next meeting held in November.	Executive Director of Finance / Head of Procurement	**05.11.2024**	**COMPLETED** On Forward Plan for November meeting and Head of Procurement notified
AAC 24/08/009	Procurement Compliance Report / Single Tender Actions	Question from the Chair of the Committee to the Head of Procurement, asking how successful the Health Board were at retrospectively implementing contract terms.	Head of Procurement	**05.11.2024**	**COMPLETED** Question sent to Head of Procurement via minutes taken. Head of Procurement will respond via email.
Actions referred to Board / Committees					
AAC 24/07/006	Internal Audit Progress Report – Medical Records Tracking (CD&T CB)	QSE Committee to consider report to ensure recommendations were being implemented	Ian Virgil / Matt Phillips	**08.10.2024**	**COMPLETED** QSE Committee received the papers to review in August 2024, and a verbal update will be received by the Committee at its October meeting.

Report Title:	**Internal Audit Progress Report**			Agenda Item no.	2.1	
Meeting:	Audit & Assurance Committee	Public	X	Meeting Date:	05/11/24	
		Private				
Status *(please tick one only)*:	Assurance	X	Approval	X	Information	X
Lead Executive:	Director of Corporate Governance					
Report Author (Title):	Head of Internal Audit					

Main Report

Background and current situation:

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

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

The 2024/25 plan was formally approved by the Audit Committee at its May 24 meeting.

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

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

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

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

The following reports informing the 24/25 Opinion have been finalised since the September 24 meeting:

- Safeguarding (Reasonable Assurance)
- Specialist Services CB Governance and Financial Arrangements (Reasonable Assurance)

The outcome of the Maternity Care – Ockenden Review audit is also being reported to the Committee, although the report remains in draft at the current time.

The Executive summaries from the final / draft reports are included within the progress report, with the full versions of the reports within the committee supporting papers.

The progress report also includes details of proposed adjustments to the 2024/25 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 2024/25 plan.

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/~~No~~
The progress report provides the Committee with a level of assurance around the management of a series of risks covered within the specific audit assignments delivered as part of the Internal Audit Plan. The report also provides information regarding the areas requiring improvement and assigned assurance ratings.
Safety: Yes/~~No~~
The progress report includes the outcome from audits that provide assurance around controls and processes relating to patient safety.
Financial: Yes/~~No~~
The progress report includes the outcome from an audit that provide assurance around controls and processes relating to Finance.
Workforce: ~~Yes~~/No
Legal: Yes/~~No~~
The progress report includes the outcome from audits that provide assurance around controls relating to legal requirements.
Reputational: Yes/~~No~~
The progress report includes the outcome from audits that provide assurance around reputational issues.
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 November 2024

NWSSP Audit and Assurance Services

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6. New Global Internal Audit Standards *5*

7.Final Report Summaries *6*

Appendix A Assignment Status Schedule

Appendix B Report Response Times

Appendix C Key Performance Indicators

Appendix D Assurance Ratings

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 2024/25 Internal Audit plan.

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

The plan for 2024/25 was agreed by the Audit & Assurance Committee in May 2024 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. Assignments with Delayed Delivery

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

Audit	Current Position	Draft Rating	Reason
Interventions Not Normally Undertaken	Draft	Limited	Delay in completion of audit due to waiting for management decision on the feasibility of an element of the fieldwork.
Follow-up: Implementation of Health Roster	Draft	Limited	Delay in completion of fieldwork due to waiting for information from management.
Legal Services	Work in Progress		Delay in completion of audit due to complexity of fieldwork and availability of Internal Audit resources.
Core Financial Systems	Work in Progress		Delay in commencing fieldwork due to availability of Internal Audit resources.
Smoking Cessation	Work in Progress		Delay in completion of audit due to the number of site visits required as part of fieldwork.
Follow-up: Surgery CB - Consultant Job Plan	Work in Progress		Delay in commencing audit due to waiting for agreement of brief by management.
Local Data Repository	Work in Progress		Initial delay in receiving information from management. Now on hold pending discussion with Executive lead.

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3. Outcomes from Completed Audit Reviews

Two audit reports have been finalised since the last meeting of the Committee in September 24.

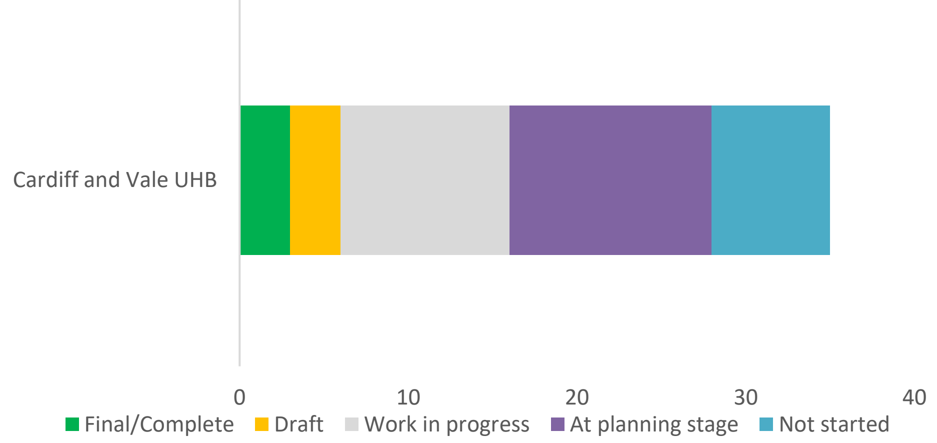
The Executive Summaries from the final reports are provided in Section five. The full reports are included separately within the Audit Committee supporting papers for information.

The Maternity Care - Ockenden Review audit was part of the 2023/24 plan but was not completed in time to feed into the 2023/24 annual opinion. Due to operational pressures within the service, the report has still not been finalised but is presented to the Committee in draft for information at this stage. The final report will be presented to a future meeting of the Committee and the outcome will inform the 2024/25 opinion.

FINALISED AUDIT REPORTS	ASSURANCE RATING
Safeguarding	Reasonable
Specialist Services CB Governance and Financial Arrangements	Reasonable
DRAFT AUDIT REPORTS	**ASSURANCE RATING**
Maternity Care - Ockenden Review	Reasonable

4. Delivery of the 2024/25 Internal Audit Plan

There are a total of 35 reviews within the 2024/25 Internal Audit Plan, (including the changes highlighted below), and overall progress is summarised below.



The illustration above shows that three audits from the 2023/24 plan have been finalised so far this year and three others have reached the draft report stage.

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

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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 two audits from the 2023/24 plan that were not sufficiently progressed to be included within the Head of Internal Audit Opinion for 2023/24. One of the audits has been finalised and the second is currently at the draft report stage and the outcomes will feed into the 2024/25 Opinion.

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

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

5. Changes to the 24/25 Internal Audit Plan

The planned audit of Charitable Funds is proposed for deferral to the 2025/26 plan as the service is currently going through an external review and also an Organisational Change Process (OCP). The deferral of the audit is supported by the Executive Director of Finance.

The audit of Planned Care is proposed for removal from the plan due to current changes in processes and personnel in this area. It is also noted that Audit Wales are doing a review of Planned Care this year. The removal of the audit is supported by the Chief Operating Officer.

6. New Global Internal Audit Standards

In January 2025 new Global Internal Audit Standards (GIAS) will become effective. The body that sets Internal Audit Standards for UK Public Sector Organisations, the UK Public Sector Internal Audit Standards Advisory Board (the IASAB), has determined that the new Standards will apply to Public Sector audits from 1 April 2025 to align with the financial year. As the new Standards have been developed to apply to all sectors, the IASAB will be producing a practice note setting out any sector specific interpretations or other material needed to make them suitable for UK public sector use.

The new GIAS requirements seek to elevate internal audit practice in five domains that cover the profession's purpose, ethics and professionalism, governance, management and performance.

We are currently undertaking preparatory work to understand the impact of the new GIAS on our work, and to ensure that we can appropriately apply these standards from 1 April 2025.

At this point we do not anticipate that there will be many changes needed to our audit approach. However, one potential change is around how we monitor and evidence the implementation of agreed management actions.

We will update the Committee at the next meeting if we identify that any other changes are needed to our approach.

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7. Final Report Summaries

7.1 Safeguarding

Purpose

The overall objective of the audit was to assess the adequacy of systems and controls in relation to Safeguarding across the Health Board and to review progress against the JICPA improvement plan.

Overview

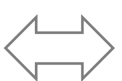
We have issued reasonable assurance on this area. The matters requiring management attention include:

- The policies and procedures that support the All-Wales Safeguarding procedures are in need of updating.
- The Health Board has no overarching Safeguarding policy.
- Clinical Board governance arrangements need improvement.
- Level 3 safeguarding training should be provided for all staff band 6 and above in line with RCN guidelines.
- Records need to be maintained for all training provided by the safeguarding team.

The above issues have all been identified through the recent JICPA review and are being addressed through the improvement plan arising from that review. We have therefore not raised individual recommendations for these issues in this report but have included a general recommendation around the on-going implementation of the improvement plan.

We have also raised one further medium priority recommendation in respect of the governance arrangements at the Safeguarding Steering Group meetings.

Report Opinion

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

Assurance summary[1]

	Objectives	Assurance
1	Safeguarding policies and procedures are in place that align with the Wales Safeguarding Procedures	Reasonable
2	Governance arrangements exist to manage safeguarding and there is a strategy in place	Reasonable
3	Staff have been provided with adequate training on safeguarding	Reasonable
4	The Health Board has produced a JICPA Improvement Plan	Substantial

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

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
2	Quorum and attendance at SSG meetings	2	Operation	Medium
4	Implementation of the JICPA Improvement Plan	1,2,3	Operation	Medium

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7.2 Specialist Services CB Governance and Financial Arrangements

Purpose

The purpose of this review has been to review the governance and financial arrangements in place within the Specialist Services Clinical Board, including escalation processes and updates to the Health Board's Committees.

Overview

We have issued reasonable assurance in this area.

The matters requiring management attention include:

- Terms of Reference (ToR) for decision making groups and governance forums within the Clinical Board are not all in place or up to date.
- Meeting notes are not always finalised in a timely manner and action logs are not always documented for key decision making groups and forums.

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

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	An appropriate governance structure is in place within SSCB with Terms of Reference (ToR) in place for decision making groups and governance forums.	Reasonable
2	Meetings are conducted in line with the ToR with adequate meeting notes, agendas and action logs maintained.	Reasonable
3	The Clinical Boards work collaboratively with Finance Business Partners to manage their financial budgets and financial position.	Substantial
4	Implementation of agreed savings plans are monitored, reported and acted upon at Clinical Board level.	Reasonable

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

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Terms of Reference (ToR) were not in place for a number of decision-making groups and governance forums and with some of the ToR's being out of date.	1	Design	High
2	Improvements required to the documentation of matters discussed and key actions agreed at groups and governance forums of the Specialist Services Clinical Board.	2	Operation	Medium

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7.3 Maternity Care - Ockenden Review (Draft)

Purpose

The overall objective of this audit was to assess the progress made by the Health Board in implementing the actions from the Ockenden review and ensuring compliance with recommendations.

Overview

We have issued reasonable assurance on this area.

We were able to evidence that a number of recommendations from the Ockenden report had been implemented. However, status updates were not being made on the progress of implementing the remaining recommendations. The matters requiring management attention include:

- Reviews of action plans and associated ongoing updates.
- Reporting of details in relation to the progress on the implementation of recommendations to the Maternity and Neonatal Oversight Group.

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

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A First Review

Assurance summary[1]

	Objectives	Assurance
1	The Health Board has produced an action plan from the Ockenden report and effective progress is being made against the actions	Reasonable
2	Appropriate governance arrangements in place which provide effective oversight of the implementation of the Ockenden report recommendations	Reasonable
3	Regular reporting and scrutinisation on the progress of implementing the recommendations to appropriate Groups and Committees	Reasonable

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

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Action plan reviews and updates	1,2	Design	Medium
2	Progress Reporting on the recommendations	2,3	Operation	Medium

ASSIGNMENT STATUS SCHEDULE

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2023/24 Plan							
Performance Reporting	11	Digital & Health Intelligence			Final Report	Reasonable	September
Maternity Care – Ockenden Review	31	Nursing			Draft Report	Reasonable	November
2023/24 Plan							
Health & Safety	4	People & Culture	Q1		Final Report	Reasonable	September
Safeguarding	15	Nursing	Q1		Final Report	Reasonable	November
Specialist Services CB Governance and Financial Arrangements	26	COO	Q1		Final Report	Reasonable	November
Interventions Not Normally Undertaken	17	Public Health	Q1		Draft Report	Limited	January
Follow-up: Implementation of Health Roster System	6	People & Culture / Nursing	Q3		Draft Report	Limited	January
Legal Services	3	Corporate Governance	Q2		Work in Progress		January
Smoking Cessation	18	Public Health	Q2		Work in Progress		January
Local Data Repository	21	Digital & Health Intelligence	Q2		Work in Progress		January
Follow-up: Surgery CB - Consultant Job Plans	28	COO	Q2		Work in Progress		January
Consent Process	29	Medical	Q1		Work in progress		January

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Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Capital Systems	*12*	*Finance*	*Q2*		*Work in Progress*		*January*
Endoscopy Unit Investment	38	Finance / COO	Q2/3		Work in Progress		January
Data Quality Strategy	20	Digital & Health Intelligence	Q2/3		Planning – Final brief issued		January
Decision Making	2	Corporate Governance	Q3		Work in Progress		January
Core Financial Systems	10	Finance	Q2		Work in Progress		May
Surgery CB - Governance Arrangements	27	COO	Q2		Planning – Final brief issued		May
Therapies and Health Sciences Agency and Locum Staff	31	Therapies and Health Sciences	Q2		Planning		May
Business Continuity Planning (Deferred from 23/24 plan)	7	Strategic Planning	~~Q1~~	Q3	Planning – Final brief issued		May
Procurement & Contract Management	9	Finance	Q3		Planning – Final brief issued		May
Waiting List Management	24	COO	Q3		Planning – Final brief issued		May
Records Management	30	Digital & Health Intelligence	Q3		Planning – Draft brief issued.		May
Medicine CB - Acute Position Model / Same Day Emergency Care	25	COO	Q3		Planning		May
Risk Management / Board Assurance Framework	1	Corporate Governance	Q4				May
Occupational Health Service	5	People & Culture	Q4		Planning		May
Hosting of the Substance Misuse Area Planning Team and Board	8	Strategic Planning	Q4		Planning		May
Follow-up: Alcohol Standards	19	Public Health	Q4				May

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Office 365 benefits realisation	22	Digital & Health Intelligence	Q4				May
Follow-up: Temporary Staffing Costs	33	People & Culture / Finance	Q4				May
Follow-up: Decarbonisation	37	Strategic Planning	Q4				May
Estates Assurance - Energy Management	*13*	*Finance*	*~~Q2~~*	*Q4*	*Planning – Final brief issued*		*May*
Follow-up: Estates Condition	*14*	*Finance*	*TBC*				*TBC*
Development of Integrated Audit Plans	*32*	*Strategic Planning/Finance*	*N/A*				*Ongoing*
Approved Integrated Audit Plan Assignments:							
• *Mortuary Refurbishment at UHW*	*36*	*Finance*	*Q2*		*Draft Report*	*Reasonable*	*January*
• *Modernisation of Passenger Lifts UHW*	*35*	*Finance*	*Q3/4*		*Work in Progress*		*January*
• *UHW Tertiary Tower*	*34*	*Finance*	*Q3/4*		*Planning – Final brief issued*		*May*

Reviews removed from the plan

Planned output	Ref No	Exec Director Lead	Comment
Concerns/ Complaints/ Putting Things Right (Duty of Candour)	16	Nursing	Proposed for removal from the plan as an audit has recently been completed by the Welsh Risk Pool and the Health Board is awaiting the reported results. Agreed by September AC.
Charitable Funds	11	Finance	Proposed for deferral to the 2025/26 plan, as the service is currently going through an external review and Organisational Change Process (OCP). To be agreed by November AC.
Planned Care Programme	23	COO	Proposed for removal from the plan due to current changes in processes and personnel in this area. It is also noted that Audit Wales are doing a review of Planned Care this year. To be agreed by November AC.

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REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Performance Reporting	Reasonable	Final	06/08/24	28/08/24	21/08/24	21/08/24	G
Health & Safety	Reasonable	Final	13/08/24	04/09/24	20/08/24	20/08/24	G
Safeguarding	Reasonable	Final	04/09/24	25/09/24	07/10/24	07/10/24	R
Specialist Services CB Governance and Financial Arrangements	Reasonable	Final	07/10/24	28/10/24	24/10/24	24/10/24	G

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2024/25	G	May 2024	By 30 June	Not agreed	Draft plan	Final plan
Audit reports to agreed Audit Committee	R	42% 5 from 12	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 8 from 8	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	75% 3 from 4	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 4 from 4	80%	v>20%	10%<v<20%	v<10%

Assurance Ratings

	Rating	Description
	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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Maternity Care – Ockenden Review Draft Internal Audit Report

Cardiff & Vale University Health Board

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Appendix B: Assurance opinion and action plan risk rating 13

Review reference:	CVU 2324-31 Maternity Care
Report status:	Draft Report
Fieldwork commencement:	11 March 2024
Fieldwork completion:	16 August 2024
Debrief meeting:	16 August 2024
Draft report issued:	19 August 2024
Management response received:	
Final report issued:	
Auditors:	Warren Alexander – Principal Auditor Lucy Jugessur – Deputy Head of Internal Audit
Executive sign-off:	Jason Roberts – Executive Director of Nursing
Distribution:	Abigail Holmes – Director of Midwifery and Neonatal Services
Committee:	Audit & Assurance Committee

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

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

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

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

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

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Executive Summary

Purpose

The overall objective of this audit was to assess the progress made by the Health Board in implementing the actions from the Ockenden review and ensuring compliance with recommendations.

Overview

We have issued reasonable assurance on this area.

We were able to evidence that a number of recommendations from the Ockenden report had been implemented. However, status updates were not being made on the progress of implementing the remaining recommendations. The matters requiring management attention include:

- Reviews of action plans and associated ongoing updates.
- Reporting of details in relation to the progress on the implementation of recommendations to the Maternity and Neonatal Oversight Group.

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

Report Opinion

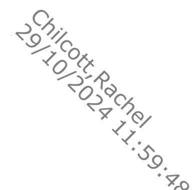
		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A First Review

Assurance summary[1]

	Objectives	Assurance
1	The Health Board has produced an action plan from the Ockenden report and effective progress is being made against the actions	Reasonable
2	Appropriate governance arrangements in place which provide effective oversight of the implementation of the Ockenden report recommendations	Reasonable
3	Regular reporting and scrutinisation on the progress of implementing the recommendations to appropriate Groups and Committees	Reasonable

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Action plan reviews and updates	1,2	Design	Medium
2	Progress Reporting on the recommendations	2,3	Operation	Medium



1. Introduction

1.1 Our audit review of Maternity Care – Ockenden Review was completed in line with the 2023/24 internal audit plan for Cardiff and Vale University Health Board (the 'Health Board').

1.2 In March 2022 the second and final Ockenden report into Maternity Services at Shrewsbury and Telford Hospital NHS Trust was published. The report detailed failings within Maternity and Neonatal services that resulted in avoidable harm to mothers and babies within their care. The report outlined 89 recommendations that all Trusts/Health Boards in the UK should adhere to, to improve the quality of maternity and neonatal services. Following its publication, the Health Board carried out an immediate self-assessment of the service and of the 89 report recommendations, 45 of the requirements were already met, 27 were partially met and 17 were not met at all. The Health Board have produced an Ockenden improvement plan to address the outstanding recommendations.

1.3 As well as the Ockenden review, Healthcare Inspectorate Wales (HIW) undertook an unannounced inspection in November 2022. Following the review, eight immediate assurance recommendations were made, and a secondary, unannounced follow-up inspection was performed in March 2023 finding that improvements had been made in many areas, whilst also indicating that significant challenges remained and that overall, improvements were not progressing at the pace required. The most recent HIW Inspection took place in March 2024, where improvements were once again noted; favourable comments were made with respect to many areas, including improvements with staffing levels, albeit with some challenges remaining around PROMPT (Practical Obstetric Multi-Professional Training) and other mandatory training compliance rates, and multidisciplinary team working.

1.4 A business case was presented to the Health Board Investment Group in January 2023 setting out proposed investments and in response, the midwifery establishment was increased.

1.5 A Maternity Oversight Group was established and chaired by the Executive Director of Nursing and attended by the Executive Medical Director as well as Clinical Board representatives to oversee progress with the Ockenden improvement plan, HIW improvement plan and wider quality and patient safety themes.

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

1.7 The principal risks under consideration in the performance of this audit have related to the Health Board's ability to demonstrate compliance with recommendations made in various external reviews and reports, including the Ockenden review, Healthcare Inspectorate Wales' unannounced inspections, and the Maternity and Neonatal Safety Support Programme (MatNeoSSP) review.

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2. Detailed Audit Findings

Objective 1: The Health Board has produced an action plan from the Ockenden report and effective progress is being made against the actions to ensure that all the partially met and unmet recommendations are implemented.

2.1 An action plan was produced in March 2022, as a response to the 89 recommendations arising from the Ockenden report. Responses to 80 recommendations had been assigned red (26), amber (22) and green ratings (32). Six of the responses did not appear to have been rated, and three recommendations were determined to be not applicable to Cardiff and Vale Maternity Services. We also found that target dates were not recorded against actions. **(Matter Arising 1 – Medium Priority)**

2.2 Progress has been made against the actions listed in the response to the Ockenden report. In the early stages following the report, it can be observed that additional funding had been secured for Maternity Services and several new posts were created within the department, in accordance with the recommendations of the report. Status updates do not appear to have been recorded against action plans since the initial combined assurance document was produced. Progress against actions has been confirmed during this audit by examination of reports made to the Quality, Safety and Experience Committee (QS&E), initial management responses detailed in action plans and enquiries with staff. **(Matter Arising 1 – Medium Priority)**

2.3 Some examples of actions which have been taken in response to the recommendations of the Ockenden report include the appointment of four new Delivery Suite Coordinators, the implementation of new training programmes and the recruitment of six band 5 neonatal nurses to support the transitional care unit.

2.4 Since the publication of the Ockenden report, Maternity Services across England and Wales have been subject to heightened scrutiny. In the case of Cardiff and Vale UHB, for the purposes of this audit, the reviews or reports which have been taken into consideration include;

- Ockenden Final Report (Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust). Publication date: 30 March 2022.
- Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (MatNeoSSP) (July 2023).
- Healthcare Inspectorate Wales Hospital Inspection Report (Unannounced) Maternity Unit, University Hospital of Wales. Inspection date: 8-10 November 2022. Follow up Inspection date: 27 – 29 March 2023. Publication date: 21 June 2023.
- Healthcare Inspectorate Wales Hospital Inspection Report (Unannounced) Maternity Unit, University Hospital of Wales. Inspection date: 19 – 21 March 2024. Publication date: 21 June 2024.

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2.5 The Maternity and Neonatal Services in Wales Assessment, Assurance and Exception Reporting Tool was also examined as part of this audit, which in addition to incorporating recommendations from the HIW reports and the Ockenden report, also included actions derived from a review of maternity services at Cwm Taf Morgannwg Health Board, and reports by MBRRACE-UK.

2.6 The MatNeoSSP Discovery Phase Report was published in July 2023, recommending 124 improvement actions, including 59 priority areas. A spreadsheet has been produced for the purposes of tracking responses to these recommendations; compliance was indicated in the case of 40 of the identified actions, non-compliance in the case of 49, whilst 24 were designated as being non-applicable, and no response was indicated in the case of 11 recommended actions.

2.7 Whilst it was evident that some of the recommended actions in the MatNeoSSP Discovery Phase Report had been acknowledged and evaluated insofar as comments were listed in relation to 69 of them, target dates were not defined, responsible Officers were not designated, and no further reviews or status updates appear to have taken place. **(Matter Arising 1 – Medium Priority)**

2.8 The Assurance and Exception Reporting Tool was produced in May 2022 in order to collate recommendations and associated actions from the various reviews and reports that had taken place at that point. This document also utilised a red, amber, green rating system and contained 80 recommendations, including 48 designated as originating from the Ockenden report; of these 48, six were rated as red, 10 as amber, with the remaining 32 being given a green rating. Again, target dates were not recorded against actions. **(Matter Arising 1 – Medium Priority)**

2.9 It can be determined from sources such as responses to HIW inspection reports, that progress has been made with respect to the implementation of management actions, and following the production of the initial action plans, some degree of ongoing monitoring of this progress appears to have taken place, although the documentation available to evidence this is limited. (**Matter Arising 1 – Medium Priority)**

2.10 Whilst additional funding has been allocated to Maternity Services in order to support the improvements recommended by the Ockenden report, the Director for Maternity and Neonatal Services indicated that there have nevertheless been restrictions to progress in some areas due to budgetary constraints.

2.11 Actions arising from all inspections and reviews are now recorded in the AMaT Audit Management system. This system was implemented after the responses to the Ockenden report were collated, and as such, the actions arising from it have not been input into it.

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Conclusion:

2.12 Action plans were found to have been produced in response to the Ockenden report and in response to a number of other third-party inspections and reviews. There is evidence from HIW inspection reports that effective progress has been made in

implementing the actions arising from HIW inspections, whilst other management responses to action plans and reports to the QSE Committee demonstrate that general progress is being made against recommended actions. We have provided **Reasonable Assurance** for this objective.

Objective 2: There are appropriate governance arrangements in place, which provide effective oversight of the implementation of the Ockenden report recommendations.

2.13 All of the management actions listed in the action plans relating to the HIW reports reviewed during the course of this exercise were found to have been assigned to individual officers who are responsible for implementing the actions at an operational level. Management actions in relation to other action plans were not assigned to individual responsible Officers. **(Matter Arising 1 – Medium Priority)**

2.14 Governance arrangements have been strengthened by the appointment of the Director for Maternity and Neonatal Services, who maintains responsibility for ensuring that the actions reviewed as part of this audit are implemented and that progress in these areas are monitored.

2.15 Regular reports have been made to the Quality, Safety and Experience Committee and the Board, although these have not always contained sufficient detail to facilitate effective oversight in respect of the Maternity Services reviews because action plans and tracker documents have not been regularly updated. **(Matter Arising 2 – Medium Priority)**

Conclusion:

2.16 Governance arrangements were generally found to be satisfactory, and a clear reporting structure is in place. Responsibility for the implementation of management actions arising from the various reviews has not always been clearly assigned. We have provided **Reasonable Assurance** for this objective.

Objective 3: There is regular reporting and scrutinisation on the progress of implementing the recommendations to appropriate Groups and Committees within the Health Board.

2.17 The Executive Nurse Director reports on matters which relate to Maternity Services to the Quality, Safety & Experience Committee and directly to the Board. We examined the QSE Committee minutes since the initial response to the publication of the Ockenden report, and it is evident that the status of Maternity Services has attracted significant attention from the Committee. Initially, a high level of detail was included in the updates, which specified the Health Board's level of compliance with the recommendations from the Ockenden report and from other reviews, but similarly detailed ongoing progress reports do not appear to have taken place. **(Matter Arising 2 – Medium Priority)**

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2.18 A maternity thematic review report was made to the QSE Committee in October 2023. This report made direct reference to the Ockenden report and included details of progress relating to some areas encompassed by the report's recommendations. However, the position statement of compliance against all recommendations does not appear to have been updated since a self-assessment exercise was carried out immediately in response to the Ockenden report.

2.19 A Maternity and Neonatal Oversight Group was formed, initially in order to co-ordinate responses to the Ockenden report. The group convenes monthly, and its attendees include the Director for Maternity and Neonatal Services and the Executive Director of Nursing. It has not been possible to determine the level of information reported to and discussed within this group. Minutes from December 2023 and January 2024 were examined, and no direct reference to the Ockenden report or the overall position with respect to the associated actions had been documented. **(Matter Arising 2 – Medium Priority)**

Conclusion:

2.20 There was little evidence to confirm that progress is being monitored via the Maternity and Neonatal Oversight Group. However, there was evidence of some progress updates being provided to the QSE Committee. We have provided **Reasonable Assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Action Plan Reviews and Updates (Design)	**Impact**
Whilst there is evidence to support that progress has been made with respect to implementing actions specified by the various external reviews. It appears that ongoing monitoring activities have been limited. The Red, Amber, Green analysis of the Ockenden Report's recommendations demonstrated that the Health Board was aware of the recommendations and the overall level of compliance in relation to them. The analysis did include prospective actions where shortcomings in compliance were identified, but responsible individuals were not specified, and target dates were not defined. These actions, amongst those arising from several other reviews and reports, were carried forward into a Assurance and Exception Reporting Tool, but this was not documented in the original action plans, and therefore the audit trail from the original action plans is incomplete. An analysis of the improvement actions recommended by the MatNeo SSP Discovery Phase Report was produced, but some actions were not directly addressed and status updates have not taken place. Additionally, responsible individuals were not designated and target dates were not defined.	Potential risk of: • Maternity Services are currently unable to demonstrate compliance against a number of recommendations against the various external reviews and reports.

Recommendations		**Priority**
1.1	Action plans relating to the reviews and reports which were incorporated into the combined assurance document should be reviewed. Status updates should be recorded against all actions and actions should be closed where appropriate. In cases where actions are carried forward to another action plan, this should be recorded in the original action plan, including reference details of the superseding action.	**Medium**
1.2	It should be assured that target dates are defined and that responsible individuals are designated in respect of each agreed action of the Assurance and Exception Reporting Tool. In cases where recommended actions are not agreed, information to show that the recommendation has been considered should be recorded.	**Medium**

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1.3	Action plans should be regularly reviewed in accordance with a prescribed schedule, and in response to progress milestones being achieved. Status updates should be entered against each action and timescales should be recalculated where appropriate.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Xxx		
1.2	Xxx		
1.3	Xxx		

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Matter Arising 2: Progress Reporting on the recommendations (Operation)	**Impact**
We were only provided with the Maternity and Neonatal Oversight Group minutes for December 2023 and January 2024 and subsequently work undertaken in the Oversight Group could not be determined during the audit. Nonetheless, it was observed that the group is well positioned to provide oversight in terms of ensuring that action plans are monitored, and that relevant information is reported to the QSE Committee where appropriate. Whilst it is evident that maternity care has been given substantial attention by the Quality, Safety and Experience (QSE) Committee, the content of updates provided to the Committee has not always included sufficient information. Reports to the QSE Committee have featured detailed progress reports against specific actions arising from the Ockenden Report and various other reviews, but it does not appear that an analysis of the overall level of compliance has been undertaken since the action plans were initially compiled. The provision of up to date assurances to the QSE Committee in relation to the Health Board's compliance with the recommendations arising from the Ockenden report and various other reviews has been precluded by the absence of management information in the form of updated action plans and related analyses.	Potential risk of: • Assurances with respect to the progress of Maternity Services in implementing recommended actions may not be measured effectively or communicated appropriately to the Health Board or nominated Committee(s).

Recommendations		**Priority**
2.1	The scope of the Maternity and Neonatal Oversight Group should be reviewed, and it should be ensured that the monitoring of progress against action plans is highlighted as a core function of the group.	**Medium**
2.2	Regular status updates should be reported to the Quality, Safety and Experience Committee with respect to overall progress against implementing actions recommended by external reviews.	**Low**

Agreed Management Action	**Target Date**	**Responsible Officer**

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2.1	Xxx		
2.2	Xxx		

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Safeguarding
Final Internal Audit Report

October 2024

Cardiff & Vale University Health Board

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Review reference:	CVU-2324-15
Report status:	Final
Fieldwork commencement:	04 July 2024
Fieldwork completion:	14 August 2024
Debrief meeting:	09 August 2024
Draft report issued:	21 August 2024 and 4 September 2024
Management response received:	7 October 2024
Final report issued:	7 October 2024
Auditors:	Ken Hughes, Audit Manager Lucy Jugessur, Deputy Head of Internal Audit
Executive sign-off:	Jason Roberts, Executive Nurse Director
Distribution:	Linda Hughes-Jones, Head of Safeguarding
Committee:	Audit & Assurance Committee

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

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

Disclaimer notice - please note

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

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

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Executive Summary

Purpose

The overall objective of the audit was to assess the adequacy of systems and controls in relation to Safeguarding across the Health Board and to review progress against the JICPA improvement plan.

Overview

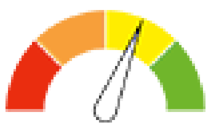
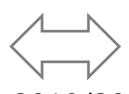
We have issued reasonable assurance on this area. The matters requiring management attention include:

- The policies and procedures that support the All-Wales Safeguarding procedures are in need of updating.
- The Health Board has no overarching Safeguarding policy.
- Clinical Board governance arrangements need improvement.
- Level 3 safeguarding training should be provided for all staff band 6 and above in line with RCN guidelines.
- Records need to be maintained for all training provided by the safeguarding team.

The above issues have all been identified through the recent JICPA review and are being addressed through the improvement plan arising from that review. We have therefore not raised individual recommendations for these issues in this report but have included a general recommendation around the on-going implementation of the improvement plan.

We have also raised one further medium priority recommendation in respect of the governance arrangements at the Safeguarding Steering Group meetings.

Report Opinion

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

Assurance summary[1]

	Objectives	Assurance
1	Safeguarding policies and procedures are in place that align with the Wales Safeguarding Procedures	Reasonable
2	Governance arrangements exist to manage safeguarding and there is a strategy in place	Reasonable
3	Staff have been provided with adequate training on safeguarding	Reasonable
4	The Health Board has produced a JICPA Improvement Plan	Substantial

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

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
2	Quorum and attendance at SSG meetings	2	Operation	Medium
4	Implementation of the JICPA Improvement Plan	1,2,3	Operation	Medium

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1. Introduction

1.1 Our audit review of Safeguarding was completed in line with the 2024/25 internal audit plan for Cardiff and Vale University Health Board (the 'Health Board').

1.2 There are national Wales Safeguarding Procedures in place detailing the essential roles and responsibilities for practitioners to ensure that they safeguard children and adults who are at risk of abuse and neglect. They have been designed to standardise practice across all of Wales and between agencies. The Safeguarding Procedures have been produced to ensure practice is in accordance with the legislative requirements and expectations of the Social Services and Well-being (Wales) Act 2014[1] and the accompanying Working Together to Safeguard People Guidance.[2]

1.3 In January 2024 the Care Inspectorate Wales (CIW), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW) and His Majesty's Chief Inspector of Education and Training in Wales (Estyn) carried out a joint inspection of multi-agency response to abuse and neglect of children in Cardiff. Following on from the review a report was produced and due to the findings, HIW has requested that the Health Board provide an immediate improvement plan for the actions it has taken and/ or intends to take.

1.4 The Executive Nurse Director is the lead for this review.

1.5 The following risks have been considered as part of this review:

- A lack of clear lines of accountability for safeguarding within the Health Board;
- A lack of communication within the Health Board to the Safeguarding team on specific safeguarding issues;
- Risk of injury and death to vulnerable patients due to insufficient procedures, resource and training; and
- A lack of training and development of staff to ensure effective and safe working.

2. Detailed Audit Findings

Objective 1: Safeguarding policies and procedures are in place that align with the Wales Safeguarding Procedures and reflect the UHB's responsibility to safeguard and promote the wellbeing of children and adults at risk.

2.1 The Safeguarding team adhere to the All-Wales Safeguarding Procedures published by the Welsh Government. They are intended to guide safeguarding practice for all those employed in the statutory, third (voluntary) and private sector in health, social care, education, police, justice and other services.

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[1] Social Services and Well-being (Wales) Act 2014 (legislation.gov.uk)
[2] Safeguarding guidance | GOV.WALES

2.2 They are applicable for all practitioners and managers working in Wales - whether employed by a devolved or non-devolved agency. The procedures are designed to standardise practice across all of Wales and between agencies. The All-Wales Safeguarding Procedures can be accessed through the Safeguarding section of the Health Board's intranet pages. They are also available for download to smart phones and tablets via an App, or to any PC from the internet.

2.3 There are a number of supporting documents published on the Safeguarding intranet pages that supplement the All-Wales Safeguarding Procedures. These include guidance for staff working with uncooperative families, the PRUDiC (Procedural Response to Unexpected Deaths in Childhood), Protocol for the Resolution of Professional Differences and the Duty of Candour Statutory Guidance.

2.4 The Safeguarding team also has a number of policies and procedures on their 'S' Drive which can only be accessed by the Safeguarding team. The Safeguarding intranet site includes just one of these policies and procedures (PRUDiC). Policies and procedures on the 'S' Drive include Ask & Act (Standard operational procedure SNA response to Ask & Act referrals), Procedure for carrying out Child or Adult Practice Reviews and Pressure Damage.

2.5 However, many of the above documents have passed their review dates and are effectively out of date. In addition, none of the documents have a document owner, version control or update history. The JICPA report issued in January 2024 also identified that the above documents 'lacked dates, author, ownership details, version controls and review dates'.

2.6 The JICPA report recommendation stated that 'to avoid confusion and to ensure staff are following correct processes, the governance and monitoring of such documents requires significant improvement'. The Health Board response stated that 'A review of safeguarding documents is required'. Once updated, it may also be beneficial to post some of the procedures from the Shared Drive to the Safeguarding intranet page so they can be shared with all Health Board staff. **(Matter Arising 1 - Low Priority)**

Conclusion:

2.7 The All-Wales safeguarding procedures issued by Welsh Government is the primary guidance for all Health Board safeguarding practitioners and staff. These are supplemented by local Standard Operating Procedures (SOP's) and guidance documents which are stored on the Safeguarding teams Sharepoint pages or the Safeguarding pages on the Health Board's intranet site. Our review identified that some of the safeguarding documents on the 'S' Drive and the intranet are out of date. Many also do not have version control, an owner, a date or review date or their approval status. It may be beneficial to share some of the SharePoint documents with all Health Board staff via the safeguarding intranet page. We have provided **Reasonable Assurance** for this objective.

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Objective 2: Governance arrangements exist to manage safeguarding and there is a clear strategy in place.

2.8 The Safeguarding Steering Group (SSG) has been established to support the Health Board Executive lead for Safeguarding (Executive Director of Nursing) to provide assurance to the Board for all matters relating to the safeguarding of children and vulnerable adults.

2.9 The SSG has a documented and approved Terms of Reference (ToR) that was last reviewed in January 2024. The SSG reports up to the Quality, Safety and Experience (QSE) Committee. The ToR specify that the SSG will work with Clinical Boards and Corporate departments to ensure that safeguarding activity is co-ordinated and to enable the Health Board to discharge its statutory safeguarding responsibilities.

2.10 The SSG has representatives from the Clinical Boards, and the ToR requires at least three Clinical Board representatives to be present at each meeting in addition to the Chair or Vice Chair for the meeting to be quorate.

2.11 Agendas, papers and minutes from the last four meetings of the SSG were reviewed to ensure that meetings were being held in accordance with their ToR. We note that one of the four meetings did not appear to be quorate, and the Chair does not formally confirm that meetings are quorate prior to the start of each meeting. However, further checks confirmed that all meetings were quorate, but this was unclear from the minutes of the January 2024 meeting. **(Matter Arising 2 - Medium Priority)**

2.12 Clinical Board attendance and representation from the Police, CAHMS and the Local Authority representatives was also poor. There was regular attendance by external agencies not on the ToR membership list, namely Spire, Latch and Public Health Wales. **(Matter Arising 2 - Medium Priority)**

2.13 Minutes and papers from the last three meetings of the QSE Committee were also reviewed which provided evidence of regular upward reporting from the SSG.

2.14 The SSG ToR requires the group to prepare an Annual Safeguarding Report for submission to the QSE Committee. We note that an Annual Safeguarding Report was prepared for 2022/23 but the Annual Report for 2023/24 has not yet been prepared. There was also no evidence that the 2022/23 report had been published on the Health Board website. **(Matter Arising 3 - Low Priority)**

2.15 We understand that meetings are held at Clinical Board level which should feed into the SSG, but we were informed that the Clinical Board meetings are not documented for confidentiality reasons. However, review of the SSG minutes did not identify any evidence of input or reporting to the SSG from Clinical Boards.

2.16 The lack of engagement from Clinical Boards with the SSG has also been identified by the recent JICPA review. The minutes from the May 2024 SSG meeting included an update on proposed new Clinical Board governance arrangements. These include the development of Clinical Board Safeguarding Groups, a new monitoring

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form, Clinical Board compliance and the sharing of data. A new Clinical Board self-assessment form to assist the completion of the Public Health Wales (PHW) Safeguarding Maturity Matrix was also proposed.

2.17 We were informed by the Head of Safeguarding that the new arrangements were effective from July 2024, and this was confirmed through review of the SSG agenda for July 2024. It can be seen from the July 2024 SSG agenda that an update on the JICPA improvement plan was provided. This included the actions noted above to improve the Clinical Board / SSG governance arrangements. The agenda also included the presentation of reports from each of the Clinical Boards, and an update on the Safeguarding Maturity Matrix.

2.18 However, at the time of our audit the minutes of the July SSG meeting had not been written up. It was therefore not possible at this time to review the documentation submitted by the Clinical Board's to the July 2024 SSG meeting.

2.19 The JICPA report noted that 'The sharing of information from the Safeguarding Steering Group (SSG) at Clinical Board meetings is limited. Safeguarding assurance data reported to the SSG is lacking with the Safeguarding Team unsighted on some safeguarding risks (for example, pressure damage on Paediatric Intensive Care Unit (PICU) and CLA statutory health assessment compliance). Senior Clinical Board representatives are not consistently in attendance. The Health Board should assure itself that robust governance arrangements are in place to report, scrutinise and disseminate safeguarding information and learning, and safeguarding assurance and risks are routinely shared at executive level'.

2.20 The Health Board's response was that 'New processes for the SSG meeting will be introduced. Clinical Board representation and reporting mechanisms will be audited'.

2.21 We also note that at the time of our audit the Health Board had no overarching Safeguarding Strategy or Policy in place. This issue was also identified during the recent JICPA review.

2.22 The JICPA report noted that 'In the absence of an overarching Health Board safeguarding policy, some Clinical Boards have developed their own policies and guidance documents. This poses a risk that safeguarding practice may be disjointed with services working differently across the organisation. This issue was addressed within the Immediate Assurance letter highlighted earlier, and the Health Board has since provided assurance to HIW on its plans to consider the implementation of an organisation safeguarding policy'.

Conclusion:

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2.23 The SSG has been established to support the Health Board Executive lead for Safeguarding to provide assurance to the Board for all matters relating to the safeguarding of children and vulnerable adults. The group reports to the QSE Committee and has an up-to-date terms of reference in place that details its

purpose, delegated powers of authority, membership, quorum, frequency of meetings and reporting lines. New Clinical Board Safeguarding Groups (CBSGs) have recently been established to improve governance arrangements. The new CBSG has a ToR and standard documentation that must be completed and submitted by each Clinical Board to each meeting of the SSG. The Health Board does not have an overarching Safeguarding Policy or Strategy. We have provided **Reasonable Assurance** for this objective.

Objective 3: Staff have been provided with adequate training on clinical safeguarding and safeguarding supervision including undertaking mandatory and statutory training.

2.24 The Royal College of Nursing (RCN) intercollegiate documents 'Adult Safeguarding: Roles and Competencies for Health Care Staff' and 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' set out the safeguarding training requirements for all NHS staff.

2.25 The above documents specify five levels of Safeguarding training and an additional Board level training. All NHS staff are required to undertake level 1 which forms part of all staff's statutory and mandatory training. Level 2 is compulsory for all staff that have patient contact.

2.26 As of April 2024, Health Board compliance rates were as follows: Level 2 Adult 80%, Level 2 Children 78.98%. This is below the Welsh Government target of 85%. The data above was submitted to the SSG in May 2024. No figures were provided for level 1 or compliance at Clinical Board level. However, we were informed that ESR data combines the Level 1 and Level 2 training data.

2.27 Since April 2024 Level 3 is recommended for all Nurses band 6 and above, F1 Doctors and above and allied professional staff at the discretion of their Manager. Level 4 is for specialist roles - named professionals, Level 5 is for specialist roles - designated professionals and Board level is for CEO's and Health Board executive and non-executive members.

2.28 We were informed that whilst level 1 and level 2 safeguarding training is compulsory and included in all Health Board staff statutory and mandatory training, level 3 is not compulsory. Some staff do complete level 3 training but to date no records are kept of this training which is provided by the Safeguarding team on a face-to-face basis. Staff can also undertake level 3 safeguarding training with other providers, for example Public Health Wales.

2.29 It was also identified that no records are kept of Board level training, so it was not possible to determine if the Chief Executive, Executive Directors and Independent Members are compliant with safeguarding training. This issue was identified during the recent JICPA review. HIW issued an Immediate Assurance letter requesting an improvement plan to address this issue which was provided by the Health Board and accepted by HIW.

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2.30 The immediate response provided in February 2024 was in addition to the multi-agency Improvement Plan submitted by Cardiff Council in June 2024. Both documents accept that level 3 training should be compulsory for all staff band 6 and above, and that proper records of staff training provided should be kept. Our testing confirmed that records of all training provided by the Safeguarding team are now being kept.

Conclusion:

2.31 Mandatory training compliance rates for safeguarding training at Health Board level are currently below the 85% Welsh Government target. Level 3 safeguarding training is not presently in line with current guidance provided by the RCN in their intercollegiate documents 'Adult Safeguarding: Roles and Competencies for Health Care Staff' and 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Adequate records are not being kept for training provided by the Safeguarding team. These issues have been identified during the recent JICPA review and a response has been provided by the Health Board in the Immediate Response in February 2024 and the June 2024 Improvement Plan. We have provided **Reasonable Assurance** for this objective.

Objective 4: The Health Board has produced an improvement plan from the findings of the joint inspection and have commenced implementing the actions.

2.32 The JICPA final report was issued to Cardiff Council, Cardiff & Vale UHB and South Wales Police in January 2024 following a joint inspection by The Care Inspectorate Wales (CIW), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW) and His Majesty's Chief Inspector of Education and Training in Wales (Estyn).

2.33 Although it is a multi-agency report, areas where improvements need to be made were set out for each inspected organisation under four headings, i.e. Well-being, People, Partnership & Integration and Prevention. Cardiff Council were required to prepare a multi-agency response / Improvement Plan on behalf of the Local Authority, UHB and Police and submit it to the CIW by the 17th June 2024.

2.34 The final JICPA report was issued in January 2024, and this required an immediate response from individual agencies under review for specific issues raised in the report. The Health Board provided their immediate response in February 2024 to all the issues where an immediate response was requested, and in each case the response was accepted by HIW.

2.35 A multiagency response and Improvement Plan was also required to be submitted by Cardiff Council on behalf of all the inspected organisations by the 17th June 2024, and this was duly done. This details all the recommendations from the JICPA report, the action required to be taken, a lead responsible for completing the action and a due date.

2.36 There are 19 recommendations for the Health Board in total. Progress in completing the actions will be reported to and monitored by the SSG. The first

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update was provided to the SSG in July 2024 as confirmed by review of the agenda and discussions with the Head of Safeguarding. However, at the time of the audit the minutes of the July SSG had not been written up.

Conclusion:

2.37 There is an Improvement Plan in place that covers all the recommendations made in the JICPA final report. All actions have a designated lead responsible for completion and a deadline. Progress is being reported to the SSG. We have provided **Substantial Assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Safeguarding Policies and Procedures (Operation)			**Impact**
The All-Wales Safeguarding Procedures can be accessed through the Safeguarding section of the Health Board intranet pages. They are also available for download to smart phones and tablets via an App, or to any PC from the internet. There are a number of supporting documents published on the Safeguarding intranet pages that supplement the All-Wales Safeguarding Procedures. The Safeguarding team also has a number of policies and procedures on their 'S' Drive which can only be accessed by the Safeguarding team, many of which are out of date and in need of review.			Potential risk of: • Incorrect procedures followed by Health Board staff outside of the Safeguarding team.
Recommendations			**Priority**
1.1	Once updated, it may be beneficial to post some of the procedures from the Shared Drive to the Safeguarding intranet page so they can be shared with all Health Board staff.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Since April 2024 the UHB has introduced a target that through the newly adopted SSG clinical governance arrangements within each Clinical Board, ensuring that the Wales Safeguarding Procedures are available on every desk top. In addition, staff are encouraged to download the app to their mobile phones. The policies and procedures held within the safeguarding team will be reviewed as a matter of urgency to provide additional assurance, appropriate documents will be uploaded on to the shared drive.	October 2024	Head of Safeguarding

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<table>
<tr><th colspan="3">Matter Arising 2: Quorum and Attendance at SSG Meetings (Operation)</th><th>Impact</th></tr>
<tr><td colspan="3">Agendas, papers and minutes from the last four meetings of the Safeguarding Steering Group were reviewed to ensure that meetings were being held in accordance with their terms of reference. We note that one of the four meetings did not appear to be quorate, and the Chair does not formally confirm that meetings are quorate prior to the start of each meeting. However, subsequent checks confirmed that all meetings were in fact quorate, but this was not clear from the meeting minutes.

Clinical Board attendance and representation from the Police, CAHMS and the Local Authority representatives was also poor. There was also regular attendance by external agencies not on the ToR membership list, namely Spire, Latch and Public Health Wales.</td><td>Potential risk of:
• Inappropriate decisions being made by the SSG.</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>2.1a

2.1b</td><td colspan="2">The Chair should formally check and confirm that meetings are quorate prior to the start of each meeting, and this should be recorded in the meeting minutes.

The membership of the SSG should be reviewed.</td><td>Medium</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>2.1a
2.1b</td><td>The UHB are satisfied with the SSG membership, having the Local Authority and police in attendance when they are available is deemed good practice to promote UHB transparency. However, it may need to be clear that attendance by both agencies is not a requirement. The SSG minutes will in future clarify which CB the attendees are representing.</td><td>October 2024</td><td>Head of Safeguarding</td></tr>
</table>

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Matter Arising 3: Safeguarding Annual Report (Operation)			**Impact**
The SSG ToR requires the group to prepare an Annual Safeguarding Report for submission to the QSE Committee. We note that an Annual Safeguarding Report was prepared for 2022/23 but the Annual Report for 2023/24 has not yet been prepared. We were advised by the Head of Safeguarding that the Annual Report is not usually published until December time. There was also no evidence that the 2022/23 report had been published on the Health Board website.			Potential risk of: • The annual report being out of date when published.
Recommendations			**Priority**
3.1	Arrangements should be made to ensure that the Safeguarding Annual Report is prepared and published on a more timely basis in future. We would suggest this is within three months of the end of the financial year. The final report should be made available to all Health Board staff and the general public via the Safeguarding section of the intranet and the Health Board website.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	The Annual Safeguarding Report is available on the Safeguarding Sharepoint pages however we have not previously checked that it is uploaded on to the UHB website. This will be rectified with immediate effect. The Head of Safeguarding will strive to ensure that the annual report is completed earlier in the year as suggested.	January 2025	Head of Safeguarding

<table>
<tr><th colspan="3">Matter Arising 4: Implementation of the JICPA Improvement Plan actions (Operation)</th><th>Impact</th></tr>
<tr><td colspan="3">Most of the issues we noted through our audit were also identified through the recent JICPA review and we have not therefore raised individual recommendations for these within this report.

The multiagency response and Improvement Plan submitted by Cardiff Council on behalf of all the inspected organisations details all the recommendations from the JICPA report, the action required to be taken, a lead responsible for completing the action and a due date. This includes the 19 recommendations for the Health Board.

It is planned that progress in completing the actions will be reported to and monitored by the SSG. The first update was provided to the SSG in July 2024 as confirmed by review of the agenda and discussions with the Head of Safeguarding.</td><td>Potential risk of:
• Actions not being implemented as planned.</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>4.1</td><td colspan="2">Ensure that the actions identified within the Improvement Plan are effectively implemented as planned and progress is regularly reported to the SSG.</td><td>Medium</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>4.1</td><td>The JIPA improvement plan will be a standard item on the SSG agenda whilst improvements are required to satisfy the UHB that any safeguarding risk is mitigated.</td><td>October 2024</td><td>Head of Safeguarding</td></tr>
</table>

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Specialist Services Clinical Board Governance and Financial Arrangements

Final Internal Audit Report

October 2024

Cardiff & Vale University Health Board

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Review reference:	CVU 2324-26
Report status:	Final Report
Fieldwork commencement:	8th July 2024
Fieldwork completion:	3rd October 2024
Debrief meeting:	3rd October 2024
Draft report issued:	7th October 2024
Management response received:	23rd October 2024
Final report issued:	24th October 2024
Auditors:	Ian Virgill – Head of Internal Audit Lucy Jugessur – Deputy Head of Internal Audit Andrea Calise – Internal Audit Manager
Executive sign-off:	Paul Bostock – Chief Operating Officer
Distribution:	Adam Wright – Head of Service Planning Catherine Phillips – Executive Director of Finance Jessica Castle – Director of Operations (SSCB) Catherine Twamley – Interim Director of Nursing
Committee:	Audit & Assurance Committee

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

Acknowledgement

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

Disclaimer notice - please note

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

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Executive Summary

Purpose

The purpose of this review has been to review the governance and financial arrangements in place within the Specialist Services Clinical Board, including escalation processes and updates to the Health Board's Committees.

Overview

We have issued reasonable assurance in this area.

The matters requiring management attention include:

- Terms of Reference (ToR) for decision making groups and governance forums within the Clinical Board are not all in place or up to date.
- Meeting notes are not always finalised in a timely manner and action logs are not always documented for key decision making groups and forums.

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

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	An appropriate governance structure is in place within SSCB with Terms of Reference (ToR) in place for decision making groups and governance forums.	Reasonable
2	Meetings are conducted in line with the ToR with adequate meeting notes, agendas and action logs maintained.	Reasonable
3	The Clinical Boards work collaboratively with Finance Business Partners to manage their financial budgets and financial position.	Substantial
4	Implementation of agreed savings plans are monitored, reported and acted upon at Clinical Board level.	Reasonable

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Terms of Reference (ToR) were not in place for a number of decision-making groups and governance forums and with some of the ToR's being out of date.	1	Design	High
2	Improvements required to the documentation of matters discussed and key actions agreed at groups and governance forums of the Specialist Services Clinical Board.	2	Operation	Medium

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1. Introduction

1.1 Our review of the Specialist Services Clinical Board Governance and Financial Management Arrangements was undertaken and completed in line with the 2024/25 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').

1.2 Governance structures and their applications are fundamental to ensuring the success of the Health Board in delivering its statutory obligations.

1.3 Good corporate governance plays a vital role in underpinning the integrity and efficiency of the Health Board and the wider community in which it operates. Robust properly developed and embedded governance structures are fundamental to ensuring the achievement of the Health Board's strategic objectives and in delivering its statutory, regulatory and legal requirements.

1.4 Each Clinical Board is led by a director and is required to have effective governance arrangements in place for the services they are accountable for, in order to provide assurance to the Board and its Committees on the quality and effectiveness of the services provided to its users, coupled with ensuring the aims and objectives set by the Board are delivered. Clinical Boards have delegated responsibility to manage their financial budgets, with support from designated Finance Business Partners.

1.5 The Specialist Services Clinical Board comprises a number of highly specialised areas serving both the South-East region and the wider all Wales population. The services also provide secondary care services to the local Cardiff and Vale of Glamorgan population. For certain specialities, services are provided on a South Wales and all Wales basis. The services provided by the Clinical Board are predominantly Joint Commissioning Committee (JCC) commissioned and are provided to the wider regional and Welsh population. Services are currently structured through seven directorates.

1.6 The scope of the review considered the governance arrangements in place and reviewed the processes operating within the Clinical Board around financial management, budgetary control and delivery of savings.

1.7 The associated risks considered as part of this audit are:

- Objectives may not be delivered if governance arrangements are not effectively identifying and escalating concerns and if arrangements are not properly discharged.
- Areas of poor performance are not identified and addressed.
- A lack of clear, consistent direction, accountability and leadership with governance arrangements not properly discharged.
- Financial targets are not met as budgets and savings plans are not effectively monitored and controlled.

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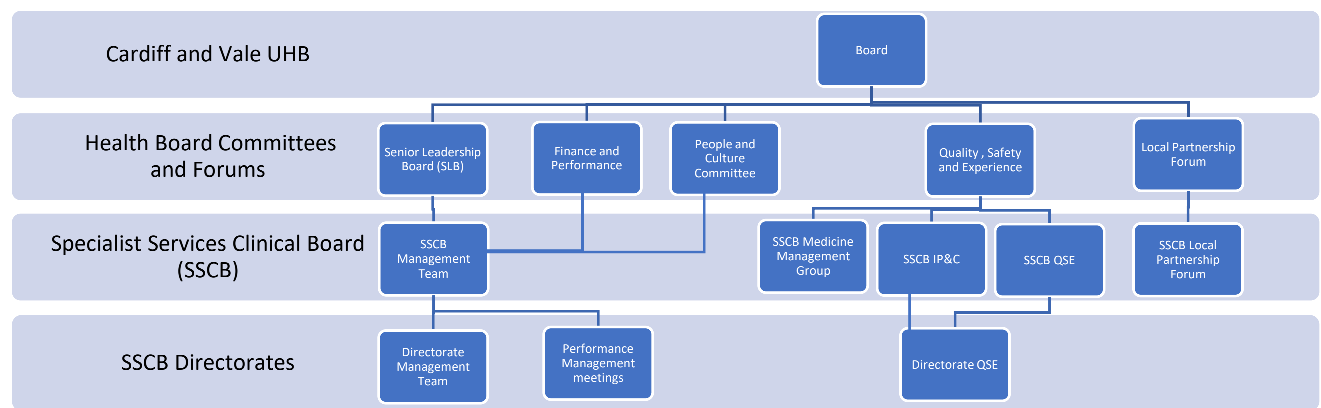
1.8 The Executive lead for this audit is the Chief Operating Officer.

2. Detailed Audit Findings

Objective 1: An appropriate governance structure is in place within the Clinical Board including all required groups, aligned to the Health Board's committee structures and directed by Terms of Reference (ToR).

2.1 To inform this objective we held several meetings with senior team members of the Specialist Service Clinical Board (SSCB) and operational management for a sample of Directorates which included Cardiothoracic, Neurosciences and Haematology and Clinical Immunology services. In addition to these discussions, we reviewed governance documentation for all of the key decision-making groups and governance forums set up within the SSCB. Documentation included Terms of Reference (ToR), agendas, minutes and where applicable action logs.

2.2 We mapped out the remits and accountability of each group/forum and determined that there are robust structures in place within the SSCB. The diagram below illustrates the governance structures and hierarchy within the SSCB and the alignment to the wider governance structures of the Health Board:



2.3 In addition to the above, we note the existence of the following:

<u>SSCB level</u>

- Business and Governance Forum – Meets weekly, and feeds into the SSCB Management Team and is attended by members of the SSCB Management Team. The group discusses and agrees on decisions which are channelled through the SSCB Management Team for wider approval.
- Pressure and Scrutiny Panel – Meets once a month and feeds into the SSCB QSE Committee under the health and safety theme.

<u>SSCB Directorates</u>

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- Ad-hoc operational team meetings including management and operational staff. Meeting frequencies vary according to directorate, however, they share similar remit and focus (operational, workforce, performance, risks etc.).

2.4 We note that for the SSCB meetings that report into the Health Board's Committees/Forums, we were able to confirm that SSCB senior staff attended where appropriate. Evidence was available to confirm that the SSCB decision making groups and governance forums were adequately feeding up to the Health Board's committees and forums ensuring that key issues are being effectively escalated.

2.5 We obtained the Terms of Reference (ToR) for the decision-making groups and governance forums for the SSCB (as per illustration in paragraph 2.2). We reviewed each ToR and noted that not all were in place and/or had not been updated in a timely manner. **(Matter Arising One – High Priority)**

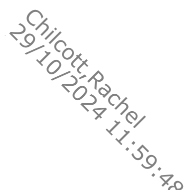
2.6 The Health Board, under the leadership of the Chief Operating Officer and collaboration with Clinical Board Directors, has undertaken a review of the Clinical Board structures and alignment of specialties, directorates and services that underpin them. A proposal of structural change was presented for approval at the Senior Leadership Board (SLB) which met on the 1st August 2024. We note that changes are expected to occur within the Specialist Services Clinical Board as well as other Clinical Boards of the Health Board which will hopefully lead to:

- Greater alignment for tertiary/Joint Commissioning Committee commissioned services;
- Spinal and Neurosurgery to be better aligned to pool resources and expertise; and
- Better profile and support for niche specialised services.

Progress against this proposal will be monitored through the SLB.

Conclusion:

2.7 The current governance structure within the Clinical Board is appropriate and reflects the Health Board Committee structure where applicable and with many of the meetings being replicated within the Clinical Board. Our testing found that Terms of Reference (ToR) were not in place for all decision-making groups/governance forums within the Specialist Services Clinical Board. Furthermore, where ToR were in place some were out of date. We have provided **Reasonable Assurance** for this objective.



Objective 2: Adequate governance arrangements are in place with meetings being conducted in line with TOR and notes or minutes being maintained that provide a record of the key discussions and decisions made during the meetings.

2.8 As per Matter Arising One, given that not all groups and governance forums of the SSCB were supported by ToR, we were unable to confirm that all meetings were being conducted in line with the respective ToR. However, we were able to undertake testing for meetings where ToR were in place. Our sample spanned across meetings that had been undertaken in the previous 9 months (January 2024 to date). The findings from our testing confirm that:

- Decision making groups and governance forums are operating as intended with mediums available for escalation of high pressing/urgent matters up to the SSCB Management Team and further up through the wider Health Board committees where applicable.
- Meetings are being conducted in line with the required frequency stated in the ToR. We note that there were a number of meetings cancelled during the summer months due to annual leave, but we do not deem this to be of a concern.
- Adequate representation was found both at SSCB level and also directorate level.
- Formal agendas were found to be in place instructing the areas of business/operational themes to be discussed. We note that there were some gaps as not all agendas could be obtained. **(Matter Arising Two – Medium Priority)**
- Most of the meetings reviewed were supported by finalised minutes and recorded action logs/matters arising. As per the finding above, we also note that not all minutes could be obtained as there were gaps in minute taking. **(See Matter Arising Two – Medium Priority)**
- Updates are provided to Health Board meetings on an exception basis, and we were able to evidence examples of this with Specialist Services Clinical Board updates having been provided at the Health Board's Senior Leadership Team, Quality, Safety and Experience Committee, Health & Safety Committee and the People and Culture Committee.

2.9 The SSCB has monthly performance management reviews with the Executive Team which include review of the operational and financial position. They include presentations and there are detailed minutes and action plans that are produced following the presentations.

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2.10 Each directorate of the SSCB also holds individual monthly performance management meetings with the SSCB Senior Management (Director of Operations, Interim Director of Nursing, Clinical Board Directors, Assistant Director of Finance).

There is a standard pack of slides that the Directorate's are required to complete ahead of the meeting for discussion. We noted that a record of actions agreed is not currently being maintained. **(See Matter Arising Two – Medium Priority)**

Conclusion:

2.11 Our findings conclude that whilst decision making groups and governance forums are operating as intended, there are some gaps in documenting the business and matters discussed at these meetings. We have provided **Reasonable Assurance** for this objective.

Objective 3: The Clinical Board works collaboratively with their Finance Business Partners to manage their financial budgets and the financial position is presented and discussed at appropriate meetings and actions are taken to address identified issues.

2.12 To inform this objective we held several meetings with corporate finance, senior and operational management from the SSCB. From our discussions we noted that there is robust financial support in place for the Clinical Board and its directorates which are each allocated a Finance Business Partner.

2.13 Finance Business Partners / Clinical Board Accountants meet with budget holders on a regular basis with actual meetings varying from in-person to via teams. The frequency of meetings can vary from bi-weekly, monthly to quarterly. The more at risk a department's financial position is deemed to be the more frequent the meeting.

2.14 All meetings that take place between the Finance Business Partners / Clinical Board Accountants are regarded as informal and so no notes are kept. However, there are often e-mail exchanges after the meetings confirming actions agreed or requesting further information.

2.15 Finance staff can be contacted by the budget holder to assist with any queries they may have between each meeting held, and the reverse is also the case.

2.16 Discussions with a sample of budget holders confirmed that Finance are always contactable to answer any queries or concerns that they may have with their financial information. Finance staff will provide additional information requested by the budget holders where possible.

2.17 The Specialist Service Clinical Boards' financial position is reviewed and discussed at the monthly SSCB Management Meeting as a standing agenda item. The Assistant Director of Finance presents "Flash reports" which summarise the financial position of the Clinical Board. We note that the Directorate level financial position is also presented to individual Directorates on a monthly basis.

2.18 A review of the minutes / notes for a sample of meetings (SSCB Management Team and Directorate Management Team meetings) confirmed that discussions have

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taken place regarding the Clinical Board and individuals Directorate's financial positions focussing on the following areas:

- Current key pressure / risk areas;
- Key priorities for the SSCB/Directorates;
- Current and forecast financial positions; and
- Delivery of the Cost Reduction Programmes.

A review of month 5 financial position highlighted that the SSCB has a current deficit of £0.958m. Discussions with the SSCB Director of Operations and the Assistant Director of Finance noted that whilst this position is not favourable, plans are in place to break even by year end.

2.19 We also note that actions are noted in minutes and notes of the SSCB Management Team, and these are followed up when reviewing the following month's financial position. We could not confirm whether the same is taking place at directorates Team meetings as currently, there are no action plans being documented (See paragraph 2.9).

Conclusion:

2.20 Finance Business Partners / Clinical Board Accountants meet with budget holders on a regular basis to review the financial position. In addition, the Finance Business Partners / Clinical Board Accountants provide additional information as required and are able to assist with any queries. The Clinical Boards' financial position is presented and discussed at appropriate meetings and also as part of the monthly performance meetings held with Health Board Executive Directors. As at month 5, the SSCB financial position shows a deficit of £0.958m, however plans are in place to break even by year end. We have provided **Substantial Assurance** for this objective.

Objective 4: Implementation of agreed savings plans are monitored, reported and acted upon at Clinical Board level, and risks to achievement of savings targets are identified.

2.21 For 2024/25, the Health Board set an ambition to achieve financial sustainability and recurrent financial balance by the end of 2025/26. For 2024/25, the UHB's Financial Plan, which was approved by the Board in March 2024, included a £47.2m savings target. Of the savings target, the SSCB has a savings plan of £5.572m which equates to 8.5% of the overall UHB's savings plan.

2.22 We note that performance against the UHB's financial plan, which includes the savings programme, is reported routinely to the Finance and Performance Committee and to the Board.

2.23 The SSCB financial position and progress against savings plans is also monitored monthly as follows:

- SSCB Management Team – Financial report is a standing agenda item and as part of the presentation slides, key information relating to progress against Cost Reduction Plans (CRP) is provided. As per paragraph 2.9, the SSCB discusses its financial position with the Executive team on a monthly basis as part of the performance reviews.
- SSCB Directorate Management Team – Financial report is presented to the Directorate on a monthly basis and includes financial position and progress against agreed CRP.
- Directorate Performance Management meetings – Directorate senior management meets with CB senior management to discuss in month operational performance, financial position and progress against directorate CRP. We received verbal confirmation from directorate and SSCB management that risks to identified saving targets are discussed at this meeting and actions to resolute are agreed however these are not formally documented. **(See Matter Arising Two)**

We reviewed the minutes/agendas for the above meetings and can confirm timely meetings with attendance from the relevant individuals from the SSCB and directorate management team.

2.24 There is a Bi-weekly Sustainability Financial Savings 2024/25 meeting – The Health Board has assembled the group with a purpose to maintain oversight of the financial stewardship within the Clinical Boards and membership of the group includes Clinical Board triumvirates as well as Senior Finance Business Partners. We can confirm that ToR are in place for this group which consider the financial savings programmes with respect to the following:

- To discuss how savings fall between Operational and Savings Themes;
- Update savings tracker following key meetings; and
- Clinical Boards who have not shown a reduction in their variable pay and agency/locum costs in their workforce plans to discuss with Finance and HR Business Partners and to update savings plan within 2 weeks.

2.25 We reviewed the financial information for the SSCB as at 6th September (Period 5) and note that for 2024/25 to date, the SSCB has reported savings of £1.924m against a budgeted saving profile of £2.114 for month 5, with a savings slippage of £0.190m. As per paragraph 2.18 both the Director of Operations and Assistant Director of Finance for the SSCB advised that the financial forecast is to break even at year end.

Conclusion:

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2.26 Updates on the progress of delivering the SSCBs' savings plans is regularly reviewed at key Clinical Board and Health Board meetings. Directorates of the SSCB also review their individual savings plans on a monthly basis and report to

the SSCB Senior Management as part of the Performance Management meetings. Whilst we acknowledge robust financial monitoring and reporting mechanisms being in place, the Clinical Board and the wider Health Board must continue with its efforts to achieve financial savings. We have provided **Reasonable Assurance** for this objective.

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Appendix A: Management Action Plan

Matter Arising 1: Terms of Reference (ToR) are not in place or out of date (Design)	**Impact**
As part of our testing, we requested the Terms of Reference (ToR) for all of the decision-making groups and governance forums currently set up within the Clinical Board. A review of the documentation identified a number of issues: Terms of Reference had not been reviewed and updated in line with required timescales: • Clinical Board Management Team ToR's were last updated/reviewed in 2017 and should be reviewed annually; • Quality and Safety Experience Group were last reviewed in 2019 and should be reviewed annually; • Infection, Prevention and Control (IP&C) were last reviewed in May 2023 and should be reviewed annually; • SSCB Local Partnership Forum were last reviewed in March 2022 and should be reviewed annually; and • SSCB Medicines Management Group was last reviewed in June 2022 and should be reviewed annually in line with the other forums. A number of decision-making groups and governance forums were operating without an approved ToR document: • Management Teams for the directorates sampled (Neurosciences, Cardiothoracic, Haematology, Immunology and Metabolic Medicine (HIMM)); and • Directorate level QSE forums.	Potential risk of: • A lack of clear, consistent direction, accountability and leadership with governance arrangements not properly discharged.
Recommendations	**Priority**

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1.1 1.2	The Specialist Clinical Board should maintain oversight of key decision-making groups and governance forums and ensure that these are governed by approved Terms of Reference. The Specialist Services Clinical Board should also maintain records of Terms of Reference in place, their ownership and the required review dates to ensure a timely process for ToR review/update.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	The Clinical Board governance structure will be updated to reflect the various decision-making groups in the Clinical Board, together with copies of the Terms of Reference for each of the groups. This will be stored in the Clinical Board Teams folder.	November 2024	Jessica Castle - Director of Operations
1.2	The Terms of Reference for each of the decision-making groups will be stored in the Clinical Board Teams folder as above. In addition, to ensure consistency, the Clinical Board will ensure that the ToR for each of the groups will be reviewed annually at the first meeting at the start of the financial year.	April 2025 and then annually ongoing	Jessica Castle - Director of Operations and, Catherine Twamley - Director of Nursing

Matter Arising 2: Meeting records for decision making groups and governance forums of the SSCB (agendas, minutes and action logs) are not always in place (Operation)	**Impact**
In line with governance best practice, matters discussed, and actions agreed at decision making groups and governance forums should be documented. We undertook a review of the groups and governance forums of the SSCB and found that not all meetings were minuted. We could not obtain the finalised minutes, agendas and action logs for the following meetings: • SSCB Partnership Forum for August 2024 (minutes not documented); • SSCB Medicine Management Group for April, June and August 2024; • SSCB IP&C Group for July 2024; • Cardiothoracic Directorate Management Team (Service Manager confirmed that agendas, minutes and action logs are not being documented for each meeting); • Haematology and Clinical Immunology Directorate Management Team (Directorate Manager provided agendas for meetings however no minutes or action logs are documented); and • Directorates of the SSCB hold monthly performance management meetings with SSCB senior management. We note that action logs/matters arising from these discussions are not currently being documented.	Potential risk of: • A lack of clear, consistent direction, accountability and leadership with governance arrangements not properly discharged. • Areas of poor performance are not identified and addressed.

Recommendations		**Priority**
2.1	The Specialist Services Clinical Board Management should ensure that agendas, minutes and action logs are documented for all decision-making groups and governance forums. Arrangements must be put in place to ensure that outstanding actions are reviewed at each meeting with clearly recorded progress on the actions recorded.	**Medium**

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Agreed Management Action		Target Date	Responsible Officer
2.1	An action log will be produced and circulated for the Directorate Performance Review meetings commencing with the meetings arranged for Quarter 3 24/25. These action logs will be reviewed and updated each quarter at subsequent Directorate Performance Review meetings.	Quarter 3 24/25 and then ongoing each quarter	Jessica Castle - Director of Operations

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:

	Rating	Definition
	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
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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*

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

Date issued: November 2024

Document reference: 4206A2024

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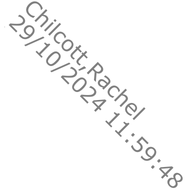
About this document

1. This document provides the Audit and Assurance Committee with an update on our current and planned accounts and performance audit work at Cardiff and Vale University Health Board. We presented our 2024 Audit Plan to the committee in May 2024.
2. We also provide additional information on:
   - Other relevant examinations and studies published by the Auditor General.
   - Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.
3. Details of future and past Good Practice Exchange (GPX) events are available on our website.



Financial audit update

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

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the 2023-24 Charitable Funds Accounts	Executive Director of Finance	To provide an audit opinion on the Health Board's Charitable Funds Accounts.	Scheduled to start in November 2024	The Board of Trustees are due to meet on 23 January 2025 to consider the audited accounts. The Auditor General is due to certify them on 24 January,

Performance audit update

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

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2024 – core	Director of Corporate Governance	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2024 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and Corporate financial planning and management arrangements.	Reporting	January 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of Unscheduled Care	Chief Operating Officer	This work examines different aspects of the unscheduled care system and includes analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work includes an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We are also reviewing progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).	Blog and data tool published in April 2022 Part 1 – draft regional and local report issued to Health Board in September 2024 Part 2 – Reporting	 January 2025 January 2025
Structured Assessment 2023 Deep Dive – review of cost	Executive Director of Finance	Given the significantly challenging financial position across NHS Wales, this review is examining the approaches NHS bodies are taking in respect of achieving cost	Draft report issued to Health Board in September 2024	January 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
savings arrangements		improvements, efficiencies, and financial sustainability.		
Planned Care Review	Chief Operating Officer	This work follows on from the national report on tackling the planned care backlog, and will consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Fieldwork underway	To be confirmed
Structured Assessment 2024 Deep Dive - Review of investment in digital systems	Director of Digital and Health Intelligence	This review will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Planning	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of eye care services (2024 local work)	Chief Operating Officer	Following on from our report on orthopaedic services last year, we will review the Health Board's speciality with the highest level of waits - eye care services. We will assess the Health Board's services to ensure they are delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs. Scoping work will be completed in due course, but we expect to include both community and acute eye care services within the scope of this work.	Project brief issued in September 2024	To be confirmed

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Other relevant publications

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

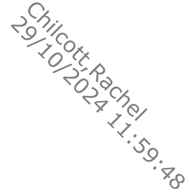
Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
The National Fraud Initiative in Wales 2022-23	**October 2024**
Active Travel (and Data Tool)	**September 2024**
Affordable Housing	**September 2024**
NHS Wales Finances Data Tool	**August 2024**
Community Pharmacy Data Matching Pilot • Article related to this report • Blog related to this report	May 2024

Additional information

7 There have been no corporate documents published by Audit Wales since the last committee update.

8 There are no relevant Audit Wales consultations currently underway.



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

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Report Title:	Procurement Compliance Report			Agenda Item no.	2.4
Meeting:	Audit Committee	Public	X	Meeting Date:	5th November 2024
		Private			
Status *(please tick one only)*:	Assurance X	Approval		Information	
Lead Executive:	Executive Director of Finance				
Report Author (Title):	Assistant Director of Procurement Services and Executive Procurement Lead – C&V				

Main Report

Background and current situation:

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

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

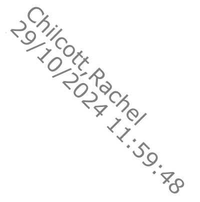
- Sole Supplier of Goods or Services
- Proprietary items, i.e. Trademarked, patented
- Capability with existing equipment or service
- Regulatory, i.e. Human Tissue Act (HTA)
- Urgent Operational Requirement
- Covid-19
- Unforeseen/unplanned circumstances
- Emergencies
- Exemptions

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

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

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

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



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

ASSESSMENT AND ASSURANCE

Non-Compliant Activity (16)

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

Description Title	Value at Risk Excl VAT	Length at Risk/ Breach	Clinical Board	Reason	Action/Status
Myriad Genetics Services	£26,400.00	One month	AWMGS	Service did not engage with Procurement	In Progress – Procurement Services reviewing with AWMGS on future requirements.
Health Charity Evaluation Review	£38,000.00	4 months	Executives	Initial Procurement undertaken as a quotation exercise with no returned bids. Corporate Governance was to re-issue the specification to Procurement who would then publish a new quotation, however, a proposal was agreed with supplier directly with no further Procurement involvement and this was over £25k which would have changed the Procurement route as well.	Closed – Contract issued.
Cardiff University Neuro Scans	£26,348.26	4 years	Specialist	Service did not engage with Procurement	In Progress – Procurement Services reviewing with Neurosciences on future requirements.
Forget Me Not Chorus Sessions	£6,752.64	12 months	Executives	Service did not engage with Procurement	Closed – Included in workplan for compliant renewal process if required.
Invivioscribe Tube Labels	£8,335.00	One off	AWMGS	Service did not engage with Procurement	In Progress – Procurement Services undertaking a tender process.
Epilepsy Brain Mapping	£12,256.00	3 months	Specialist	Service did not engage with Procurement	In Progress – Procurement Services reviewing with Neurosciences on future requirements.
POI HSL Pathology LLP	£11,731.00	Ongoing	Clinical Diagnostics & Therapies	Service did not engage with Procurement	In Progress – Procurement arranging compliant contract.
REDBOX	£5,600.00	12 months	PCIC	Service did not engage with Procurement	Closed – Included in workplan for compliant renewal process.

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UPSW Conduct Investigation	£9,512.73	One off	Children and Women	Service did not engage with Procurement	Closed – single requirement.
Vehicle Hires	£14,359.10	Ongoing	Capital Planning Estates and Facilities	Service did not engage with Procurement	In Progress – Procurement arranging compliant contract.
Repair of Lecia machines in the main lab, UHW	£13,151.40	One off repair	Clinical Diagnostics & Therapies	Service did not engage with Procurement	Closed – one off repair.
Medical Transport Services with E ZEC Medical Transport Service Ltd	£7,762.50	Ongoing	Mental Health	Service did not engage with Procurement	In Progress – National team are looking at procuring long term, however, the local C&V Procurement team will arrange a interim contract.
Clinimacs CD34 Reagent, Prodigy TS 310 and PBS/EDTA Buffer 2x3L	£9,086.00	Ongoing	Clinical Diagnostics & Therapies	Service did not engage with Procurement	In Progress – Procurement arranging compliant contract.
Mercure Hotel - CEF Staff Awards 2024	£10,259.00	One off event	Capital Planning Estates and Facilities	Service did not engage with Procurement	Closed – Event.
Measles - MMR campaign	£25,000.00	One off project	Executives	A quotation was undertaken by Procurement at the end of previous financial year although no award was made due to lack of funding. Service went ahead with work without informing Procurement to award a formal contract following securing of new funding.	Closed – one off requirement.
CAHVIS Security Cover	£54,600.00	6 months	PCIC	Service did not engage with Procurement	In Progress – Procurement arranging compliant contract.

Contracts value breached/ extended at risk as a result of emergency/unforeseen circumstances (1)

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status
Insourcing of Endoscopy	£40k	Contract finished	2 weeks	Medicine	Patient volumes increased	Closed – new contract in place

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Other Non-Compliant Activity (1 Return)

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

- Emergency activity

- Unforeseen/Unplanned circumstances
- Exemptions

Title	Value at Risk	Length at Risk/Breach	Clinical Board	Reason	Action /Status
SRS Support in respect of the Health Protection Partnership	£128,506.10	12 months	Executives	Internal arrangement between Vale of Glamorgan, Health Board and WG for Health Protection Partnership Team which came into being 2024/25.	In Progress – internal approval being formalised for ongoing SLA arrangements.

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

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

It should be noted that Procurement have booked training refresher sessions with areas of high non compliance on Standing Financial Instructions (SFI's) and Public Contracts Regulations (PCR) to proactively reduce the number of breaches by Clinical Boards.

Report of Single Tender/Quotations Actions

Retrospective – (1 Return)

The report outlines all SQA/STA (1) requests during the period the 1st August 2024 to 30th September 2024.

Clinical Board	Supplier	Name of Project	Retrospective Value of Contract Excl VAT	STA Type
AWMGS	Sophia Genetics	Alamut Visual Licenses	£39,792.33	Sole Supplier of Goods or Services

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

Prospective (within the permitted guidelines)

The report outlines all SQA/STA (6) requests during the period the 1st August 2024 to 30th September 2024.The volume processed was higher than normal activity, as a consequence of the following:-

1. Bevan Exemplar initiatives – WG approved
2. Year-end Monies/ Capital
3. National Programmes
4. Trials, Testing and Education Programmes
5. Bespoke software support and/or licences
6. Specialist Maintenance and Repairs
7. Partnership Arrangements
8. Compliance / Regulatory Requirements
9. Charitable Funds

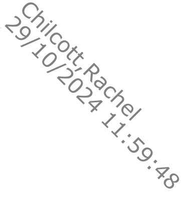
10. Standardisation of goods or services
11. Covid-19/ Unforeseen circumstances/Emergencies
12. Exemptions

Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract excl VAT	Type
Executives	Cardiff University	Post Registration academic clinical education for nurse and midwives L6&L7	£60,000.00	Sole Supplier of Goods or Services
Executives	University of South Wales	MSc clinical education for nurses and midwives	£26,680.00	Sole Supplier of Goods or Services
Executives	Goldsland Farm	Polytunnel growing system	£7,500.00	Sole Supplier of Goods or Services
C,D&T	MZ Events	EuroMedLab Exhibition Brussels 2025	£8,950.98	Sole Supplier of Goods or Services
Surgery	OR3D Limited	Geomagic Service and Maintenance Renewal	£33,829.10	Sole Supplier of Goods or Services

Non-Compliant Activity / Contract Breach Summary

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

Year	2022/23			2023/24			2024/25 (YTD)	
Clinical Board	Non-Compliant Breaches	Exemption	Covid-19	Non-Compliant Breaches	Exemption	Covid-19	Non-Compliant Breaches	Exemption
AWMGS	1	0	0	1	0	0	5	0
Children and Women	2	0	0	3	0	0	1	0
Capital Planning, Estates and Facilities	3	2	1	2	3	0	7	6
Clinical, Diagnostics and Therapies	2	0	0	11	4	0	12	2
Executives	8	5	0	21	9	0	14	11
Medicine	2	1	0	1	0	0	1	0
Mental Health	0	0	0	2	1	0	9	0
PCIC	0	0	0	2	0	0	5	0
Specialist	3	1	0	10	1	0	4	2
Surgery and Dental	9	1	0	10	0	0	5	1
TOTALS	**31**	**10**	**1**	**63**	**18**	**0**	**63**	**22**



STA/SQA's by Department

Clinical Board	2022/23 No. of SQA's/STA's	2022/23 SQA/STA's Breached	2023/24 No. of SQA's/STA's	2023/24 SQA/STA's Breached	2024/25 (YTD) No. of SQA's/STA's	2024/25 (YTD) SQA/STA's Breached
AWMGS	3	3	0	0	2	1
Children and Women	3	1	4	0	1	0
Capital Planning, Estates and Facilities	15	2	2	0	3	0
Clinical, Diagnostics and Therapies	26	2	23	0	17	0
Executives	23	1	13	2	11	0
Medicine	4	0	0	0	2	0
Mental Health	3	0	1	0	1	0
PCIC	11	3	3	0	1	0
Specialist Services	11	1	3	0	3	1
Surgery Services and Dental	11	0	5	1	3	0
Grand Total	**117**	**13**	**54**	**3**	**44**	**1**

Recommendation:

The Board / Committee are requested to:

- **NOTE** the contents of the Report
- **APPROVE / AGREE** the contents of the Report

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

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

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

Prevention		Long term		Integration		Collaboration		Involvement	

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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:

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Report Title:	Internal Audit Tracker Update Report				Agenda Item no.	2.6
Meeting:	Audit and Assurance Committee		Public	x	Meeting Date:	05.11.2024
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Director of Corporate Governance					
Report Author:	Corporate Governance Officer					

Main Report

Background and current situation:

The purpose of the report is to provide Members of the Audit and Assurance Committee ("the Committee") with assurance on the implementation of recommendations which have been made by Internal Audit.

This report provides an update on the Internal Audit Tracker, providing a brief overview of the work that has been underway to migrate this tracker to AMAT and a visual to demonstrate to committee how the tracker displays information extracted from the AMAT system.

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

Internal Audit Tracker Update

Since the last Audit Committee, a synchronisation exercise has been underway to migrate the entire Internal Audit Tracker into the AMAT system. This work is nearing completion, with action leads now allocated in AMAT to complete and update outstanding actions.

The next phase of this work will see bespoke guidance and training developed along with engagement sessions to assist action owners with understanding what the AMAT system is, why we are using it to host the internal audit tracker and what they need to do in the system to manage their internal audit actions. All action owners have been notified in advance that they are being added to the AMAT system and that training and guidance will follow.

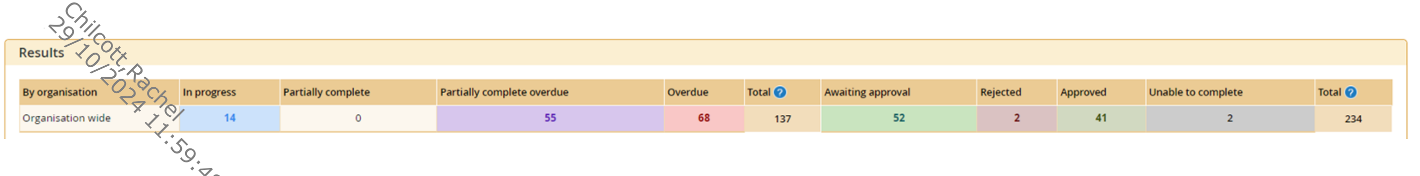
Access to the Internal Audit tracker in the AMAT system has now been given to the Head and Deputy Head of Internal Audit along with a brief overview of how to access and use the system. Conversations are evolving to determine how processes can be streamlined for all parties to benefit from the digitalisation of hosting the tracker in the AMAT system.

Current Internal Audit Tracker Statistics

Whilst synchronisation of the internal audit tracker is not yet fully complete, as of the 25th October 2024, the Tracker records 234 management actions broken down as:

- 40 are High Priority
- 138 are Medium Priority
- 56 are Low Priority.

The image below displays the current data extracted from AMAT detailing the status of the actions.



Results

By organisation	In progress	Partially complete	Partially complete overdue	Overdue	Total	Awaiting approval	Rejected	Approved	Unable to complete	Total
Organisation wide	14	0	55	68	137	52	2	41	2	234

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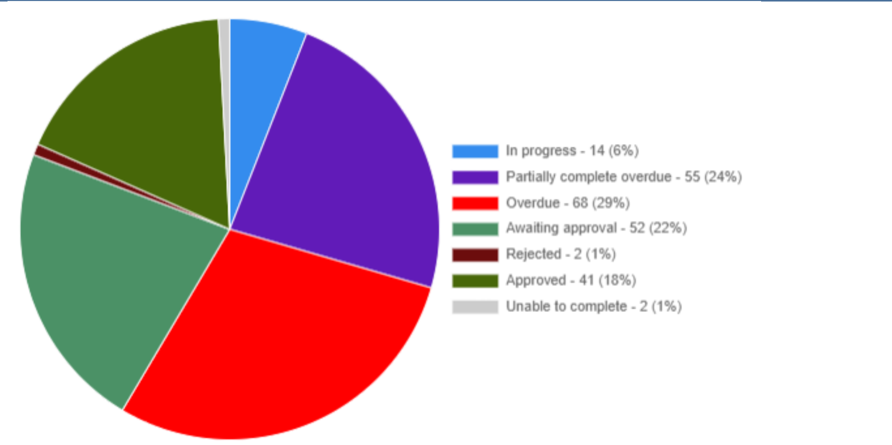

Appendix 1 demonstrates all actions relating to any Internal Audit reports.

Appendix 2 demonstrates all overdue actions for all Internal Audit reports. This overview provides an insight into the age of these actions and who is responsible for completing them for the Committee's awareness.

For committee members, the AMAT system can be accessed here: Audit Management and Tracking - Welcome (amat.co.uk) with information and supporting guidance available internally via AMaT. Members will be enabled to set up accounts through which to interrogate the information as required. A live demonstration of the tracker in the AMAT system will be provided during Committee to give insight to Committee members of how AMAT works to manage the Internal Audit tracker.

Recommendation:

The Committee are requested to:

(a) Note and receive assurance from the progress which has been made in completing management actions that continues to be monitored and updated made by Internal Audit
(b) Note and be assured by the progress which has been made on transferring to the AMAT system.

Impact Assessment:
Risk: Yes/No
By maintaining an up to date Internal Audit Recommendation Tracker the Health Board mitigates the risk that it may be subject to legal or regulatory penalty.
Safety: Yes/No
N/A
Financial: Yes/No
N/A
Workforce: Yes/No
N/A
Legal: Yes/No
N/A
Reputational: Yes/No
N/A
Socio Economic: Yes/No
N/A
Equality and Health: Yes/No
N/A
Decarbonisation: Yes/No
N/A
Approval/Scrutiny Route:

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Committee/Group/Exec	Date:

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Inspection Code	Inspection Title	Recommendation Priority	Recommendation	Action	Person Responsible	Lead Person	Current Due Date	Date Last Updated	Action Rating	Progress Status	Progress Status Reason	Comments/Updates
Risk and Regulation/ 2022/261	Internal Audit - Welsh Language Standards	Must do	To enhance the maturity of the risk management arrangements, the recording of the risks associated with the Welsh Language Standards should be strengthened to include risk mitigation and the nature of the risk score, to better inform the oversight and assurance forums.	Develop an enhanced dashboard to reflect recommendations. Present to ESWLSG for comment / agreement. Finalise for effective updating and reporting of risk.	Mr Mitchell Jones	Mr Mitchell Jones	30/05/2022	06/08/2024	Amber	Unable to complete	It is unclear what is required by a Dashboard, options have been explored internally but have not been deemed as satisfactory. It is necessary as an organisation to review the position of all the standards and this will be reported to the People and Culture committee.	
Risk and Regulation/ 2024/833	Internal Audit - PCIC Governance Arrangements	Must do	All TOR for the groups within the PCIC Clinical Board should be reviewed to assess whether they are up to date, updated where necessary and then formally approved. As part of the review, consideration should be given to whether attendees are core or optional and this should be clearly stated.	All Terms of Reference to be reviewed, updated and formally approved highest priority to be given to: • PCIC SMT • PCIC QS&E • PCIC Clinical Board • PCIC Local Partnership Forum • Current Clinical Services Reference Group • Primary Care Panel Consideration to be given to timescale for reinstatement of PCIC IG Group and review and formal approval of Terms of Reference.	Mrs Anna Llewellin	Ms Anna Mogie	30/09/2024	15/10/2024	Amber	Partially complete (Overdue)		ToR for all key groups referenced in action plan have been reviewed and signed off. Consideration still being given to re-establishment of PCIC IG Group
Risk and Regulation/ 2024/832	Internal Audit - LIMITED - Decarbonisation	Must do	Appropriate strategies should be developed to ensure that recruitment and retention issues experienced to date do not impact significantly on the achievement of the DAPs.	This is not an issue for C&V at this time. An Environmental Sustainability Manager was appointed in May 2022.	Ms Rachel Chilcott	Ms Rachel Chilcott	01/11/2024	14/10/2024	Amber	Fully complete (Awaiting approval)		
Risk and Regulation/ 2024/831	Internal Audit - IMTP Development Process	Must do	Management should ensure that in future plans are identified to deliver the full annual savings requirement at the point that the MDS is provided to Welsh Government.	Stronger emphasis on savings plans up front in the planning process (July - September) and increased scrutiny of the plans earlier in the process (October).	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2024	14/10/2024	Red	Overdue		
Risk and Regulation/ 2024/829	Internal Audit - Performance Reporting (Data Quality)	Must do	To continue as planned to finalise and seek approval of the 'Procedure to compile the Cardiff and Vale Integrated Performance Report for Executive Management Team and Public Board Meeting'.	The content of the "Cardiff and Vale Integrated Performance Report for Executive Management Team and Public Board Meeting" has changed considerably recently and will continue to evolve as we test the effectiveness of the report with Board members. To support future content changes, we will refine our process to ensure this is clearly documented and shared with all executive director leads and their staff.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2022	14/10/2024	Green	Fully complete (Awaiting approval)		

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Risk and Regulation/ 2023/286	Internal Audit - Financial Reports and Savings Targets	Must do	To enhance resilience management should consider creating a desktop procedure, which outlines those responsible for collating data to inform each of the tables within the Monthly Monitoring Return to Welsh Government and the source of the data within the tables.	Produce a Desktop Procedure outlining data sources and process for collation and completion of the Monthly Monitoring Return to Welsh Government.	Mr Andrew Gough	Mr Andrew Gough	31/07/2023	19/09/2024	Amber	Fully complete (Approved)		A working copy of the process note was developed in February 2024. This will be reviewed periodcially when fundamental change are made to the Finance Committee Monthly Finance Report and the Welsh Government Monthly Monitoring returns.
Risk and Regulation/ 2023/278	Internal Audit - Core Financial Systems (Treasury Management)	Must do	The Treasury Management (Incorporating Cash Forecasting and Bank Account Controls) Financial Control Procedure should be strengthened as follows: - The requirements of the Standing Financial Instructions, section 7.3.1 (d) Banking Procedures should be addressed; - Consideration of developing, if not included within the FCP, a separate procedure to cover the access and control arrangements of the online banking system, Bankline; and - To enhance resilience, the inclusion of the process for developing the monthly cashflow forecast, which is a key document used to inform Welsh Government on a monthly basis of the Health Board's cash requirements.	- Agreed to revise FCP to include the requirements of 7.3.1 (d) also addressed in point 2 on management actions. - Agreed FCP to be updated to include control arrangements for access, inputting and authorisation of the online banking system. - Agreed to update the process document for developing the monthly cashflow	Mrs Rebecca Holliday	Mrs Rebecca Holliday	28/02/2023	24/07/2024	Amber	Overdue		Action points 1 & 2 have been completed in full. Point 3 - Monthly Cashflow The FCP has been updated to address the points outlined in the internal report. The department has commenced a review of the cashflow process; it has become apparent that this review is quite extensive, taking into account the modernisation agenda and priority areas for improvement in the current system. Therefore, taking all these factors into account, it has been identified that cashflow modernisation/ review will be an ongoing process for the remainder of this financial year. An interim SOP has been developed as of April 2024, while the cashflow review is ongoing. The cashflow review will recommence post yearend, July 2024. July 2024 - The new "monthly
Risk and Regulation/ 2023/290	Internal Audit - Data Warehouse	Must do	A map of feeds should be produced.	Documentation of all feeds will be put in place with outine procedure to maintain and keep up to date.	Kerry Ashmore	Kerry Ashmore	31/07/2023	08/07/2024	Green	Partially complete (Overdue)		Mar 2024 - vacancy for data warehouse manager is on hold so resource gap still exists.
Risk and Regulation/ 2024/751	Internal Audit - Risk Management and Board Assurance Framework	Must do	There should be a central point where all of the Health Board's risk registers are held. The Corporate Governance and Risk team should liaise with the risk owners/facilitators, IT, and procurement as necessary to procure/develop a single solution that suits all users.	An external IT solutions company is developing new software that will allow all risk registers to be allocated to a single central point. Once the risk module is complete the Programme Manager will provide a demonstration to the Department of Corporate Governance in order to refine any adjustments and potential report export requirements.	Ms Glynis Mulford	Ms Glynis Mulford	31/12/2024	16/10/2024	Green	Rejected (To be resubmitted)	The action will be complete when AMAT is in use as a single system for risk in CAVUHB.	Risk Module in AMAT is being handed over for testing w/commencing 16/09/24. Implementation group established to test and roll out. Action to be updated once clearer understanding regarding how the Risk Module will operate but this work is in hand and progressing.

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Risk and Regulation/ 2024/750	Internal Audit - Mortality Reviews	Must do	The Health Board should develop an overarching policy and procedure following completion and approval of the All-Wales Learning for Mortality Review Model Framework which sets out the respective roles and responsibilities and the procedures which should be followed.	Development of a learning from morality framework.	Dr Aled Roberts	Dr Aled Roberts	01/04/2025	10/07/2024	Amber	In progress		
Risk and Regulation/ 2024/749	Internal Audit - Patient Safety Incident Management	Must do	1. Management should review the Incident, Hazard and Near Miss Reporting Policy and Procedure and update accordingly. 2. Management should ensure that the out-of-date Incident, Hazard and Near Miss reporting Policy and Procedure are removed from the intranet and only the current policy and procedure is made available.	1. Terminology to be updated as per recommendations. Section 4.1 covers general incident reporting. A paragraph is to be added to include the role of QSE meetings in monitoring and learning from incidents. 2. Out of date policies to be removed from SharePoint – Patient Safety Team to contact Corporate Governance Team to action.	Mrs tara Cardew	Mrs tara Cardew	31/07/2024	15/10/2024	Amber	Overdue		
Risk and Regulation/ 2023/291	Internal Audit - Inclusion and Equality	Must do	A review of the Terms of Reference along with the membership and remit of the ESWLSG is required by management, along with the formation of subgroups to facilitate decision-making and implementation.	The Terms of Reference, including membership and governance requirements of the ESWLSG are currently under review. This review will be informed by the governance surrounding the UHB's Equality, Equity and Experience Framework (currently at consultation), the requirements of the People and Culture Committee and the outcome of this audit. This review will include the identification of any required sub groups / steering groups / working groups and subsequent membership requirements and TORs.	Mr Andrew Partridge	Mr Andrew Partridge	31/07/2023	06/08/2024	Amber	Partially complete (Overdue)		The Terms of Reference for a future iteration of ESWLSG has been drafted for consideration by the Health Board. However, a decision regarding the future of the group is currently on hold whilst considerations regarding the future of equity, equality, inclusion and its management within the Health Board are underway. In the meantime, matters in relation to equity, inclusion and the Welsh language are reported directly to the People & Culture Committee. The Head of Equity & Inclusion is a regular attendee at the committee. Awaiting confirmation from the Director of Corporate Governance.

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Risk and Regulation/ 2024/748	Internal Audit - Cancer Services	Must do	Management should consider the purpose and operating arrangements of the weekly cancer tracker meetings and clarify these and the roles of those in attendance in documented terms of reference/operating arrangements.	Standard Operating Procedure and Terms of Reference documents to be created in collaboration with appropriate clinical board managers outlining the scope and purpose of the cancer tracking meetings. This document should also include a roles and responsibilities component for the relevant Cancer Services and Clinical Board staff.	Michael Eastwell	Michael Eastwell	30/05/2024	08/07/2024	Amber	Overdue		
Risk and Regulation/ 2023/292	Internal Audit - Management of Health Board Policies	Must do	The out of date policies and procedures should be reviewed, updated and published as soon as possible.	Whilst a detailed plan to address to the previous recommendations made by Internal Audit in 2019/20 was drawn up and presented to the Audit and Assurance Committee in November last year, unfortunately it has been very challenging adhering to the timescales set out in the plan. This has been due to a number of reasons, including limited resource with the Corporate Governance team to undertake this large piece of work. The plan will be updated to reflect the recommendations made (see agreed management action 7 below), but in the meantime the following actions will be undertaken as soon as possible:- a) Head of Corporate Governance to review the current Policies Tracker and ensure that each Policy/other controlled document referenced on the Tracker has an Executive Lead sponsor; b) Produce an updated list of out of date Policies/other controlled documents per Executive Lead and issue to the same for comment with regards to	Miss Francesca Thomas	Miss Francesca Thomas	31/07/2023	18/09/2024	Red	Fully complete (Awaiting approval)		This work has now been completed by the Corporate Archivist &Records Management Manager. a) Head of Corporate Governance to review the current Policies Tracker and ensure that each Policy/other controlled document referenced on the Tracker has an Executive Lead sponsor - COMPLETE b) Produce an updated list of out of date Policies/other controlled documents per Executive Lead and issue to the same for comment with regards to likely timescales to review each policy - COMPLETE - AMAT NOW BEING USED TO DRIVE THIS WORK AS ALL POLICIES HOSTED IN AMAT c) Executive Leads to work with the Head of Corporate Governance to provide a completed list of all of those out of date policies/other written controlled documents by the end

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Risk and Regulation/ 2024/747	Internal Audit - Information Governance	Must do	1. Management should consider undertaking a full assessment of needs and resources to identify potential gaps and risk areas upon which capacity and resilience can be appropriately measured.	The Cardiff and Vale UHB Information Governance workforce resource since 2018, remains limited, especially in comparison with other Welsh Health Boards of a similar size. However, this capacity is being well used and core legislative functions are being performed but we accept that there are some gaps in the proactive work that we should be undertaking. To some extent, and linked to recommendation 2.1, the department has recently started work on how to improve some of these gaps including seeking funds to secure additional IG training for 3 team members. A full gap analysis will be performed during Q1 of 2024/25. This will also consider the departments resilience to ensure it can still function should any staff leave their current roles.	Mr James Webb	Mr James Webb	01/04/2024	10/07/2024	Amber	Overdue		
Risk and Regulation/ 2023/287	Internal Audit - Nurse Staffing Levels Act Final Internal Audit	Must do	The 'Nurse Staffing Levels Operating Framework' should be updated and made available on the intranet so that staff can access it. There should also be information on the nurse staffing levels act on the intranet	A) Work has started to create a Nurse Staffing Levels Act information page on C&VUHB SharePoint (intranet). The page will contain the Nurse Staffing Levels Operating Framework as well as other resources such as the Frequently Asked Questions and the All Wales Informing Patients poster for adults and paediatrics. B) The Operating Framework will be reviewed and updated to incorporate changes as a result of the introduction of SafeCare across C&VUHB. Specific additions to the framework will include: o Disaggregated SafeCare responsibilities for wards, senior nurse, temporary staffing department and agencies; o Management of red flags and routes of escalation; o Expectations of daily staffing meetings; and o Responsibilities for evidencing mitigating actions. The Operating Framework will be signed off by the designated person. The updated version will be uploaded onto the	Mr Jason Roberts	Mr Jason Roberts	31/05/2023	19/09/2024	Amber	Fully complete (Approved)		A) A Nurse Staffing Levels page is available on SharePoint which can be accessed here: https://nhswales365.sharepoint.com/sites/CAV_Nursing/SitePages/E-Rostering.aspx B) A Rostering Principles and Good Practice Guide has been added to the SharePoint, this is in addition to the Nurse Staffing Operating Framework. Within the Good Practice Guide is information around the operational use of SafeCare and the scheme of delegation. It was produced in this style to ensure ease of use for staff and also recognise the changing way that nurse staffing is reviewed since the introudction of SafeCare and the likely need to update and adapt it going forward. This guide was agreed during a formal Directors of Nurses meeting with the Executive Nurse Director present. The operational guide

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Risk and Regulation/ 2024/745	Internal Audit - Financial Management within Clinical Boards	Must do	Consideration should be taken by Management as to whether they want to provide additional information concerning the reported financial position by department in the monthly email that is issued to budget holders.	Finance support teams have been asked to liaise with their budget holders to review how reports are to be prepared and delivered.	robert mahoney	robert mahoney	30/09/2024	15/10/2024	Green	Overdue		
Risk and Regulation/ 2024/744	Internal Audit - Core Financial Systems (Asset Register Management)	Must do	An asset register identification label should be attached to each asset unless there is an operational constraint which prevents it. Where this arises, the reason for the exception should be recorded and approved.	Agree with recommendation, exercise to revise labelling to be carried out in 24/25.	Rhian Selwood	Rhian Selwood	31/03/2025	08/07/2024	Green	In progress		
Risk and Regulation/ 2023/293	Internal Audit - UHW Hybrid and Major Trauma Theatres	Must do	The Project Execution Plan should be updated to reflect current governance arrangements.	Agreed – The Project Execution Plan will be updated. The project is currently on hold, subject to Welsh Government approval of the required funding. Therefore, whilst a July date is included as update they will not be ratified by the Group until the project re-commences	Mr Andrew Partridge	Mr Andrew Partridge	31/07/2023	31/05/2024	Green	Partially complete (Overdue)		The scheme is currently in delay as a result of the preferred supplier withdrawing the proposed equipment for the new facility and a new tendering exercise will be undertaken to confirm a new provider. Given the time elapsed between the submission of the FBC it is intended to request the SCP to undertake an additional market testing exercise to inform a revised business case for consideration by WG.
Risk and Regulation/ 2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	There should be a review of the level of Programme governance activities required, and the viability of progressing with the aim of developing a SOC, until wider concerns over affordability / funding models have been addressed: to be approved at Board / SOFH Committee level.	Agreed. This will be informed by the outcome of the clinical review and attendance at WG IIB. Executives met with WG at the beginning of September to understand likelihood of funding. There is currently no line of sight to funding but have been invited to an IIB in on 13/11/23. Programme Boards and Project Boards have been stood down. The outcome of discussions with WG along with the Nuffield report should drive a review of next steps and Governance (including frequency) and the assistance of the Corporate Governance team will be requested. This said, communication from WG was pointing to funding before the NHS Wales cost pressures changed messaging to be less certain of funding the SOC. The SRO and PD had been keen to maintain rhythm of governance within C&V and the need for SOFH to be progressed given unsustainable estate condition. The members of the Programme Board	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue		

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Risk and Regulation/ 2024/311	Internal Audit - Alcohol Standards	Must do	1.1 - Health Board should compile guidance which aligns to the NICE recommendations on detailing the screening process, the brief interventions that will be followed, and who should be targeted and action that should be taken. 2.2 - the fact that alcohol related harm is a major health problem, internal reporting within the Health Board should be undertaken to ensure that Senior Managers are aware of the number of patients who are presenting with alcohol issues.	Funding for fixed term post (to March 2025) for Alcohol Programme Manager secured to support the implementation of management actions: 1.1 - Guidance for the screening process, the brief interventions to be followed and 2.2 - who should be targeted will be produced and disseminated to relevant staff. The collation of data from the screening process will be standardised and reported quarterly to the appropriate Senior Managers.	Lauren Idowu	Lauren Idowu	30/06/2024	19/09/2024	Red	Partially complete (Overdue)		1. WG funding secured for Alcohol Programme Manager post. Preparing for recruitment of post.
Risk and Regulation/ 2023/294	Internal Audit - Planned Care Transformation Delivery	Must do	The terms of reference and work programmes for committees and the workstream groups need to be reviewed and updated to reflect the current governance arrangements	1.1 The Terms of Reference for the Planned Care Improvement Board were approved on the 28th April 2023. 1.2 The Terms of Reference for the Outpatients Delivery Group (formerly Outpatient Transformation Programme Board) have been re-drafted in June 2023 and will be approved at the first meeting of the refreshed Outpatient Delivery Group on 28 June 2023 1.3 The Terms of Reference for the Diagnostics Delivery Group and Theatres Delivery Group (formerly Theatres Improvement Group) require updating to reflect the changes in governance structure as above. 1.4 The Risks and Issues Log for the Diagnostics Delivery Group requires completion as above.	Ms Joanna North	Ms Joanna North	30/06/2023	10/07/2024	Amber	Partially complete (Overdue)		1.2 - ToR assumed accepted August 2023. 1.3 - Diagnostics Delivery Group ToR accepted as approved Oct 2023; Theatres Delivery Group ToR requires updating and approval. 1.4 - risk log has been updated.
Risk and Regulation/ 2023/295	Internal Audit - Recommendation Tracking	Must do	The reports and tracker should be scrutinised in more depth at the Committee meetings to ensure that outstanding recommendations from previous years that have not yet been implemented are challenged and scrutinised.	Recommendation Agreed – Work will be undertaken to ensure that items for scrutiny are highlighted to the Committee within reports. Conversations have been had and will continue to be had with the Audit and Assurance Committee Chair to support this process.	Miss Francesca Thomas	Miss Francesca Thomas	23/11/2023	11/10/2024	Green	Fully complete (Awaiting approval)		Discussions have been had with the Committee chair to encourage robust review of recommendations. It is anticipated that this receommendation will be completed following the November Committee meeting.
Risk and Regulation/ 2023/298	Internal Audit - Refresh of the Health Board's Strategy	Must do	Management should ensure a risk register is adequately maintained to include all relevant fields and is updated regularly with the progress and date of progress for future programmes and projects.	This will be reflected in the planning toolkit that will be developed in response to the UHB's strategic programme governance review.	Mr Andrew Partridge	Mr Andrew Partridge	31/12/2023	11/10/2024	Amber	Fully complete (Awaiting approval)		

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Risk and Regulation/ 2024/309	Internal Audit - Estates Condition	Must do	1.1 - The lead executive should approve the proposed approach to the surveys, recognising any benefits/limitations of the approach taken 1.2 Surveys should be carried out on the UHB estate with the results informing both an updated estates strategy and EFPMS returns	Agreed - Condition surveys were tendered in November 2023. The tenders received did not provide a competitive response. Therefore, the tender is being re-issued in Jan 2024. It is anticipated that the surveys and completion of the reports will not be achieved until July 2025.EFPMS will continue to be updated, until after the condition survey update, using informed data.	Mr Andrew Partridge	Mr Andrew Partridge	29/02/2024	04/03/2024	Amber	Overdue		
Risk and Regulation/ 2023/303	Internal Audit - Surgery Clinical Board - Consultant Job Plans - LIMITED	Must do	The Directorate General Manager should ensure that there is a job plan on the Allocate e-Job Planning system for all Consultants.	Orthopaedics - Missing consultants are currently being added to eAllocate, and their job plans will be signed off by 30/09/2023.	Mr Antonio Roccioli	Mr Antonio Roccioli	30/09/2023	10/07/2024	Amber	Overdue		All consultants are on eAllocate in T&O.
Risk and Regulation/ 2024/308	Internal Audit - Technical Continuity	Must do	The risk relating to geographical resilience and the impact on All Wales services should be appropriately included within the risk register.	Added to the Digital Risk Register (Confirmation required it is already in the Server Team Risk Register).	Mr James Webb	Mr James Webb	01/04/2024	10/07/2024	Amber	Partially complete (Overdue)		June 2024 Limited progression made on this recommendation due to UPS and electrical work requirements in UHL. UHL is expected to be operation for the placement of servers and backups from Q2/3 2024.
Risk and Regulation/ 2024/307	Internal Audit - Infection, Prevention & Control	Must do	The IPC policies and procedures that have passed their review dates should be reviewed and updated as a matter of urgency. Review dates should be accurately recorded on the reviewed documents. A log of all IPC policies and procedures should be maintained that records the review dates. All IPC policies and procedures should be posted on Sharepoint as soon as is practicably possible.	The 3 procedures that have passed the review date are currently under review and drafts will be circulated to the members of the IPCG for review. All complete policies and procedures will be reviewed and updated to the correct Health Board format. This will be complete by the March 2024 meeting of the IP&C Group. Once updated to the correct format they will be updated to Sharepoint and out of date procedures will be removed.	Mrs Yvonne Hyde	Mrs Yvonne Hyde	30/04/2024	15/10/2024	Red	Partially complete (Overdue)		30/09/2024 - The needlestick injury and TB procedures were approved at the IPCG meeting on 24/09/2024 The Incident and Outbreak procedure needs a couple of amendments and will be sent out to members of the IPCG for comments in the next couple of weeks 3 named polices have been updated and due to IPCG in June 2024. All IPC policies and procedures are in the process of being reviewed to ensure compliance with UHB format. All up to date procedures have been reviewed, are in the correct format and are available on Sharepoint A log of all IP&C procedures with review dates is available

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Risk and Regulation/ 2023/306	Internal Audit - Capital Systems	Must do	Project officers should ensure that returned contracts and Chair’s action are signed, initialled, and dated consistently.	Guidance will be issued across the Project Management and Executive cohort to remind approvers of the importance of clearly dating formal documents when signing.	Mr Stephen Gardiner	Mr Stephen Gardiner	31/10/2023	10/07/2024	Amber	Overdue			
Risk and Regulation/ 2023/305	Internal Audit - Mental Health Clinical Board Governance Arrangements	Must do	Clinical Board Management should ensure that there are terms of reference in place for all groups and committees and that they are up to date. Management should ensure where terms of reference are in place that as a minimum they detail the purpose of the meeting, accountability arrangements, membership to include identifying Chair and Vice Chair, quoracy, meeting frequency and review arrangements.	The identified meetings above will require either a review and completion of TORs or a renewal of TORs. These are being addressed and Directorate teams are taking this opportunity to review quoracy, frequency, attendance and purpose.	Mr Andrew Partridge	Mr Andrew Partridge	07/11/2023	11/10/2024	Red	Fully complete (Approved)			
Risk and Regulation/ 2024/840	Internal Audit - Implementation of the People and Culture Plan	Must do	Management should ensure that the 2024 performance indicators are reported to the next Board and the People and Culture Committee meetings.	The following KPIs are included in the Integrated Performance Report from May 24: • Values Based Appraisal (VBA) • Medical Appraisals • Sickness absence (12 month cumulative) • Turnover • Statutory & Mandatory Training • Formal disciplinary cases • Form Respect & Resolution cases • Time to Hire • Time to shortlist • Monthly agency spend as a % of total pay bill • Monthly variable pay as a % of total pay bill • Job planning	Mrs Louise Blunsdon	Dr Rachel Pressley	31/05/2024	18/10/2024	Green	Fully complete (Awaiting approval)			

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Risk and Regulation/ 2022/269	Internal Audit - Development of Genomics Partnership Wales	Must do	4.1a A lessons learned review should be undertaken by Capital, Estates & Facilities, to ensure full understanding of the factors leading to the budget overspend in respect of management of the construction contract. 4.1b A lessons learned review should be undertaken by Digital to ensure full understanding of the factors leading to the budget overspend; and to ensure improved processes can be applied at future projects in respect of the determination of the IT budget requirements at the business case stage. 4.1c A report should be presented to an appropriate forum (e.g., Capital Management Group)setting out the findings of the above exercises.	a. Agreed b. Agreed c. Agreed	Mr Alex Morris	Mr Geoff Walsh	31/12/2023	14/02/2024	Amber	Fully complete (Awaiting approval)		A lessons learned exercise was undertaken and a Board Paper prepared and considered at the UHB Board meeting on 30th March 2023.
Risk and Regulation/ 2024/838	Internal Audit - Performance Reporting	Must do	Management should ensure that information/data submitted for publishing within the IPR hasundergone the relevant checks to confirm that it is accurate prior to submission to the Information team.	Agreed. The over 65's data will now be included and the age range renamed to adult mental health (18-65).	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2024	16/10/2024	Amber	Overdue		
Risk and Regulation/ 2024/837	Internal Audit - Safeguarding	Must do	Once updated, it may be beneficial to post some of the procedures from the Shared Drive to the Safeguarding intranet page so they can be shared with all Health Board staff.	Since April 2024 the UHB has introduced a target that through the newly adopted SSG clinical governance arrangements within each Clinical Board, ensuring that the Wales Safeguarding Procedures are available on every desk top. In addition, staff are encouraged to download the app to their mobile phones. The policies and procedures held within the safeguarding team will be reviewed as a matter of urgency to provide additional assurance, appropriate documents will be uploaded on to the shared drive.	Ms Linda Hughes-Jones	Ms Linda Hughes-Jones	31/10/2024	16/10/2024	Green	In progress		

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Risk and Regulation/ 2024/839	Internal Audit - Health and Safety	Must do	1. In cases where target dates elapse in respect of an action detailed in the Health and Safety Culture Plan, an entry should be made in the live action tracker document containing reasons for the overrun, the redefined target date, and the date of the Health and Safety Sub-Committee meeting to which the revised target date was reported. A record of the original target date and any amendments should be retained for monitoring purposes, and general status updates should also be recorded against all actions that are in progress. 2. In cases where target dates elapse in respect of an action detailed in the Health and Safety Culture Plan, a report should be made to the Health and Safety Sub-Committee containing reasons for the overrun and the revised target date.	There is a planning meeting with the department leads on 02/09/2024 to discuss the scope of work for a full department down day in November. Revised dates with the leads will be determined in this September meeting along with comments for the overrun. The original dates will be retained. Entries will be made in the live action tracker document containing reasons for the overrun, the redefined target date, and the date of the Health and Safety Sub-Committee meeting to which the revised target date was reported.	Mr Robert Warren	Mr Robert Warren	15/10/2024	16/10/2024	Amber	Fully complete (Awaiting approval)		New dates and reasons for overrun have been added to the live tracker document. This was presented to the H&S committee for assurance on 15/10/2024
Risk and Regulation/ 2023/281	Internal Audit - Access to in-hours GMS Service Standards	Must do	Management should revisit Welsh Government guidance to ensure Access Standards' performance and reporting requirements are met by the Health Board.	We reviewed the Terms of Reference and attendance of four Access Forums meetings, for the period 2021- 2022, and note the following: - The Terms of Reference should undergo annual review according to its own review requirements, but we found no evidence of it being reviewed since it was finalised in January 2020. - Whilst reviewing Access Forum attendance, we found one forum was not quorate. The Terms of Reference considers the Access Forum to be quorate with the following members in attendance, but we noted the absence of the Local Medical Committee representative at the December 2021 Access Forum: Director of Operations or delegate; Representative from the Primary Care Team; Locality Manager/Assistant Locality Manager; Community Health Council representative; Local Medical Committee Representative; and Practice Manager Representative. - Further, we also note the absence	Mr Sarah Griffiths	Mr Sarah Griffiths	28/02/2023	09/07/2024	Amber	Fully complete (Awaiting approval)		08/04/24 - TOR reviewed in June 2023 (next review June 2024 - update June 2024, deferred to September 2024 meeting). Reporting structure through Director of Operations to Chief Operating Officer. Minutes to Clinical Board for assurance ; achievement/escalation through performance report to CB. Practice Manager role reviewed, removed from quoracy and person spec clearly setting out expectations sent to Cardiff and Vale Practices for interest. Role is not a requirement for the Access Forum but felt to be good practice. Arrangements also put in place that if LMC or Llais are unable to attend, they are asked to provide formal comment on the papers to ensure appropriate participation. Actions from audit, complete.

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Risk and Regulation/ 2023/282	Internal Audit - Medical Records Tracking (CDT)	Must do	In alignment with the review of the Records Management Policy and Procedure, the governance arrangements should be redesigned to provide effective oversight of the tracking of health records, to ensure there is a line of sight to the accountable executive of the policy and procedure.	The Health Board has a monthly Information Governance Sub-group chaired by the SIRO and attended by senior leaders including the Medical Director. Matters relating to the tracking of medical records can be escalated there. The group is linked to the Digital and Health Intelligence Committee (formerly the Information Governance Sub-Committee), and as such relevant points and actions will be raised accordingly at organisational governance fora. It is acknowledged that the mechanism for receiving points of escalation is often responsive in nature. Review of current governance arrangements related to medical records management will be undertaken with recommendations made, and subsequently enacted, to ensure a clearer line of sight to the accountable executive of related policy and procedures and related Heath Board.	Mr James Webb	Mr James Webb	31/03/2023	15/10/2024	Red	Partially complete (Overdue)		Update 05.06.24 Meeting with Interim Medical Director postponed due to their competing commitments from 10.05.24 rescheduled to 18.06.24. Function and requirements of the new group will link to the newly established Clinical Information Programme, as well as steer elements of it where relevant and receive assurances
Risk and Regulation/ 2022/266	Internal Audit - Implementation of National IT Systems (WNCR)	Must do	Noting the improvements in communications with DHCW. The UHB should build on this by ensuring it is aware of the 3-5 year DHCW plan and the level of expected resource commitment from the Health Board for each item. This should feed into the C&V planning process.	Working with DHCW executive director colleagues, the national DHCW plan will be reviewed to ensure there is alignment with C&V's own strategic plans. Once the DHCW plan is available to C&V, we will incorporate into our strategic roadmap and planning process. The existing communication arrangements will continue. The process established includes: • Digital Directors Peer Group. At which DHCW provide an update of their plans and ongoing work; • Quarterly planning sessions with the Health Board and DHCW. These are two way and aim to ensure that plans are synchronised and allow the Health Board to influence and help inform the DHCW plans; • Informal executive to executive meetings planned for every 3 months.	Russell Kent	Russell Kent	31/12/2022	05/07/2024	Amber	Partially complete (Overdue)		June 2024 WNCR continues to progress from a Digital point of view with the deployment of the first 50 iPads and testing. The rest of the devices are scheduled to be deployed subject to approval of testing in Q2/3 2024.

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Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	1. Establish a routine review of the tracker to the data within Patchwork to identify discrepancies between requested and actual WLI sessions. This should be undertaken monthly to ensure all sessions are accurately recorded. 2. Management should emphasise the importance of completing and submitting the form for every WL Isession request. This will ensure all sessions are documented in the tracker. 3. Management should evaluate and enhance the integration between the Teams Channel form and the tracking spreadsheet to ensure no data is lost or overlooked during the automatic population process.	A new WLI approval process was communicated on 07/06/24 and implemented from 10/06/24. The previous MS Form and Team channel has been removed, all requests for WLI shifts are entered into the Patchwork shift system and a report is sent to the COO's office by the Medical Staff Bank on a daily basis. The COO's office review requests and approve or decline – before sending back to the team for processing.	Ms Catherine Wood	Ms Catherine Wood	16/10/2024	16/10/2024	Red	Fully complete (Approved)		
Risk and Regulation/ 2022/264	Internal Audit - Medical and Dental Staff Bank	Must do	Management need to review the 'Recruitment of Locum Doctors and Dentists Operational Procedure' (UHB 131), which has been superseded by online resources and consider whether they update it in line with current processes.	The 'Recruitment of Locum Doctors and Dentists Operational Procedure' to be deleted off the online resources as the new Terms of Business for the Medical and Dental Staffbank now override.	Mr Andrew Partridge	Mr Andrew Partridge	31/10/2022	30/05/2024	Green	Partially complete (Overdue)		Old documentation deleted. All locum provision is actioned via the Medical Managed Bank. All current documentation can be easily accessed via the Internet/SharePoint.
Risk and Regulation/ 2023/283	Internal Audit - Decarbonisation Final Report February 2023	Must do	DAPS should be costed to fully determine the total funding required.	This point is noted. C&V are producing their new DAP before end March 2023. Feasibility studies will need to be commissioned as part of that plan.	Mrs Abigail Harris	Mrs Abigail Harris	29/02/2024	19/09/2024	Amber	Fully complete (Approved)		No funds have been requested in light of the financial situation. Staff time has been forthcoming to make change happen across the health board. Notably, the impact of delivering against our operational priorities has uncovered unseen carbon avoidance benefits that have been noted. These are as a result of considerable effort by colleagues. [close action]
Risk and Regulation/ 2022/263	Internal Audit - Waste Management	Must do	Budget processes should be defined, including cost allocation, query, and escalation mechanisms.	Agreed. Process map finance - budget allocation, issues, errors etc., to be detailed (ref MA2). Some areas have already been mapped out since the completion of the audit fieldwork.	Mr Andrew Partridge	Mr Andrew Partridge	31/08/2022	30/05/2024	Green	Partially complete (Overdue)		Working with Finance department to realign budgets against individual waste streams.

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Risk and Regulation/ 2024/840	Internal Audit - Implementation of the People and Culture Plan	Must do	Management should ensure that the 2024 performance indicators are reported to the next Board and the People and Culture Committee meetings.	The following KPIs are included in the Integrated Performance Report from June 2024: • Exit questionnaire completion • Registered Nurse vacancy rate b5&6 • EDI Captured on ESR • Staff with Welsh language skills 2-5 To be included annually linked to staff survey results: • Staff completing staff survey • Increase engagement score	Dr Rachel Pressley	Dr Rachel Pressley	30/06/2024	18/10/2024	Green	Fully complete (Awaiting approval)		
Risk and Regulation/ 2024/830	Internal Audit - LIMITED Cyber Security Follow up	Must do	A realistic timetable should be developed, and accountable officer(s) assigned to progress the Cyber Security Improvement Plan.	We do recognise progress has been slower than we would like. It is widely reported over many years empirically that recruiting to cyber roles is highly competitive with the public sector often struggling for capable resources as pay points are lower, hence we have spent 12 months running numerous unsuccessful recruitment campaigns including the use of agency to no avail. Our most recent campaign however was successful after we increased the pay scale for an appointee to Band 8a (from Band 7). The Cyber Security Lead is due to commence in post on the 14th May 2024. The improvement plan was largely written in the context of the critical system assessed in 2022 (PMS). PMS is currently migrating to a new environment and once migrated, currently scheduled for April 2024, a number of recommendations will be addressed. This, in addition to the Cyber Security Lead position being	Ms Rachel Chilcott	Ms Rachel Chilcott	30/06/2024	14/10/2024	Green	Fully complete (Awaiting approval)		

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Risk and Regulation/ 2024/839	Internal Audit - Health and Safety	Must do	1. In cases where target dates elapse in respect of an action detailed in the Health and Safety Culture Plan, an entry should be made in the live action tracker document containing reasons for the overrun, the redefined target date, and the date of the Health and Safety Sub-Committee meeting to which the revised target date was reported. A record of the original target date and any amendments should be retained for monitoring purposes, and general status updates should also be recorded against all actions that are in progress. 2. In cases where target dates elapse in respect of an action detailed in the Health and Safety Culture Plan, a report should be made to the Health and Safety Sub-Committee containing reasons for the overrun and the revised target date.	A report detailing the overrun actions will be presented at the October Health and Safety Committee meeting.	Mr Robert Warren	Mr Robert Warren	15/10/2024	16/10/2024	Green	Fully complete (Awaiting approval)		Report and culture plan presented at the H&S Committee 15/10/2024
Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	1. Establish a routine review of the tracker to the data within Patchwork to identify discrepancies between requested and actual WLI sessions. This should be undertaken monthly to ensure all sessions are accurately recorded. 2. Management should emphasise the importance of completing and submitting the form for every WL Isession request. This will ensure all sessions are documented in the tracker. 3. Management should evaluate and enhance the integration between the Teams Channel form and the tracking spreadsheet to ensure no data is lost or overlooked during the automatic population process.	A new WLI approval process was communicated on 07/06/24 and implemented from 10/06/24. The previous MS Form and Team channel has been removed, all requests for WLI shifts are entered into the Patchwork shift system and a report is sent to the COO's office by the Medical Staff Bank on a daily basis. The COO's office review requests and approve or decline – before sending back to the team for processing.	Ms Catherine Wood	Ms Catherine Wood	16/10/2024	16/10/2024	Amber	Fully complete (Approved)		

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Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1.1 Internal financial reporting should be enhanced to clearly show the forecast position against the annual CRL, and the position against the approved contingency budget. 1.2 WG PPRs should be updated to reflect the current allocation of funds across each budget area.	Agreed. This matter has already been discussed in project team meetings, and it has been agreed that papers need to be reviewed for accuracy before inclusion in agendas.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Green	Overdue		
Risk and Regulation/ 2024/838	Internal Audit - Performance Reporting	Must do	Management should ensure that information/data submitted for publishing within the IPR hasundergone the relevant checks to confirm that it is accurate prior to submission to the Information team.	The Information team will communicate the requirement for services to carry out relevant checks prior to submission for inclusion with the IPR document.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2024	16/10/2024	Amber	Overdue		
Risk and Regulation/ 2023/287	Internal Audit - Nurse Staffing Levels Act Final Internal Audit	Must do	The 'Nurse Staffing Levels Operating Framework' should be updated and made available on the intranet so that staff can access it. There should also be information on the nurse staffing levels act on the intranet	2.1 A) The establishment review process is well established in C&VUHB. Establishment reviews take place with the Designated Person and dates have been confirmed for the upcoming reviews in preparation for presentation to board in May 2023. B) The Designated Person to sign the workforce planning template. Nurse Staffing Levels Lead to confirm this prior to inclusion in the board report. C) Review the establishment review process as part of the Operating Framework setting out a clear timeline for future establishment review. 2.2 A) As per the Operating Framework, Finance Partners in each Clinical Board to be present during establishment reviews. Ensure the signed off establishment templates	Miss Francesca Thomas	Miss Francesca Thomas	01/06/2023	19/09/2024	Amber	Fully complete (Approved)		A) The nurse staffing levels continues to be presented to Board and were presented in May 2023 and November 2023. B) The designated person, the Executive Nurse Director reviews and agrees the establishments during the establishment review meetings. The establishment templates are signed during this meeting and the Nurse Staffing Levels Lead ensures the templates have been agreed prior to the inclusion in the board paper. C) The establishment process is well established in Cardiff and Vale UHB . There has been no significant change to the process and the establishments are reviewed prior to completion of the All Wales Nurse Staffing Papers to Board in May and November.

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Risk and Regulation/ 2023/288	Internal Audit - Clinical Audit Follow-Up	Must do	Management need to ensure that the Clinical Audit Policy is formally approved by the Quality, Safety and Experience Committee. Following approval, the policy should be made available on the Clinical Audit Sharepoint page.	The Clinical Audit Policy has been developed and circulated for comment to the Clinical Effectiveness Committee and the Clinical Board Directors. It will be circulated wider through the UHB policy ratification process by Corporate Governance, followed by discussion at the Senior Leadership Board, and finally approval in the Quality Safety and Experience Committee. It will be made available to staff via the Clinical Audit Share point page.	Miss Francesca Thomas	Miss Francesca Thomas	31/07/2023	19/09/2024	Green	Fully complete (Approved)		This action is now complete
Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1.1 Internal financial reporting should be enhanced to clearly show the forecast position against the annual CRL, and the position against the approved contingency budget. 1.2 WG PPRs should be updated to reflect the current allocation of funds across each budget area.	Agreed. The report will be updated to reflect the current allocation of funds across each budget area.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Green	Overdue		
Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	1. Establish a routine review of the tracker to the data within Patchwork to identify discrepancies between requested and actual WLI sessions. This should be undertaken monthly to ensure all sessions are accurately recorded. 2. Management should emphasise the importance of completing and submitting the form for every WL Isession request. This will ensure all sessions are documented in the tracker. 3. Management should evaluate and enhance the integration between the Teams Channel form and the tracking spreadsheet to ensure no data is lost or overlooked during the automatic population process.	The use of WLI's is monitored on a weekly basis by members of the Workforce Sustainability Group and the Sustainability Programme Board are updated at regular intervals.	Ms Rachel Chilcott	Ms Rachel Chilcott	16/10/2024	16/10/2024	Green	Fully complete (Approved)		
Risk and Regulation/ 2024/840	Internal Audit - Implementation of the People and Culture Plan	Must do	Management should ensure that the 2024 performance indicators are reported to the next Board and the People and Culture Committee meetings.	We will also aim to include Violence & Aggression data going forward.	Mr Robert Warren	Mr Robert Warren	30/09/2024	16/10/2024	Green	Overdue		

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Risk and Regulation/ 2024/745	Internal Audit - Financial Management within Clinical Boards	Must do	The Clinical Board Finance Teams should review the 'reports database' to ensure that all budget holders details are up to date and take appropriate action to remove those staff that are no longer budget holders and if applicable add the details of any budget holders that are missing. Consideration should also be given that the Financial Systems Team issue the report to each Clinical Board Finance Team on a quarterly basis for review.	The Reports database is not the only platform for availability and review of financial information and support teams follow up with primary budget holders in monthly (or more often) meetings. Finance support teams will review their distribution at the same time as they liaise with budget holders on information needs to ensure that distribution lists are appropriate and up to date.	robert mahoney	robert mahoney	30/09/2024	15/10/2024	Amber	Overdue		
Risk and Regulation/ 2024/829	Internal Audit - Performance Reporting (Data Quality)	Must do	The quality assurance arrangements of the Integrated Performance Report should be reviewed to ensure processes are in place to mitigate the risk of the anomalies highlighted within the audit sample.	Where no source information or data are available a standard message or indication (with an asterisk) of "No information or data available at source" will be used. With regards to decimal place accuracy, we will seek advice from the relevant leads for individual measure accuracy and introduce a new quality check.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/06/2022	14/10/2024	Amber	Fully complete (Awaiting approval)		
Risk and Regulation/ 2023/305	Internal Audit - Mental Health Clinical Board Governance Arrangements	Must do	Management should ensure that meetings are held in accordance with the frequency detailed within their terms of reference. Chairs / Vice Chairs of all meetings should also remind all members of their responsibility to attend required meetings or send a representative when they are unable to attend. Management should also ensure that all records of meetings identify all attendees and in the capacity that they are attending.	Representatives for the meetings listed above will need to be reviewed. Quoracy and chairship will be agreed. Reviews of frequency of the above meetings will be reviewed and completed.	Mr Andrew Partridge	Mr Andrew Partridge	31/12/2023	11/10/2024	Amber	Fully complete (Approved)		Exceeded the agreed implementation date Limited information to be able to assess if all actions are complete.
Risk and Regulation/ 2023/306	Internal Audit - Capital Systems	Must do	Standardised reference numbers and descriptive titles should be used for schemes across all reporting, forms, applications, and minutes. It was noted that the Procurement reference number was used in the Procurement Report and often the Request for Approval form, but thereafter, any consistency was often lost.	Standardised reference numbers and descriptive titles will be used for schemes across all reporting, forms, applications, and minutes.	Mr Stephen Gardiner	Mr Stephen Gardiner	31/10/2023	10/07/2024	Green	Overdue		

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Risk and Regulation/ 2024/830	Internal Audit - LIMITED Cyber Security Follow up	Must do	Key cyber security figures relating to server patching and perimeter controls should be consistently recorded, upon which performance measures and indicators can be developed and regularly reported to the Digital Health and Intelligence Committee.	There have been numerous attempts made to reflect key performance indicators into the Cyber Security Digital Health and Intelligence Committee report. Standard performance indicators are difficult to measure and whilst we have consistently reported legacy Operating System figures, this doesn't truly represent our cyber security position. This will improve as we complete Performance Measures and Metrics. The February 2024 committee paper did report on a number of cyber metrics but this was more for awareness than a representation of performance. We can ensure we continue to report on legacy server OS and include metrics/indicators for other measures for future committees.	Ms Rachel Chilcott	Ms Rachel Chilcott	31/05/2024	14/10/2024	Amber	Fully complete (Awaiting approval)		
Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	1. Management should investigate why WLI sessions are being paid for reasons unrelated to their intended purpose and provide training to staff on the correct classification and payment process for different types of sessions. 2. Management should consider modifying the system to eliminate free-text entry for WLI session cost and introduce a process to approve any deviations from the standard rate of £690. 3. Regular monitoring should be conducted to ensure that WLI sessions are correctly paid and approved in accordance with the WLI procedure.	Data is shared with the CB on a monthly basis, which includes the reasons for WLI sessions. Bi-monthly meetings have been established and a dashboard has been created to allow the Assistant Medical Director for Workforce to discuss WLI data. The most recent report from the Staff Bank shows that WLI payments for non-WLI activity have stopped w/c 01/07/24 (graph below), this will be monitored. on a weekly basis.	Mr Michael Stephens	Mrs Louise Blunsdon	16/10/2024	16/10/2024	Red	Fully complete (Approved)		

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Risk and Regulation/ 2024/831	Internal Audit - IMTP Development Process	Must do	Prior to resubmission of the IMTP and MDS to the WG the Board should undertake the following: • The IMTP/MDS data should be reconciled. • Prior to submission to the Board, it should be reviewed and signed off by an appropriate delegated authority. • The IMTP planning process should be revised to include appropriate reconciliation checks.	Reconciliation checks - Arrange for an internal team independent of the core team that input the data and write the narrative plan to review the final MDS and reconcile back to the narrative before it is submitted in February/March to SLB, Finance and Board.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2024	14/10/2024	Red	Overdue		
Risk and Regulation/ 2024/309	Internal Audit - Estates Condition	Must do	The Estate strategy should be updated to reflect items including performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc.	Agreed in principle - The estates strategy has constantly been reviewed, with many aspects within the document updated to provide responses to previous Board queries and the Welsh Government requests. The condition survey findings will help inform the direction of investment in relation to backlog maintenance, space utilisation, functional suitability and investment strategies. This information, along with reviewing the IMTP of clinical departments and the strategic direction of the Board will help inform the Estates Strategy.	Mr Andrew Partridge	Mr Andrew Partridge	31/03/2024	04/03/2024	Amber	Overdue		
Risk and Regulation/ 2024/832	Internal Audit - LIMITED - Decarbonisation	Must do	DAPs should be fully costed to fully determine the total funding required.	This point is noted. C&V are producing their new DAP before end March 2023.Feasibility studies will need to be commissioned as part of that plan.	Ms Rachel Chilcott	Ms Rachel Chilcott	31/03/2023	14/10/2024	Amber	Fully complete (Awaiting approval)		

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Risk and Regulation/ 2024/748	Internal Audit - Cancer Services	Must do	1. A system-wide project should be undertaken with the aim of improving integrity/quality for Suspected Cancer Pathway data. 2. Management should undertake a technology gap analysis of the current IT Infrastructure and its ability to support the cancer delivery remit.	1. Cancer Services, led by the General Manager for Cancer Services will deliver on a continual improvement plan for refining and improving the quality of the SCP cancer data set. Aspects of this are outlined within the digital plan within the cancer strategy. 2. The Cardiff and Vale UHB Cancer Strategy 2023-2028 identifies "Adopting Digital First" as a key component. In December 2023 the 1, 3 and 5 year priorities were presented and agreed outlining the direction towards refining and improving the IT infrastructure, reducing duplication and automation of data collection. As part of this work, a gap analysis was undertaken specifically around digital requirements. The Executive Cancer Board will act as the overriding governance structure monitoring the delivery against these key objectives.	Michael Eastwell	Angela Parratt	30/05/2024	23/07/2024	Red	Partially complete (Overdue)		This action reflects a continual pathway of improvement that will be gradually implemented over a period of 5 years. Implementing next steps is reliant on completion of the CANISC replacement. This action will be continually revisited through the executive cancer board
Risk and Regulation/ 2024/311	Internal Audit - Alcohol Standards	Must do	The Health Board should introduce an appropriate alcohol screening tool, in order to provide a more consistent approach to noting patient information and assisting in identifying people who potentially have an alcohol-use disorder.	Consistent recording mechanism for the chosen screening tool implemented and rolled out to all relevant teams. E.g. Electronic workstation	Lauren Idowu	Lauren Idowu	30/09/2024	19/09/2024	Red	Overdue		1. This action will be undertaken by the Alcohol Programme Manager post.
Risk and Regulation/ 2024/833	Internal Audit - PCIC Governance Arrangements	Must do	Management should ensure that meetings are held in accordance with the frequency detailed within the TOR.	Frequency of all meetings to be reviewed and formally approved as part of review of terms of reference. Should meetings need to be stood down/rescheduled due to factors outside of the Clinical Board's control rationale to be formally recorded within the next meeting minutes.	Mrs Anna Llewellin	Ms Anna Mogie	30/09/2024	15/10/2024	Green	Fully complete (Awaiting approval)		Now in place

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Risk and Regulation/ 2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	Noting the current wait for funding, it is timely to evaluate terms of reference and governance structures to ensure each forum is appropriately focused.	Agreed. This will be informed by the outcome of the clinical review and forthcoming attendance at WG IIB. The SOC production is considered a project and was being reported into the Programme Board. As the only project, it was the only Project Board. It is acknowledged that it is in the programme's early stages and the only group meeting, the Project Board was also covering more general ground by updating stakeholders on matters.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue		
Risk and Regulation/ 2024/839	Internal Audit - Health and Safety	Must do	1. The scope of the regular Health and Safety Update Report, or the Health and Safety Sub-Committee Chair's Report to the People and Culture Committee should be supplemented to include information with respect to general progress against the H&S Culture Plan, particular attention should be given to elapsed or recalculated target dates and any obstacles to progress. 2. In all cases where alternative resolutions to the recommendations made by the external review have been adopted, this should be specifically highlighted to the Health and Safety Sub-Committee and details of the reasons behind the decision to adopt an alternative resolution should be clearly documented.	The chair of the H&S Committee to be requested to provide an update to the People and Culture Committee in his 'Chairs report' to this meeting.	Mr Robert Warren	Mr Robert Warren	15/10/2024	16/10/2024	Green	Fully complete (Awaiting approval)		The chair of the H&S Committee has been asked by the Assistant Director of Health, Safety and Fire to present a H&S Culture plan paper to the People and Culture Committee. Whilst this action is against the Assistant Director of Health, Safety and Fire it is not in his gift to ensure it is completed.
Risk and Regulation/ 2024/744	Internal Audit - Core Financial Systems (Asset Register Management)	Must do	• The normal assets lives review with Clinical Engineering should be brought up to date. • A review template should be completed for assets whose lives may differ from the norm.	• Asset life review to be carried out in 24/25 with Clinical engineering • A process review will be carried out in 24/25 to establish how exceptional asset life is best evidenced.	Rhian Selwood	Rhian Selwood	31/03/2025	08/07/2024	Green	In progress		

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Risk and Regulation/ 2024/751	Internal Audit - Risk Management and Board Assurance Framework	Must do	All risks on all registers should be completed with risk and action owners named with their role and title recorded. All review dates should be at least one month in the future. This should be done with some urgency as if a software solution is found (MA1) then the information initially entered should be 100% accurate and have a future review date set. The defined procedure should be strengthened to mandate the up-to-date registers should be copied to the Risk and Regulation officer after every meeting that results in a change to the registers.	Agreed. Meetings are being arranged with Risk Managers / Facilitators to review registers and to provide further training. This will include ensuring the risk and action owners are named on the register to ensure consistency across Clinical Boards / Corporate Departments. Agreed. When the new module is installed, the registers can be quickly updated prior to any meetings where the registers will be reviewed.	Ms Glynis Mulford	Ms Glynis Mulford	31/12/2024	15/10/2024	Amber	Fully complete (Awaiting approval)		This will be picked up as part of the implementation of the new risk module
Risk and Regulation/ 2024/750	Internal Audit - Mortality Reviews	Must do	The Health Board should attempt to: • Clear the backlog of open cases as soon as possible, ideally by its intended deadline of March 2024. • Ensure that new cases are reviewed and responded to on a timely basis.	1) Delivery of C&V scrutiny panel to review all cases referred from ME 2) Development of reporting measures to ensure timely internal responses to ME referrals.	Dr Aled Roberts	Dr Aled Roberts	30/06/2024	10/07/2024	Amber	Overdue		
Risk and Regulation/ 2024/838	Internal Audit - Performance Reporting	Must do	Management should ensure the guidance document is finalised and brought into use as it would support in mitigating some of the exceptions highlighted within the report and support the production of a robust IPR.	The IPR has changed significantly since the audit in 2021/22. A revised guidance document will be produced to reflect the staff roles/responsibilities, governance arrangements and associated processes for managing under-performance.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/11/2024	16/10/2024	Amber	In progress		

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Risk and Regulation/ 2024/747	Internal Audit - Information Governance	Must do	Management should consider identifying appropriate IG Leads / Champions within the Health Board, and to support the IG team by promoting good information governance practice.	With the existing limited capacity, ensuring that other departments have staff with specific data protection responsibilities is desirable but we need to ensure that this doesn't adversely impact their primary roles which, in the main, are already under strain. One role that needs to be conducted is the role of a Information Asset Owner (IAO) who should be responsible for completing a Information Asset Register (IAR) for their area. It would therefore make sense to explore whether the scope of this role could be extended to also include other data protection responsibilities, such as breach reporting/management and a general IG point of contact for their department.	Mr James Webb	Mr James Webb	01/04/2024	10/07/2024	Amber	Overdue		
Risk and Regulation/ 2024/749	Internal Audit - Patient Safety Incident Management	Must do	Management should review the National Incident Tool Kit to ensure it is relevant and up to date and should also consider formally publishing it. Management should also ensure the NRI section of the patient safety team's page on the Health Board's intranet is updated with current information.	Toolkit to be updated as above and publish on SharePoint.	Mrs tara Cardew	Miss Catherine Evans	30/06/2024	15/10/2024	Green	Fully complete (Awaiting approval)		Toolkit updated and published on sharepoint page June 2024
Risk and Regulation/ 2024/837	Internal Audit - Safeguarding	Must do	1. The Chair should formally check and confirm that meetings are quorate prior to the start of each meeting, and this should be recorded in the meeting minutes. 2. The membership of the SSG should be reviewed.	The UHB are satisfied with the SSG membership, having the Local Authority and police in attendance when they are available is deemed good practice to promote UHB transparency. However, it may need to be clear that attendance by both agencies is not a requirement. The SSG minutes will in future clarify which CB the attendees are representing.	Ms Linda Hughes-Jones	Ms Linda Hughes-Jones	31/10/2024	16/10/2024	Amber	In progress		

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Risk and Regulation/ 2023/282	Internal Audit - Medical Records Tracking (CDT)	Must do	Management should formally track progress of taking forward lessons learnt to mitigate the risk of known issues recurring and to assist in identifying barriers that can be escalated for resolution.	A Health Board 'Tracking of Medical Record Learning and Improvement Proposal' will be developed. This will incorporate the points outlined in the Ombudsman response November 2021. Learning and progress on improvement will be assessed through Clinical Board's Quality, Safety & Patient Experience meetings, with further oversight	Mr Andrew Partridge	Mr Andrew Partridge	03/03/2023	10/07/2024	Amber	Partially complete (Overdue)		Update 05.06.24 The medical records delivery group, has been established as part of the Clinical Information Programme. The Clinical Information Programme Board, led by the Director of Operations for CD&T and clinical representation provided by the Chief Clinical Information Officer and Associate Medical Director for Professional Standards, had its inaugural meeting on 09.05.24. The programme has three key workstreams of which the elements in the 'Learning and Improvement Proposal' will be outlined and progressed within the 'Consistency of Approach' workstream. Progress against these will be monitored by the Programme Board
Risk and Regulation/ 2023/287	Internal Audit - Nurse Staffing Levels Act Final Internal Audit	Must do	2.1 - Approval of the agreed nurse staffing levels by the Designated Person should be evidenced on the Nurse Staffing Level - Workforce Planning templates. 2.2 - The Finance budget reports for the WTE staff should be amended to align with the correct Nurse staffing levels.	2.1 - A) The establishment review process is well established in C&VUHB. Establishment reviews take place with the Designated Person and dates have been confirmed for the upcoming reviews in preparation for presentation to board in May 2023. B) The Designated Person to sign the workforce planning template. Nurse Staffing Levels Lead to confirm this prior to inclusion in the board report.C) Review the establishment review process as part of the Operating Framework setting out a clear timeline for future establishment review. 2.2 - A) As per the Operating Framework, Finance Partners in each Clinical Board to be present during establishment reviews. Ensure the signed off establishment templates are signed by finance partners and that these templates are used to inform the budget reports. B) Ensure agreed establishments are updated in Health Roster and this is reviewed bi-	Mr Jason Roberts	Mr Jason Roberts	30/06/2023	19/09/2024	Amber	Fully complete (Approved)		A) The nurse staffing levels continues to be presented to Board and were presented in May 2023 and November 2023. B) The designated person, the Executive Nurse Director reviews and agrees the establishments during the establishment review meetings. The establishment templates are signed during this meeting and the Nurse Staffing Levels Lead ensures the templates have been agreed prior to the inclusion in the board paper. C) The establishment process is well estbalished in Cardiff and Vale UHB . There has been no significant change to the process and the establishments are reviewed prior to completion of the All Wales Nurse Staffing Papers to Board in May and November.

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Risk and Regulation/ 2022/266	Internal Audit - Implementation of National IT Systems (WNCR)	Must do	All digital projects should be subject to a formal governance structure.	A formal project governance structure has been put in place including risk monitoring for the whole of the programme including digital. Formal monitoring will be provided via the WNCR Board meetings and any digital risks arising will be reported upwards to exec director level and, if necessary, to the Senior Leadership Board (formerly HSMB). Regular updates will also be submitted to the Digital & Health Intelligence committee.	Mr Aron White	Mr Aron White	31/10/2022	15/07/2024	Amber	Partially complete (Overdue)		June 2024 Audit completed by external supplier. Report submitted to network team to indicate extent of wifi coverage. For network team to progress this work.
Risk and Regulation/ 2023/286	Internal Audit - Financial Reports and Savings Targets	Must do	To support the robustness of the financial reporting process, the sources of data which inform the monthly 'Finance Report' should be evident and retraceable.	o support the robustness of the financial reporting process, the sources of data which inform the monthly 'Finance Report' should be evident and retraceable.	Mr Andrew Gough	Mr Andrew Gough	31/07/2023	19/09/2024	Green	Fully complete (Approved)		A working copy of the process note was developed in February 2024. This will be reviewed periodically when fundamental change are made to the Finance Committee Monthly Finance Report and the Welsh Government Monthly Monitoring returns.
Risk and Regulation/ 2022/268	Internal Audit - Medical Equipment	Must do	The Medical Equipment Group should seek assurance from its members that they have raised the awareness of the revised policy and procedure within their areas of the Health Board, to ensure staff are aware of any changes to their responsibilities.	Add agenda item to next MEG and MDSO meeting, asking membership to disseminate Policy and Procedure to ensure their staff are aware of the new versions. Senior Leadership Board to discuss policy and disseminate the revised policy.	Mr Ed Chapman	Mr Ed Chapman	07/12/2022	10/07/2024	Amber	Partially complete (Overdue)		Digital Advisory Board, Clinical Design Authority and Technical Design Authority are established and scheduled to meet monthly. Each has its own TOR and emerging workplans.

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Risk and Regulation/ 2023/289	Internal Audit - Charitable Funds	Must do	An annual operating plan for the fundraising department should be submitted to the Charitable Funds Committee at the beginning of each financial year. The plan should provide specific details regarding the structure of the department, individual staff costs and also non staff costs. Details should also be provided of an estimate of staff costs that can be recharged to specific appeals and funds that the fundraising staff support noting the net costs that can be expected to be recharged to the 'general fund'. An update on the plan should be reported at each meeting of the Charitable Funds Committee noting any changes to the structure that will impact on the 'recharge' to the general fund.	The Health Charity is currently reviewing its strategy and in line with good practice has been engaging with CFC members and others to review and redevelop it collaboratively. Part of the strategy review entailed a recognition to include an Annual Operational Plan. This will be developed in Quarter 1 of 2023 and will be reviewed agreed via the Charitable Funds Committee and be embedded as part of its annual governance reporting mechanisms. This will include staff structure, costings and projections on any identified changes to the core staff establishment that require additional funding. Operational changes to staffing, responding and reacting to workforce or project requirements that do not require additional funding from general reserves, specific funds or have external funding will continue to follow the current reporting mechanisms and sign off via the Day to day operational responsibilities of the	Mr Andrew Partridge	Mr Andrew Partridge	01/04/2023	08/07/2024	Red	Partially complete (Overdue)		8 July 2024 The Health Charity Strategy and Operational Plan has been paused whilst the team go through an Operational Change Process (OCP) The Health Charity has developed a draft Operational Plan for 2023/24 which has been submitted to the quarterly Charitable Funds Committee meeting scheduled for 20.06.23*. The plan includes projected income/expenditure and current/projected staff costs for this period. The Health Charity and Charitable Funds Finance team are working collaboratively to ensure that the projected financial plan is regularly revised and updated to reflect actual income/expenditure, which will be reported back to the CFC meetings via a newly developed Events reporting template. This template will also be used to
Risk and Regulation/ 2023/290	Internal Audit - Data Warehouse	Must do	As the LDR is developed, the department should prioritise the development of replacement feeds from the LDR for those feeds that are currently a manual process.	An assessment of manual data feeds will be undertaken to identify and document which would be suitable for and benefit from migrating to the LDR. Note actual redevelopment of feeds would be subject to resource and prioritisation in the longer term.	Kerry Ashmore	Kerry Ashmore	31/07/2023	08/07/2024	Amber	Partially complete (Overdue)		Mar 2024 - new data feeds are assessed for their suitability to be managed via the LDR however resource constraints in both the warehouse and LDR teams mean replacing existing manual feeds are not currently a priority.
Risk and Regulation/ 2022/265	Internal Audit - Staff Wellbeing Culture and Values	Must do	The monitoring arrangements for the Wellbeing Plan should be enhanced to ensure the timely delivery of agreed actions, within agreed funds available.	The UHB are currently developing the Wellbeing Strategy and Framework, which will include information on measures and monitoring. This will be put to Board for approval in February 2023. The Assistant Director of OD, Wellbeing and Culture is currently working with the Innovation and Improvement Team to develop the monitoring mechanism for the wellbeing projects, which will align with the measurements under the P&C Plan.	Mrs Claire Whiles	Mr Andrew Partridge	28/02/2023	06/08/2024	Amber	Partially complete (Overdue)		The draft Wellbeing framework is being completed to be taken to SLB for consultation and engagement to be presented at People and Culture committee in November 2024.

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Risk and Regulation/ 2023/291	Internal Audit - Inclusion and Equality	Must do	To ensure compliance with the organisation's objectives and legislative requirements, management should undertake a review of the responsibilities of the team members and the structures in place within the Health Board to support the team.	The People and Culture Directorate will commence a benchmarking exercise to assess the effectiveness of current capacity compared to other NHS organisations. This is not restricted to the Equity and Inclusion Team, but also looking at Welsh Language, and Education, Culture and OD. This is being looked at alongside the UHBs commitment to delivering the SEP, meeting its SocioEconomic Duties, and responding to WG direction, including the Anti-Racist Wales Action Plan; WRES etc. This will be completed, and the UHB will be presented with a paper, outlining the findings, team capacity findingshighlighting any areas of risk / any short-falls. This will go to the People and Culture Committee in the first instance.	Mr Mitchell Jones	Mr Mitchell Jones	30/09/2023	06/08/2024	Red	Partially complete (Overdue)		The benchmarking exercise has been completed and a paper discussed with the Executive Director of P&C in the first instance. Current organisational demands have highlighted areas of risk around organisational development, culture, leadership, workforce planning and analytics. Work is currently underway to prioritise organisational to inform further investment. Business Case currently in development to be presented April 2024/ The department recognises a limited resource within Equity & Inclusion; however, the current financial climate impacts on the ability to move forward with this. This will continue to be logged as a risk. with a view to revist in 2024. The business case to be presented to the IG in October 2024.
Risk and Regulation/ 2023/292	Internal Audit - Management of Health Board Policies	Must do	• Further work is required to resolve the 44 blank rows with Date to Review to 2022 where no Executive Lead is identified; • Comments on the tracker should include sufficient information so that the status of policies and procedures can be clearly understood including what further action is required; • The large number of gaps in the tracker spreadsheet should be reviewed and cleared; and • The multiple variants of Executive Lead titles should be reviewed and amended so that there is a consistent approach.	"The Head of Corporate Governance will undertake a comprehensive review of the policies tracker to address the recommendations made. The Corporate Governance team developed the “tracker” last year as a starting point for this large piece or work in order to record the policies/procedures which were registered on the Corporate Governance team’s system and the review dates of the same etc. It is also used by the Corporate Governance team to record the work which the team is and has been undertaking since August last year with regards to putting the Corporate Policies register on a much better footing. For example, it provides the team with a status position of policies/procedures as we work through the tracker list). It is a tool to record the work being undertaken by the Corporate Governance team to produce a fully functioning policy management system."	Miss Francesca Thomas	Miss Francesca Thomas	31/07/2023	18/09/2024	Amber	Fully complete (Awaiting approval)		This work has been completed by the Corporate Archivist &Records Management Manager. All policies have been reviewed and all policies are now available on AMAT, Sharepoint and the Internet. AMAT is now being utilised to manage the expiry of policies and assist with keeping as many as possible in date.

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Risk and Regulation/ 2022/264	Internal Audit - Medical and Dental Staff Bank	Must do	Rota-Coordinators need to ensure that shifts are made available in a timely manner on the Envoy system to ensure a greater chance of take up by Bank Staff. In instances where the Rota-Coordinator is unavailable, contingency and cover arrangements should be considered.	Short term absence will inevitably take place which will not always allow for a shift to be put on prospectively e.g. same day sickness etc. There will also be occasions whereby a locum will be required over a weekend/bank holiday that was not planned within the week and as the rota co-ordinator only work M-F/BH this will require action on their return. We can adopt a measure that all retrospective shifts are to be put on no later than 72 hours. The Medical and Dental Staffbank team will create a communication to go out to all service areas to update them of the above and will monitor over the next quarter to monitor adherence and report into MWAG.	Hilary Sharp	Hilary Sharp	31/10/2022	02/08/2024	Amber	Fully complete (Approved)		Communication was sent out. New Patchwork system introduced (in place of Envoy). Updates provided to MWAG
Risk and Regulation/ 2022/263	Internal Audit - Waste Management	Must do	The UHB should conclude the formulation and operation of Key Performance indicators in respect of contracted parties to complement contractual arrangements.	Agreed, KPIs to be set for external contractors (ref MA5). A number of contracts are currently going through procurement, there is therefore an opportunity to now build these in.	Mr Andrew Partridge	Mr Andrew Partridge	31/08/2022	30/05/2024	Amber	Partially complete (Overdue)		Agreed, KPIs to be set for external contractors (ref MA5). A number of contracts have been processed via procurement, and agreed data/KPIs are in place.
Risk and Regulation/ 2023/293	Internal Audit - UHW Hybrid and Major Trauma Theatres	Must do	The UHB should consider putting in place a dedicated Project Board for this scheme ahead of the Construction phase commencing to ensure appropriate oversight.	Agreed – Director of Capital, Estates & Facilities to initiate discussions with an aim to take forward within the UHB. This will not be finalised until Welsh Government approval of funding has been approved, therefore target date will need to be reviewed.	Mr Andrew Partridge	Mr Andrew Partridge	31/08/2023	31/05/2024	Amber	Partially complete (Overdue)		A dedicated Project Board will be established following approval of the scheme by WG
Risk and Regulation/ 2023/283	Internal Audit - Decarbonisation Final Report February 2023	Must do	DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	Mrs Abigail Harris	Mrs Abigail Harris	20/02/2024	19/09/2024	Amber	Fully complete (Approved)		Funding for the Estates based actions such as EFAB and REFIT have been delivered with additional funding bids submitted in January 2024. The majority of actions have been delivered within existing funding and resources. [close action]
Risk and Regulation/ 2022/269	Internal Audit - Development of Genomics Partnership Wales	Must do	Payments should be made in accordance with contractual and/or legislative requirements.	greed. The DocuSign system has recently been implemented, which will expediate the process of payment approvals going forward.	Mr Clive Morgan	Mr Geoff Walsh	30/11/2022	14/02/2024	Red	Fully complete (Awaiting approval)		Docusign fully integrated to manage payments

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Risk and Regulation/ 2023/303	Internal Audit - Surgery Clinical Board - Consultant Job Plans - LIMITED	Must do	2a - Orthopaedics and General Surgery Directorate management should review the current process for agreeing and signing off Consultant job plans with a view to streamlining the process. Arrangements should be put in place to ensure that all Consultants within Orthopaedics and General Surgery have up to date, signed off job plans as soon as practicably possible. Given the delays in agreeing and signing off job plans, consideration should be given to the feasibility of recording the end date of job plans as 12 months from the date they were agreed and signed off, rather than 'ongoing'. 2b - Orthopaedics and General Surgery All job plans should include Clinical Board (service outcomes), the achievement of which should be subject to annual assessment.	2a - Orthopaedics All job plans will be signed off by the 31/10/2023, including the newly added ones. End dates will be set up so that a reminder of job plan renewal and update will be triggered after 12 months of sign-off date. Because of the recent changes in the service, numerous consultants are still in the process of signing off. 2b - Orthopaedics Outcomes and objectives will be assigned to each job plan, and will be aligned to the clinical board deliverables for the current financial year. 2a - General Surgery In General Surgery there is a process in place for job plan sign off, however not all job plans have been straightforward and have been complicated by enforced regionalisation. Start dates on the Allocate system were incorrect, this has been rectified by the project	Mr Antonio Roccioli	Mr Antonio Roccioli	31/12/2023	10/07/2024	Red	Overdue		T&O 2a - The system does not send reminders, however it will move expired job plans into the "Expired" category, which will trigger a job planning meeting. In terms of compliance, all job plans have been defined, however on e Allocate only 19/35 have been signed off. 11 awaiting clinician sign off, 5 in discussion, however will be sent for sign off soon. 2b - Specific directorate service outcomes and deliverables have been added to eAllocate for each consultant, linked too Board outcomes. Only two consultants have personal outcomes, however if no specific are added by the consultants, service outcomes will become part of their objectives.
Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	1. Management should investigate why WLI sessions are being paid for reasons unrelated to their intended purpose and provide training to staff on the correct classification and payment process for different types of sessions. 2. Management should consider modifying the system to eliminate free-text entry for WLI session cost and introduce a process to approve any deviations from the standard rate of £690. 3. Regular monitoring should be conducted to ensure that WLI sessions are correctly paid and approved in accordance with the WLI procedure.	Yes, the information can be obtained within the system.	Mr Michael Stephens	Mr Michael Stephens	16/10/2024	16/10/2024	Amber	Fully complete (Approved)		

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Risk and Regulation/ 2024/831	Internal Audit - IMTP Development Process	Must do	Prior to resubmission of the IMTP and MDS to the WG the Board should undertake the following: • The IMTP/MDS data should be reconciled. • Prior to submission to the Board, it should be reviewed and signed off by an appropriate delegated authority. • The IMTP planning process should be revised to include appropriate reconciliation checks.	Delegated Authority - Finance and Performance Committee to be given delegated authority for the MDS submission - Proposal to Director of Corporate Governance and Committee Chair.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2024	14/10/2024	Red	Overdue		
Risk and Regulation/ 2024/839	Internal Audit - Health and Safety	Must do	1. The scope of the regular Health and Safety Update Report, or the Health and Safety Sub-Committee Chair's Report to the People and Culture Committee should be supplemented to include information with respect to general progress against the H&S Culture Plan, particular attention should be given to elapsed or recalculated target dates and any obstacles to progress. 2. In all cases where alternative resolutions to the recommendations made by the external review have been adopted, this should be specifically highlighted to the Health and Safety Sub-Committee and details of the reasons behind the decision to adopt an alternative resolution should be clearly documented.	The RLB report recommended actions 6 and 9 that were not implemented were explained and discussed at the H&S committee meeting 19.07.2022 along with the recommended name change to the department and requirement for additional head count. The department workshop day on 27th November is concentrating on the H&S culture plan and a review will be conducted against the RLB report actions. Anynon-addressed actions will form the basis of forward strategies. This in turn will be fed back to the H&S Committee in Q4 2024.	Mr Robert Warren	Mr Robert Warren	31/03/2025	16/10/2024	Green	In progress		
Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	1. Management should investigate why WLI sessions are being paid for reasons unrelated to their intended purpose and provide training to staff on the correct classification and payment process for different types of sessions. 2. Management should consider modifying the system to eliminate free-text entry for WLI session cost and introduce a process to approve any deviations from the standard rate of £690. 3. Regular monitoring should be conducted to ensure that WLI sessions are correctly paid and approved in accordance with the WLI procedure.	The use of WLI's is monitored on a weekly basis by members of the Workforce Sustainability Group and the Sustainability Programme Board are updated at regular intervals. Bi-monthly meetings have been established and a dashboard has been created to allow the Assistant Medical Director for Workforce to discuss WLI data.	Mr Michael Stephens	Mrs Louise Blunsdon	16/10/2024	16/10/2024	Green	Fully complete (Approved)		

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Risk and Regulation/ 2023/291	Internal Audit - Inclusion and Equality	Must do	Management should ensure that a robust process is in place to enable the required action plans to be effectively developed and delivered. This should include effective structures to support the Inclusion and Equality Team, including development of the Inclusion Ambassadors and Equality sub-groups.	The review and refresh of the TORs of the ESWLSG (Action 1), will reinforce the reporting and local accountability against equality actions, while enabling a forum that shapes strategic direction against EDI (and Welsh Language). The reviewed TORs will include reporting accountability for Clinical and Service Boards, along with reporting to the People and Culture Committee, and Board.	Mr Andrew Partridge	Mr Andrew Partridge	31/05/2023	06/08/2024	Amber	Partially complete (Overdue)		A Terms of Reference for a future iteration of ESWLSG has been drafted for consideration by the Health Board. However, a decision regarding the future of the group is currently on hold whilst considerations regarding the future of equity, equality, inclusion and its management within the Health Board are underway. Awaiting a decision from the Director of Corporate Governance.
Risk and Regulation/ 2024/307	Internal Audit - Infection, Prevention & Control	Must do	The IPC Group Terms of Reference should be reviewed annually.	The IPC Group Terms of Reference will be reviewed and taken to the IPC Cell at the beginning of February for discussion. The document will be taken to the March IPC Group meeting for comment and ratification.	Mrs Yvonne Hyde	Mr Andrew Partridge	24/03/2024	08/07/2024	Amber	Partially complete (Overdue)		The IPCG TOR were supposed to have been shared in March 2024 however was cancelled due to Doctor IA. Therefore the TOR will now go to the IPCG in June 2024.
Risk and Regulation/ 2022/264	Internal Audit - Medical and Dental Staff Bank	Must do	Management need to ensure that they meet regularly with Medacs, in accordance with the requirements of the Framework Agreement, so that the performance is regularly reviewed, and any issues can be discussed during the meeting.	These meetings are now scheduled monthly. Audience to include, Head of Medical Resourcing and Systems, Deputy Director of People & Culture, Deputy Medical Director and Medacs Healthcare.	Hilary Sharp	Hilary Sharp	31/10/2022	02/08/2024	Green	Fully complete (Approved)		No updates received.

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Risk and Regulation/ 2022/266	Internal Audit - Implementation of National IT Systems (WNCR)	Must do	A project plan should be developed that shows the scheduling of wards, and the processes required to implement within wards, along with the timescales and resource requirements.	There are two components to this recommendation: 1. Development of an implementation schedule A provision roll-out schedule was devised in March 2022. This schedule indicated the data for implementation and equipment required on each ward. However, further WNCR implementation is unlikely to progress in the UHB until April 2023. This pause is necessitated to accommodate the launch of another digital platform Safecare. The UHB will also enter its ePMA implementation phase in April 2023. Actions: - Revise the WNCR roll out schedule in response to the Safecare and ePMA schedule (in to prevent wards having to adopt more than one digital platform at a time). Include within this schedule: • Number of colleagues to train • Quantity/type of equipment to deliver	Mr Aron White	Mr Aron White	31/12/2022	05/07/2024	Amber	Partially complete (Overdue)		June '24: Managed devices, using cisco solution and dhcw provided KPI certififcates, are being tested. Further configuration required, but ePMA demo event and e-triage have needed to be prioritised for past 2months. Hoping device management team will be able to support imminently. Awaiting business continuity solution to be signed off by IG/Cyber.
Risk and Regulation/ 2024/838	Internal Audit - Performance Reporting	Must do	Management should ensure that staff responsible for collating the information provide it in line with the timetable so that all periods are reported on.	The IPR is a monthly report and should not be delayed due to services not submitting their data on time. The IPR schedule will be recirculated widely, so that services are clear on the timetable and requirements. Previously the general consensus was that in the event of data being unavailable, the information team used the last set of data submitted. The executive leads will be asked to ensure that the requested data as per the publication schedule is followed and any exceptions managed to ensure timely submission of data, avoiding gaps or reliance on previous data.	Ms Rachel Chilcott	Ms Rachel Chilcott	31/10/2024	16/10/2024	Amber	In progress		

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Risk and Regulation/ 2024/745	Internal Audit - Financial Management within Clinical Boards	Must do	Clinical Board Finance Senior Management need to work with Heads of Services/Departments to identify deliverable savings schemes in order to meet its delegated savings target for Corporate Central Savings Themes. Where existing savings schemes are failing to deliver their planned savings in total, Finance and Senior Management need to work with Heads of Services/Departments to identify actions that can be introduced to deliver the delegated savings targets. Where it has been identified/confirmed that identified schemes will not deliver expected savings then Heads of Services/Departments should ensure that additional deliverable savings schemes are identified to address the shortfall. Where non recurrent savings have been identified management should review schemes to ascertain if they could be made recurrent, or identify	The responsibility for delivery of the financial savings target is a key objective for the senior leadership team in each Clinical Board with the support and key input of the respective Finance Business Partner / Head of Finance. All savings targets for the UHB in the financial year are allocated to a Clinical Board level in the annual budget setting exercise as part of the development of the UHB financial plan. Finance Business Partners work with the Clinical Board leadership teams to continually develop savings ideas for Month 1 and then throughout the financial year. The Chief Operating Officer and Director of Finance, alongside the planning functions, ensure that the savings targets are shared and that plans are actively developed before the beginning of the financial year, and onwards into the financial year where shortfalls still exist. The delivery of the cost savings target is a fundamental, high risk, component of the financial strategy of the UHB and	robert mahoney	robert mahoney	01/04/2024	15/10/2024	Amber	Overdue		
Risk and Regulation/ 2023/292	Internal Audit - Management of Health Board Policies	Must do	• Staff should be notified when draft policies and procedures are added to the consultation page on Sharepoint; and • The cover emails accompanying draft policies and procedures provided to South Glamorgan Community Health Council, the Stakeholder Reference Group and the Local Partnership Forum for comment should make it clear that the documents are being provided for consultation and the deadline by which any responses must be received.	The Corporate Governance team notify the relevant contact/policy author as soon as the policy/procedure document has been published for consultation and a link to the relevant SharePoint link is provided. The relevant policy author should notify relevant members of staff once the document has been published on Sharepoint. Cover emails accompanying draft policies and procedures provided to Llais (formerly the Community Health Council), the Stakeholder Reference Group and the Local Partnership Forum for comment now clearly state that the documents are being provided for consultation and the deadline by which any responses must be received.	Mr Andrew Partridge	Mr Andrew Partridge	31/05/2023	15/10/2024	Amber	Fully complete (Awaiting approval)		This work remains ongoing within the Corporate Governance Team

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Risk and Regulation/ 2023/303	Internal Audit - Surgery Clinical Board - Consultant Job Plans - LIMITED	Must do	3a - Orthopaedics and General Surgery All Consultant job plans with more than 12 sessions per week should be approved in line with the Consultant Job planning Procedure. The approval should be evidenced on the Allocate system using the third sign off field.	3a Orthopaedics Consultants who are working on a 12 sessions job plan were authorised in previous years, and as service changes did not impact their sessional allocation, it has not been changed. However, as per the audit team request, we will action 2.1 a and b and make sure a third sign-off function is enabled. General Surgery Discussed with the CBD and the AMD for workforce, this was fed back on many occasions to the MD's office. A number of General Surgeons also have extra sessions in their job plans for external duties/responsibilities with Welsh Government, MoD and the University.	Mr Antonio Roccioli	Mr Antonio Roccioli	11/11/2023	10/07/2024	Amber	Overdue		3a Orthopaedics - this change would affect the entire organisation and possibly compliance will decrease. This function won't be enabled at present, at it showed as not bringing any added value.
Risk and Regulation/ 2022/265	Internal Audit - Staff Wellbeing Culture and Values	Must do	The 'Board Assurance Framework Risk: Staff Wellbeing', should be reviewed to ensure key actions being taken to address the Occupational Health referral wait times are included. Where gaps in controls and assurances are identified these should be considered too.	Development is underway to ensure the KPIs of the People Health Services Team, which includes Occupational Health, Physiotherapy, and Employee Wellbeing Services are reported upon monthly as part of the wider reporting within People and Culture. This will be added onto the Board Assurance Framework. It is important to note that the issue is exacerbated by absence within the team due to sickness absence, and the relevant support is being provided to staff to enable timely return to work, including phased return etc.	Mrs Claire Whiles	Mrs Claire Whiles	31/01/2023	06/08/2024	Amber	Partially complete (Overdue)		National KPI targets have now been adopted and are being implemented and reported upon as part of the non pay deal. Internal reporting mechanisms to be explored.
Risk and Regulation/ 2022/269	Internal Audit - Development of Genomics Partnership Wales	Must do	Further work is required to ensure the Project Bank Account is established and operating in line with Welsh Government policy.	Agreed. Further discussion ongoing with Contractor to enable project bank account to be put in place for the scheme.	Mr Clive Morgan	Mr Clive Morgan	31/03/2023	30/01/2024	Red	Overdue		No updates received

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Risk and Regulation/ 2024/748	Internal Audit - Cancer Services	Must do	Arrangements should be put in place to ensure that the business of the Executive Cancer Board is appropriately documented. As a minimum we would expect there to be: • Minutes for each Executive Cancer Board meeting; • Members attendance; • Standing agenda of items to be discussed; and • Log of key actions/decisions from each meeting.	The General Manager for Cancer Services will produce a needs requirement paper outlining the administrative support required for the service to deliver on the recommendation to be presented to the Director for Planned and Specialised Care. In the interim, options for administrative support to the Executive Cancer Board will be sought within the current establishment.	Michael Eastwell	Ms Catherine Wood	01/06/2024	23/07/2024	Amber	Fully complete (Awaiting approval)		This action was reviewed in executive cancer board with direction from the COO that there will not be formal minute taking and that a simple form of action taking will suffice
Risk and Regulation/ 2023/305	Internal Audit - Mental Health Clinical Board Governance Arrangements	Must do	Management should ensure the following: • The minutes / notes of meetings should clearly record actions identified and the title/name of person taking the lead. • The minutes / notes of the meetings should clearly align with the meeting agendas. Management should also consider recommending to the meeting chairs that where actions are identified that they are recorded on a meeting action log which should be reviewed at each meeting and clearly record the progress on the actions recorded.	Communication to all meeting chairs that the above actions are implemented.	Mr Andrew Partridge	Mr Andrew Partridge	31/12/2023	11/10/2024	Amber	Fully complete (Approved)		Exceeded the agreed implementation date Limited information to be able to assess if all actions are complete.
Risk and Regulation/ 2023/306	Internal Audit - Capital Systems	Must do	The preferred method of reporting should be consistently completed on a pre-determined frequency.	Agreed. Standardised reporting arrangements are being implemented, which will be consistently applied across all UHB projects.	Mr Stephen Gardiner	Mr Stephen Gardiner	31/10/2023	10/07/2024	Green	Overdue		
Risk and Regulation/ 2022/268	Internal Audit - Medical Equipment	Must do	The Clinical Engineering Department should liaise with Directorate and Ward Management on a planned and scheduled basis to confirm the ongoing existence and location of medical equipment items, to ensure the accuracy of the Medusa medical equipment database.	Initially, Clinical Engineering will perform an audit of items not seen for over 10 years. Confirmation of accuracy will be sought from Directorates and Ward Management. Depending on the results of this initial audit follow up audits will be scheduled on a regular basis.	Mr Ed Chapman	Mr Ed Chapman	01/02/2023	10/07/2024	Amber	Partially complete (Overdue)		No, a further extension to the implementation date is required. Feb 2024. [EC aDoTH 10/23] Please extend to May 2024 . The member of staff tasked with this (and other actions) has left since the July update and we are recuiting a replacement. Some preparatory work has begun on the audit, but operational pressures and lack of staff resource have delayed further progress. Implementation date changed to May 2023 to allow time to train staff and carry out work.

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Risk and Regulation/ 2024/749	Internal Audit - Patient Safety Incident Management	Must do	Management should ensure that incidents are processed within the expected timeframes and reported as stated in the Welsh Government policy, Welsh Government supporting documents and Health Board policy and procedure. Management should also review the incident process where significant delays are occurring with a view to understanding any reasons behind the delay and revising or refining approaches to help reduce these delays. The Health Board should ensure where lessons learnt have occurred improvement plans are completed. With the continuous adoption and use of AMaT by the Health Board, it would be good practice to indicate within Datix that the incident has an improvement plan recorded on AMaT. Also, in situations where improvement plans have been developed in themes	1a. Quarterly emails to incident managers from the Datix Central Team to highlight overdue incidents. 1b. Patient Safety Team and Clinical Board QSE leads with support from Superusers to identify and support incident managers with long standing overdue incidents to support them in managing and closing their incidents. 1c. Management of overdue Datix Incidents has been identified as a performance measure for 2024 /2025 with a goal to reduce incidents open for over 90 days by 60% from the April 2024 bench mark by the end of Q3 1d. Executive Performance Reviews to include need for assurance on timely incident management within the 1e. Clinical Boards, queue position to be added to the assurance report. 2. Datix team to explore with Datix Central Team the inclusion of an additional field to reference AMAT entry. Explore with Clinical Assurance	Mrs tara Cardew	Mrs tara Cardew	31/12/2024	10/07/2024	Amber	In progress		
Risk and Regulation/ 2024/833	Internal Audit - PCIC Governance Arrangements	Must do	1. Chairs / Vice Chairs of all meetings should remind all members of their responsibility to attend required meetings or send a representative when they are unable to attend. 2. Where presenters are listed against agenda items then they should be present at the meeting.	Chair/Vice Chair of all meetings to remind members of their responsibility for attendance or ensuring somebody deputises as part for the formal approval of reviewed ToR.	Mrs Anna Llewellin	Ms Anna Mogie	30/09/2024	15/10/2024	Green	Fully complete (Awaiting approval)		Reiterated at all key meetings and as part of the review of Terms of Reference
Risk and Regulation/ 2023/299	Internal Audit - Urgent and Emergency Care - Welsh Government Six Goals Programme	Must do	Any lengthy and ongoing absence of Six Goals Delivery Board core members should be monitored by the secretariat to ascertain the reasons for absence and have other named representatives when they are unable to attend the meetings. The secretariat of the Six Goals Delivery Board should also ensure that all membership absences are supported wherever possible by an apology for absence.	Ongoing absence will be picked up with the members of the board where appropriate or addressed through the workstreams.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/10/2023	14/10/2024	Green	Fully complete (Awaiting approval)		

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Risk and Regulation/ 2024/750	Internal Audit - Mortality Reviews	Must do	Ensure that the key priorities for 2024 are effectively implemented.	1 – Delivery of C&V scrutiny panel to review all cases referred from ME. 2 – Setting up a Mortality and Morbidity (M&M) Group is in progress. 3 – Making information from the Medical Examiner process available is in progress in conjunction with delivery of ME scrutiny panel. 4 – Bereavement processes T&F group in progress.	Dr Aled Roberts	Dr Aled Roberts	01/09/2024	10/07/2024	Amber	Overdue		
Risk and Regulation/ 2023/290	Internal Audit - Data Warehouse	Must do	The database should be upgraded. A patch strategy should be defined and implemented.	The PMS database is planned for upgrade in September/October 2023. Following the upgrade of PMS, the Data Warehouse database will also be migrated to the latest Oracle database and be included within our new Oracle Goldengate infrastructure. A patching strategy will be implemented for both the PMS and Data Warehouse databases.	Ian Rees	Ian Rees	31/07/2023	10/07/2024	Red	Partially complete (Overdue)		Mar '24 - Further delays, again outside our control, have put the migration on hold. The PMS 11g database must be patched to allow Goldengate to be implemented. The SBAR has been presented and approved, work is scheduled to restart with Oracle 15th April. July '24 - This work cannot start until the PMS migration completes. We are not expecting this to complete until the later this year (Oct/Nov)
Risk and Regulation/ 2023/293	Internal Audit - UHW Hybrid and Major Trauma Theatres	Must do	Terms of Reference for the Project Team should be developed and ratified.	Agreed- the Terms of Reference will be developed and ratified. The project is currently on hold, subject to Welsh Government approval of the required funding. Therefore, whilst an August date is included as un update, the ToR's will not be ratified by the Group until the project re-commences.	Mr Andrew Partridge	Mr Andrew Partridge	31/08/2023	31/05/2024	Green	Partially complete (Overdue)		A new Terms of Reference will be developed in advance of the project team meeting and new project board when the project restarts

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Risk and Regulation/ 2023/282	Internal Audit - Medical Records Tracking (CDT)	Must do	Management should ensure staff are reminded of their responsibilities to return health records once used and the importance of updating PMS or PARIS following a change in location.	This will be taken forward as part of Agreed Management Action 4, specifically in relation to point 4 of Matters Arising 4. Departmental (Health Records), reinforcement of correct processes and good practice related to storage of medical records, will be undertaken prior to this.	Mr Andrew Partridge	Mr Andrew Partridge	31/03/2023	10/07/2024	Red	Partially complete (Overdue)		05.06.24 The Clinical Information Programme has a communication and engagement workstream supporting and enabling the three key workstreams. Responsibility for the appropriate handling and transfer of clinical records will be emphasised widely across the UHB through this work. The workstream will stand up specific and regular campaigns as part of this. These obligations will also be reinforced through the Medical Director's new Clinical Information Management Group
Risk and Regulation/ 2024/832	Internal Audit - LIMITED - Decarbonisation	Must do	DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	This point is noted. C&V are producing their new DAP before end March 2023. For this year, funding has been received from WG Decarb fund, and Re:Fit. Bids have gone in to EFAB. To quantify.	Ms Rachel Chilcott	Ms Rachel Chilcott	31/03/2023	14/10/2024	Amber	Fully complete (Awaiting approval)		
Risk and Regulation/ 2024/309	Internal Audit - Estates Condition	Must do	Recognising the limited progress reporting to the Board on the delivery of its Estates Strategy objectives for the period 2018-2022 and the recent (February 2023 – Board development session) red status reported against the mid-point delivery of the Estate Strategy objectives; the Board or nominated committee should receive regular updates on the delivery of the Estate Strategy and 10-year capital programme (particularly any risks/impact resulting from delay/non delivery).	Agreed in principle. The Board is updated in many areas in relation to the requirements of the estate and the funding implications thereof. The Board will be further informed of the continuing shortfall in availability of funding and the need to address ongoing financial implications of the estate at regular intervals. A programme of update reports will be agreed to be included in the future Board agendas.	Mr Andrew Partridge	Mr Andrew Partridge	31/03/2024	04/03/2024	Red	Overdue		

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Risk and Regulation/ 2024/831	Internal Audit - IMTP Development Process	Must do	Prior to resubmission of the IMTP to the WG the Health Board should undertake the following: • Prior to submission to the Board, the Annual Plan/MDS should be reviewed and signed off by an appropriate delegated authority. • The annual planning process should be revised to include appropriate reconciliation controls.	Reconciliation checks - Arrange for an internal team independent of the core team that input the data and write the narrative plan to review the final MDS and reconcile back to the narrative before it is submitted in February/March to SLB, Finance and Board.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2024	14/10/2024	Amber	Overdue		
Risk and Regulation/ 2024/311	Internal Audit - Alcohol Standards	Must do	Management should consider completing a resource needs analysis to ensure that the SMLT are meeting the demand, and they are providing an effective service to meet needs of patients who have substance misuse issues.	SMLT to review where resource within the team is currently being utilised via a resource needs analysis and where there are currently gaps and proposals to address these, either singularly or in partnership with MH Liaison Team.	Desmond Collins	Dr NEIL JONES	30/06/2024	19/09/2024	Red	Partially complete (Overdue)		1. Resource review undertaken, and recommendations being considered.
Risk and Regulation/ 2024/308	Internal Audit - Technical Continuity	Must do	The record of hosted services should be updated to include consideration of RTO/RPO, and all services required to complete the HBA which includes an assessment of impact.	Migration of existing RBAC spreadsheet to Online dynamic forms for all servers and applications.	Gareth Richards	Gareth Richards	01/04/2024	10/07/2024	Amber	Partially complete (Overdue)		June 2024 RBAC spreadsheet has been uploaded into SharePoint although the content has not been fully "Digitised". This further work has been stalled due to resourcing within the team. It is functional but not ideal and is expected to be completed Q4 2024.
Risk and Regulation/ 2024/829	Internal Audit - Performance Reporting (Data Quality)	Must do	Consideration should be given to risk assessing the defined indicators within the Balanced Scorecard, to identify those at greater risk of error. Appropriate quality assurance arrangements should be defined to mitigate the potential risk of error.	The compilation of the report is mainly a manual administrative task with limited automation. We have introduced additional quality assurance tasks to reduce administrative error.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/06/2022	14/10/2024	Green	Fully complete (Awaiting approval)		

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Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	1. Establish a clear and approved pay rate for junior doctors, specifying whether they should receive the full contract rate or a percentage of it. This must be reflected in the WLI procedure and communicated to all relevant staff. 2. Rota Co-ordinators and authorising officers need to ensure that all WLI sessions shift grade are correctly classified within the system, regardless of who performs the work. 3. Conduct regular audits to ensure compliance with the junior doctors WLI pay rate and to address any discrepancies promptly.	Further discussions with the AMD workforce and Medical Director are required to decide if appropriate to pay a % of the WLI consultant rate.	Hilary Sharp	Hilary Sharp	30/09/2024	16/10/2024	Amber	Overdue		
Risk and Regulation/ 2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	The above review may include consideration of reinstatement of the SOFH Committee, or utilisation of an existing Committee, to provide periodic scrutiny and oversight of programme activities.	Agreed. This will be informed by the outcome of the clinical review and forthcoming attendance at WG IIB.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue		
Risk and Regulation/ 2022/263	Internal Audit - Waste Management	Must do	1. Waste signage at storage locations should be reviewed and improved to ensure clear, accurate instructions are provided for waste segregation and disposal. 2. Waste yards should be maintained to an appropriate standard and ensure that waste is correctly stored and segregated.	1. Agreed, a review of all bin signage/labelling (ref MA6), will be undertaken. 2. Agreed.	Mr Andrew Partridge	Mr Andrew Partridge	31/08/2022	30/05/2024	Amber	Partially complete (Overdue)		Many contract change over has taken place and has resulted in main storage and segregation areas being redesigned. Currently mapping new signage requirements to fit with changes and the increase in waste streams.

Risk and Regulation/ 2023/283	Internal Audit - Decarbonisation Final Report February 2023	Must do	NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	C&V do not have confidence in this data given that the means of calculation was different to the reporting WG requested in 2022. Using data input into EFPMS, C&V have established a carbon footprint for 18/19 through to 21/22. Stripping out supply chain it shows a 1% reduction in emissions over that period. WG have provided an interim response to these and other data concerns and they will determine what action to be taken to baselines and targets after the next set of data is complied in summer 2023 (foir f/y 22/23)	Mrs Abigail Harris	Mrs Abigail Harris	20/02/2024	19/09/2024	Amber	Fully complete (Approved)		The baseline emissions of the Welsh NHS are under review by Welsh Government. The emissions reporting required by Welsh Government has seen new categories of reporting added which have increased our totals, such as streetlighting and f-gasses. CAVUHB data, except supply chain, has remained consistent for at least 2 reporting periods (from EFPMS). In the emissions we control we have seen a reduction of c7% since 2018. Supply chain emissions are likely to continue to evolve over the coming years as data and reporting becomes more mature. [close action]
Risk and Regulation/ 2024/837	Internal Audit - Safeguarding	Must do	Arrangements should be made to ensure that the Safeguarding Annual Report is prepared and published on a more timely basis in future. We would suggest this is within three months of the end of the financial year. The final report should be made available to all Health Board staff and the general public via the Safeguarding section of the intranet and the Health Board website.	The Annual Safeguarding Report is available on the Safeguarding Sharepoint pages however we have not previously checked that it is uploaded on to the UHB website. This will be rectified with immediate effect. The Head of Safeguarding will strive to ensure that the annual report is completed earlier in the year as suggested.	Ms Linda Hughes-Jones	Ms Linda Hughes-Jones	31/01/2025	16/10/2024	Green	In progress		
Risk and Regulation/ 2024/833	Internal Audit - PCIC Governance Arrangements	Must do	1. Chairs / Vice Chairs of all meetings should remind all members of their responsibility to attend required meetings or send a representative when they are unable to attend. 2. Where presenters are listed against agenda items then they should be present at the meeting.	All Chairs/Vice Chairs to be reminded that agenda items should identify who will be present and responsible for that item.	Mrs Anna Llewellin	Ms Anna Mogie	30/09/2024	15/10/2024	Green	Fully complete (Awaiting approval)		Internal Audit report and action plan shared with all members of SMT and Chairs/Vice Chairs with action plan noted and signed off at SMT

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Risk and Regulation/ 2024/831	Internal Audit - IMTP Development Process	Must do	Prior to resubmission of the IMTP to the WG the Health Board should undertake the following: • Prior to submission to the Board, the Annual Plan/MDS should be reviewed and signed off by an appropriate delegated authority. • The annual planning process should be revised to include appropriate reconciliation controls.	Delegated Authority - Finance and Performance Committee to be given delegated authority for the MDS submission - Proposal to Director of Corporate Governance and Committee Chair.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2024	14/10/2024	Amber	Overdue		
Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	1. Establish a clear and approved pay rate for junior doctors, specifying whether they should receive the full contract rate or a percentage of it. This must be reflected in the WLI procedure and communicated to all relevant staff. 2. Rota Co-ordinators and authorising officers need to ensure that all WLI sessions shift grade are correctly classified within the system, regardless of who performs the work. 3. Conduct regular audits to ensure compliance with the junior doctors WLI pay rate and to address any discrepancies promptly.	New scheme of delegation has been created and published to all service areas which outlines the new WLI process which is now pre-approved via the COO Office.	Hilary Sharp	Hilary Sharp	16/10/2024	16/10/2024	Amber	Fully complete (Awaiting approval)		
Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	1. Establish a clear and approved pay rate for junior doctors, specifying whether they should receive the full contract rate or a percentage of it. This must be reflected in the WLI procedure and communicated to all relevant staff. 2. Rota Co-ordinators and authorising officers need to ensure that all WLI sessions shift grade are correctly classified within the system, regardless of who performs the work. 3. Conduct regular audits to ensure compliance with the junior doctors WLI pay rate and to address any discrepancies promptly.	3.1 would need to be addressed and approved/implemented. Bank team to provide reports to AMD workforce or representative on a quarterly basis	Hilary Sharp	Hilary Sharp	30/09/2024	16/10/2024	Amber	Overdue		

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Risk and Regulation/ 2023/290	Internal Audit - Data Warehouse	Must do	Leads for data use should be identified within Clinical Boards in order to facilitate better links with Digital. Lead contacts for each Clinical Board should be defined within Digital, within the constraints of the staff resource available.	List of current digital coordinators in clinical boards will be reviewed and gaps identified. D&HI will work with Clinical Boards who haven't nominated a coordinator to demonstrate the benefits of the approach.	Kerry Ashmore	Kerry Ashmore	31/10/2023	08/07/2024	Amber	Partially complete (Overdue)		Mar '24: New business structure4 to support additional reporting being developed to include dedicated BI partners aligned to each Clinical Board (May '24)
Risk and Regulation/ 2024/832	Internal Audit - LIMITED - Decarbonisation	Must do	NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	C&V do not have confidence in this data given that the means of calculation was different to the reporting WG requested in 2022. Using data input into EFPMS, C&V have established a carbon footprint for 18/19 through to 21/22. Stripping out supply chain it shows a 1% reduction in emissions over that period. WG have provided an interim response to these and other data concerns and they will determine what action to be taken to baselines and targets after the next set of data is compiled in summer 2023 (for f/y 22/23).	Ms Rachel Chilcott	Ms Rachel Chilcott	14/10/2024	14/10/2024	Amber	Fully complete (Awaiting approval)		
Risk and Regulation/ 2022/266	Internal Audit - Implementation of National IT Systems (WNCR)	Must do	The baseline assessment should be fed into a benefits register, and a benefits assessment and realisation process should be included within the project plan.	A benefits register will be developed to record: - Digital skills of nursing workforce - Comparison of documentation completion rates before/after WNCR implementation - Use of WNCR analytics to inform improvement work - Staff feedback - Patient feedback (undertaken by patient experience team) - Cost savings (based on removal of paper documents) - Time savings	Mr Aron White	Mr Aron White	03/08/2023	05/07/2024	Amber	Partially complete (Overdue)		June 2024 Ongoing. Awaiting WNCR roll out
Risk and Regulation/ 2023/299	Internal Audit - Urgent and Emergency Care - Welsh Government Six Goals Programme	Must do	As the objectives of each workstream approach maturity, sharing of learning should be formalised and documented within Workstream and Six Goals Delivery Board meeting notes so as to maximise their respective interrelationships and help to ensure relevant crossover of key delivery aims.	A quarterly or twice yearly sharing of learning meeting will be created for the workstream leads to cross reference and learn from each other.	Ms Rachel Chilcott	Ms Rachel Chilcott	23/01/2024	14/10/2024	Green	Fully complete (Awaiting approval)		

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Risk and Regulation/ 2024/833	Internal Audit - PCIC Governance Arrangements	Must do	Accurate records of meetings should be produced and should be adequately reviewed before being accepted at the subsequent meeting.	Robust PCIC Meetings Share Point already set up and to be maintained by the Clinical Board corporate administration team. All Chairs/Vice Chairs to be reminded of the need to review minutes of meetings for accuracy before formal sign off at the following meeting.	Mrs Anna Llewellin	Ms Anna Mogie	30/09/2024	15/10/2024	Green	Fully complete (Awaiting approval)		Internal Audit and action plan shared and signed off by all Chairs/Vice Chairs and business units. Covered in reviews of Terms of Reference
Risk and Regulation/ 2023/283	Internal Audit - Decarbonisation Final Report February 2023	Must do	Proposed management/accountability structures should be fully implemented as intended within the DAPs.	Governance in place, though is still new with first gathering of Delivery and Working Group members formally in November.	Mrs Abigail Harris	Mrs Abigail Harris	20/02/2024	19/09/2024	Amber	Fully complete (Approved)		The Decarbonisation Delivery Group has been in place and running. With internal audit undertaking a review during Q4, we look forward to their report and using that intelligence, will consider how our governance could be strengthened. [close action]
Risk and Regulation/ 2024/838	Internal Audit - Performance Reporting	Must do	In accordance with the Audit Wales Structured Assessment recommendation, Management should agree on a consistent approach to address (agreeing on tolerance level) and monitor the underperformance of relevant performance measures. This can be further strengthened with the inclusion of the agreed approach within relevant sections of the guidance document.	Where there are no targets set (usually indicated by TBC), the information team will go back to the KPI owner and ask for an update to set these targets. Where there has been "no explanation for under performance or possible actions within the cover paper", guidance will be issued to clarify that it is the responsibility of the information provider to offer these explanations.	Ms Rachel Chilcott	Ms Rachel Chilcott	31/10/2024	16/10/2024	Amber	In progress		
Risk and Regulation/ 2022/268	Internal Audit - Medical Equipment	Must do	A periodic review of the Medusa medical equipment database should be undertaken to ascertain the status and current use of loaned medical equipment items. At the next review, the Management of Medical Equipment Procedure should be revised to provide guidance relating to the recording, oversight and active management of externally loaned medical equipment items.	The commissioning process for long term loan equipment will be changed to record information regarding the basis of the loan where available. Users will be reminded via the MEG and MDSO groups to record or share this information. The action in recommendation 4 will serve to audit old, loaned equipment.	Mr Ed Chapman	Mr Ed Chapman	01/04/2023	10/07/2024	Amber	Partially complete (Overdue)		Recommendation re-added following Internal Audit Recommendation. [EC aDoTH 10/23] Please could we extend implementation date to May 24. Discussed loaned equipment at December 2022 MEG, and requested that users inform CE of basis of loan agreements. Medical Equipment Procedure is currently being updated to include guidance to capture information as required in the recommendation.

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Risk and Regulation/ 2024/837	Internal Audit - Safeguarding	Must do	Ensure that the actions identified within the Improvement Plan are effectively implemented as planned and progress is regularly reported to the SSG.	The JIPA improvement plan will be a standard item on the SSG agenda whilst improvements are required to satisfy the UHB that any safeguarding risk is mitigated.	Ms Linda Hughes-Jones	Ms Linda Hughes-Jones	31/10/2024	16/10/2024	Amber	In progress		
Risk and Regulation/ 2024/829	Internal Audit - Performance Reporting (Data Quality)	Must do	In keeping with managements intention to further develop the Balanced Scorecard and Integrated Performance Report, the audit observations should be addressed in future reporting periods to enhance the completeness and transparency of the report.	We have accepted your recommendations and have implemented steps to mitigate these risks. For example, we have expanded on the indicator labels to ensure those people with limited knowledge of these can understand these and we will indicate where a target is inappropriate or not required for an indicator. We have also introduced a new quality check.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/06/2022	14/10/2024	Amber	Fully complete (Awaiting approval)		
Risk and Regulation/ 2023/282	Internal Audit - Medical Records Tracking (CDT)	Must do	Management should consider enhancing the operational efficiency and effectiveness to track medical records, based on our findings associated with the alternative filing systems in use, the indexing of records, the inconsistencies between UHL and UHW, and random spot checks on locations.	The department will revise its related local Standard Operating Procedures to ensure consistency of practice across sites, particularly in relation to the points outlined. Emphasis will be placed on regular sample location and tracking checks and hierarchy of actions depending on findings. A specific plan to complete the progress made towards a universal filing system (location-based tracking), will be developed. This will link to the Security and Storage action plan aligned to Recommendation 3.	Mr Andrew Partridge	Mr Andrew Partridge	28/02/2023	10/07/2024	Amber	Partially complete (Overdue)		Update 05.06.24 The Clinical Information Programme has a 'Storage of Notes' workstream. Within this there will be a focus on the functions and practice of the Health Records department. It will support and monitor the plan for achieving full Location Based Filing (rooms 4 and 5). Progress against this will be outlined at monthly CD&T Directorate Performance reviews, as will quality control metrics; principally the results of spot check audits. It also link to the Clinical Information Programme's ‘Consistency of Approach’ workstream where assessment of practice occurs and where recognised good exemplars are shared.
Risk and Regulation/ 2024/831	Internal Audit - IMTP Development Process	Must do	It is recommended that the Strategy Development and Delivery Group Terms of Reference state: • The date that they have been approved and who approved them. • The date of next review and version number. • A clearly defined review procedure including auditable approval documents e.g. meeting minutes.	- Terms of Reference are under review and will be presented to and signed off by Senior Leadership Board. - The approval date and approving body will be noted on the new terms of reference including the date of next review. - The terms of reference will include a review procedure. - Auditable documents will include meeting papers and action and decision notes.	Ms Rachel Chilcott	Ms Rachel Chilcott	01/08/2024	14/10/2024	Amber	Overdue		

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Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	1. Upgrade the tracking spreadsheet to capture all sessions from approval/booked/payment by comparing to generated reports. This will verify that the tracker and payment system data are aligned. Reconciliation should be carried out on a monthly basis. 2. Management should consider introducing a workflow that requires dual verification for session approvals and payments. This could involve another level of review before final payment authorisation to add an extra layer of oversight. 3. Management must remind staff that all sessions should be booked on the system prior to being worked.	The implementation of the new WLI approval process resolves this matter.	Ms Catherine Wood	Mr Michael Stephens	16/10/2024	16/10/2024	Amber	Fully complete (Awaiting approval)		
Risk and Regulation/ 2024/309	Internal Audit - Estates Condition	Must do	A full review should be undertaken of the Estates workforce to analyse the current position in terms of capability and capacity. Following this, a clear financial model for the revenue support needed to manage the estate should be developed.	Agreed in principle - 12 months data has been collated and reports are being run to establish the various levels of staffing required.	Mr Andrew Partridge	Mr Andrew Partridge	31/03/2024	04/03/2024	Red	Overdue		
Risk and Regulation/ 2024/308	Internal Audit - Technical Continuity	Must do	As part of the move to the new architecture, consideration should be given to providing more holistic management of hosted applications to maximise the resilience position, with Digital providing greater input into design. Services on physical servers should be moved into the virtual environment.	Work with the Clinical Boards, Services and Departments to migrate their servers to new OS, Hardware and introduce HA and Fault Tolerance.	Gareth Richards	Gareth Richards	01/04/2024	10/07/2024	Green	Overdue		June 2024 Good progress has been made with over 50 servers updated or replaced. Work continues to address legacy OS and Databases. This request is meeting signficant resistance due lack of application supprt or commercial implications. Progression is slower than expected as escalation to IT Director and CAV Cyber teams is often required. Completion date estimated Q4 2024 - Q1 2025

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Risk and Regulation/ 2023/293	Internal Audit - UHW Hybrid and Major Trauma Theatres	Must do	1. The SCP Call off Contract will be resubmitted for signature by the UHB Chair. 2. The UHB should confirm that appropriate insurances are in place in respect of the SCP. 3. At future projects Contracts should be executed prior to the commencement of works / duties. 4. At future projects All contracts should be dated.	1. Agreed - the SCP Call off Contract will be resubmitted for signature by the UHB Chair. 2. Agreed the UHB will confirm at the earliest opportunity that appropriate insurances are in place in respect of the SCP. 3. Agreed -Future Projects Contracts will be signed prior to the commencement of works. 4. Agreed - Future Projects - Contracts will be dated.	Mr Andrew Partridge	Mr Andrew Partridge	31/07/2023	31/05/2024	Amber	Partially complete (Overdue)		Items 1 & 2 will be addressed when the scheme re-commences. Items 3 & 4 being addressed at all future projects
Risk and Regulation/ 2023/305	Internal Audit - Mental Health Clinical Board Governance Arrangements	Must do	Management should ensure that once the minutes of each Mental Health Clinical Board Quality & Safety Committee meeting have been formally approved, they should be sent to the Secretariat for the Health Board's Quality, Safety & Experience Committee for noting at the next scheduled meeting.	To be implemented by Chair of the MHCB QSE meeting.	Mr Andrew Partridge	Mr Andrew Partridge	31/12/2023	11/10/2024	Green	Fully complete (Approved)		
Risk and Regulation/ 2024/311	Internal Audit - Alcohol Standards	Must do	Management should implement the referral form as soon as possible in order to provide a consistent approach to the referral process and enable an audit trail of all referrals that have been made.	Referral processes to be standardised and recorded for all referrals made. To include reason and type of referral, any action taken, further referrals onwards or interventions given. Processes to be simple to follow and easily retrieved and accessible for monitoring and reporting purposes.	Lauren Idowu	Mr Owen Price	30/06/2024	08/07/2024	Red	Partially complete (Overdue)		1. Substance Misuse Liaison Team (SMLT) have made improvements to the referral process. The Alcohol Programme Manager will continue to work on this action for further improvements.
Risk and Regulation/ 2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	A Programme / Project -specific Scheme of Delegation should be developed.	Agreed.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue		

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Risk and Regulation/ 2024/748	Internal Audit - Cancer Services	Must do	Risk management and risk reporting approach for the Cancer Services Team be agreed and as a minimum consider the arrangements for: • Identifying the risk; • Analysing the risk; • Prioritising the risk; • Treating the risk; and • Monitoring / escalating the risk as appropriate	The Lead Cancer Nurse will create a unified risk register for cancer which will be governed via the Executive Cancer Board. This will be compiled in accordance with the Clinical Boards identifying, risk reviewing and unifying all relevant risks from within their individual risk registers, as well as risks identified internally from within Cancer Services. Those risks identified as most vulnerable will be reviewed at Cancer Executive Board with an expectation that remedial actions be identified and implemented at the point of presentation.	Annette Beasley	Annette Beasley	31/03/2024	08/07/2024	Amber	Overdue		
Risk and Regulation/ 2023/292	Internal Audit - Management of Health Board Policies	Must do	The links to UHB 001 Management of Policies, Procedures and Other Written Control Documents Policy and UHB 242 Written Control Documents - Development and Approval Procedure should be amended so that they work correctly.	Noted. The Policy (UHB 001) and accompanying Procedure (UHB 242) are to be reviewed and all links will be updated to ensure that they operate properly. There is a template section on the Policies page of Sharepoint where staff can access the Health Board's templates for a Policy and (ii) a Procedure. This section will be updated to include the other template documents referred to in Policy UHB 001 and Procedure UHB 242.	Mr Andrew Partridge	Miss Francesca Thomas	31/07/2023	15/10/2024	Green	Fully complete (Awaiting approval)		This work is now complete - The Policy (UHB 001) and accompanying Procedure (UHB 242) have now merged into one document and the updated draft was approved at Audit Committee on the 3 September 2024. The action remaind open whilst the Corporate Archivist and Records Management Manager finalises the remaining changes to the document which will then be uploaded to the Policies page of sharepoint.
Risk and Regulation/ 2024/307	Internal Audit - Infection, Prevention & Control	Must do	The format and content of the IPC Annual Programme should be reviewed and updated. This should include setting of targets for the number of pro-active audits to be carried out in clinical areas. The Head of Nursing for IPC should also seek Clinical Board input when compiling the IPC Annual Programme and should request each Clinical Board to prepare their own IPC annual plans. The annual IPC Programme should be completed and submitted to the IPC Group for approval every year prior to the start of the year.	The Annual IPC Programme is being reviewed and will b presented to the IPCG June 2024/	Mrs Yvonne Hyde	Mrs Yvonne Hyde	30/09/2024	08/07/2024	Red	Partially complete (Overdue)		The Annual IPC programme is being reviewed and will be presented to the IPCG June 2024.

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Risk and Regulation/ 2022/263	Internal Audit - Waste Management	Must do	A critical review of waste volumes and types across the UHB should be considered, to identify potential for waste minimisation in accordance with WHTM 07-01 (5.3 - 8).	Agreed. A critical review of waste volumes and types across the UHB will be considered to identify potential for waste minimisation. This is currently in progress.	Mr Andrew Partridge	Mr Andrew Partridge	31/12/2022	30/05/2024	Green	Partially complete (Overdue)		A review of waste streams has been underway and linked with procurement tendering process for many waste streams 23/24 will be a year of collating data on all waste streams inclusive of increased recycling of UHB wastes.
Risk and Regulation/ 2023/303	Internal Audit - Surgery Clinical Board - Consultant Job Plans - LIMITED	Must do	Orthopaedics and General Surgery - Directorate management should ensure that all Consultant job plans include personal outcomes and service (Clinical Board) outcomes, and that personal outcomes are linked to service outcomes.	Orthopaedics Once clinical board outcomes are assigned to each consultant, the personal outcomes will be specified and attached to them. General Surgery Clinical Board Outcomes to be set by Clinical Board Triumvirate. Team job planning will inform the service outcomes along with expectations for delivery following annualization.	Mr Antonio Roccioli	Mr Antonio Roccioli	11/11/2023	10/07/2024	Red	Partially complete (Overdue)		2a - The system does not send reminders, however it will move expired job plans into the "Expired" category, which will trigger a job planning meeting. In terms of compliance, all job plans have been defined, however on e Allocate only 19/35 have been signed off. 11 awaiting clinician sign off, 5 in discussion, however will be sent for sign off soon.
Risk and Regulation/ 2023/306	Internal Audit - Capital Systems	Must do	Project Issues Form's will be completed for all project changes to demonstrate compliance with delegated limits.	Agreed – the Health Board have already commenced transitioning to this approach.	Mr Stephen Gardiner	Mr Stephen Gardiner	30/09/2023	10/07/2024	Amber	Overdue		
Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	1. Upgrade the tracking spreadsheet to capture all sessions from approval/booked/payment by comparing to generated reports. This will verify that the tracker and payment system data are aligned. Reconciliation should be carried out on a monthly basis. 2. Management should consider introducing a workflow that requires dual verification for session approvals and payments. This could involve another level of review before final payment authorisation to add an extra layer of oversight. 3. Management must remind staff that all sessions should be booked on the system prior to being worked.	The implementation of the new WLI approval process resolves this matter.	Ms Catherine Wood	Mr Michael Stephens	16/10/2024	16/10/2024	Amber	Fully complete (Awaiting approval)		

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Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	1. Upgrade the tracking spreadsheet to capture all sessions from approval/booked/payment by comparing to generated reports. This will verify that the tracker and payment system data are aligned. Reconciliation should be carried out on a monthly basis. 2. Management should consider introducing a workflow that requires dual verification for session approvals and payments. This could involve another level of review before final payment authorisation to add an extra layer of oversight. 3. Management must remind staff that all sessions should be booked on the system prior to being worked.	The implementation of the new WLI approval process resolves this matter.	Ms Catherine Wood	Mr Michael Stephens	16/10/2024	16/10/2024	Amber	Fully complete (Approved)		
Risk and Regulation/ 2024/311	Internal Audit - Alcohol Standards	Must do	Management should review the current process and consider implementing a central database that includes the records of all appropriate staff across the organisation and detailing the alcohol awareness training undertaken, the date provided and the date for renewal.	Embed alcohol training within current training schedule for relevant staff and trainees. Ensure training records centralised and kept up to date, including dates for refresher training when required and what areas the staff work in.	Lauren Idowu	Mr Owen Price	30/09/2024	08/07/2024	Red	Overdue		1. This action will be undertaken by the Alcohol Programme Manager post. 2. No changes to implementation date 3. None. 4. N/A
Risk and Regulation/ 2024/308	Internal Audit - Technical Continuity	Must do	The DR plan should be updated to include: • Procedures or signposting to procedures for varying failure types • Updating for the new architecture • Prioritised order of restoration, which is agreed with services • Explicit consideration of RTO/RPO Services should be requested to provide DR plans that synchronise with the Digital Directorate. As part of this the RTO/RPP provided by digital should be agreed.	As part of the NIS 2 Directive there is an expectation that all "Critical" systems have resilience. Often this is overlooked due to cost and lack of technical information provided at the point of implementation. A task to go through all the systems and confirm resilience, RPO and RTO abilities has started and will continue for the foreseeable future.	Mr James Webb	Mr James Webb	01/04/2024	10/07/2024	Red	Partially complete (Overdue)		June 2024 The revised DR plan is currently under review and being updated by the CAV IT/Cyber team.

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Risk and Regulation/ 2023/280	Internal Audit - New IT service Desk System	Must do	1.1 A Standard Operating Procedure should be developed for the monitoring of open calls and calls set to 'Waiting for Customer' status. Customers with calls set to 'Waiting for Customer' status should receive two reminders, and these calls should be closed if the customer fails to respond after the second reminder. 1.2 Consideration should be given to making the target resolution date a mandatory field for all calls.	1.1 Service Desk Standard Operating Procedures have been created as part of the implementation. Standard reporting within the software has been configured to report Incidents and Service Requests which has passed baseline SLAs. Advanced reporting is currently being installed and configured using dynamic Microsoft Power Business Information reporting tools. 1.2 Target resolution date is already configured within the system, as this is linked to the SLA. Inclusion of a target resolution date is difficult to predict for nonstandard requests due to external factors, however, an indicative date will be included.	Keith Magarimbo	Keith Magarimbo	01/10/2024	10/07/2024	Red	Partially complete (Overdue)		June '24: Open calls can be reported on through the PowerBI setup available on Teams but waiting on calls is in development. We are looking to automate the reminders. Target date is a predfined field and exisits on all calls. SLTs for service requests - service leval target dates and SLAs for incidents. These need to be agreed with other teams and departments.
Risk and Regulation/ 2024/309	Internal Audit - Estates Condition	Must do	The UHB should clearly defined a process for monitoring and reporting the estates condition on a periodic basis (minimum annually) including the backlog maintenance position.	Agreed in principle. The appropriate timing will be agreed with information governance and a report generated in accordance with the recommendation, on an annual basis.	Mr Andrew Partridge	Mr Andrew Partridge	31/03/2024	04/03/2024	Red	Overdue		
Risk and Regulation/ 2023/283	Internal Audit - Decarbonisation Final Report February 2023	Must do	Where decarbonisation falls within the existing environmental remit of committees/ meetings, it is important that an appropriate profile is set. Terms of Reference and agendas should be reviewed to ensure that sufficient focus is provided.	Decarbonisation governance has been established as an independent entity. Requirements to review Terms of Reference has been noted and feature in C&V's draft DAP for 23/24.	Mrs Abigail Harris	Mrs Abigail Harris	20/02/2024	19/09/2024	Amber	Fully complete (Approved)		Quarterly, an update is provided to the Finance and Performance Committee. [close action]
Risk and Regulation/ 2023/282	Internal Audit - Medical Records Tracking (CDT)	Must do	Following the implementation of recommendations 1 and 2 within this report, consideration should be given by management and the relevant governance forums of how the known barriers to digitisation can be addressed, if the Health Board aspires to digitise Health Records.	An assessment and proposal document will be created outlining known and potential barriers to digitisation and how they can be addressed, linking to current Health Board strategies and programmes, and specifically to national and organisational Digital work plans and schemes.	Mr Andrew Partridge	Mr Andrew Partridge	31/07/2023	10/07/2024	Green	Partially complete (Overdue)		Update 05.06.24 Executive follow-up meeting undertaken 15.05.24. Agreement to the Clinical Information Programme plan and workstreams, with digitisation a specific and significant element. Progression to be monitored via the Clinical Information Programme Board

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Risk and Regulation/ 2023/290	Internal Audit - Data Warehouse	Must do	A report / information catalogue should be devised in order to make clear what information is available to staff.	It is planned to build catalogues as part of the implementation of Power BI and the LDR	Dave Price	Dave Price	31/03/2024	17/07/2024	Amber	Partially complete (Overdue)		17-Jul-2024: It has only just been decided on the data catalogue technology (Unity). There will need a period of upskilling, training and familiarity before installing the software. Mar '24: A meta data catalogue will be installed within the LDR architecture for all users to contribute and consume. This will happen following the final configuration of the LDR architecture which is imminent. However, a decision will be made soon for the particular product to install.
Risk and Regulation/ 2022/268	Internal Audit - Medical Equipment	Must do	All medical equipment items that have undergone local decontamination prior to submission to the Clinical Engineering Department should be supported by a completed Contamination Status Clearance Certificate and the issuing book should be retained by the Emergency Unit. Additionally, the Management of Medical Equipment Procedure should be revised and updated to reflect the Ward/Unit based decontamination processes.	Clinical Engineering will work with the EU management to ensure decontamination certificates are available and completed. The Medical Equipment and Devices task and finish group will include the decontamination process in their revisions of the Policy and Procedure.	Mr Ed Chapman	Mr Ed Chapman	01/04/2023	10/07/2024	Amber	Partially complete (Overdue)		Recommendation re-added following Internal Audit Recommendation. [EC aDoTH 10/23] The revision of the policy is a significant piece of work, would a draft version containing this process would be sufficient evidence, otherwise and extension to December 2024 may be required. EC (aDoTH Med Equip) met with EU manager Craig Davies to discuss decontamination and cleaning equipment in the EU. There is now a HCA with responsibility for medical equipment who will assist the department in meeting this recommendation. Explicit guidance on the need for decontamination certificates will be included in the revised Med Equip Procedure.
Risk and Regulation/ 2024/832	Internal Audit - LIMITED - Decarbonisation	Must do	As a major contributor to the achievement of the targeted reductions appropriate engagement will be established with NWSSP Procurement Services (and formalised as appropriate).	C&V have engaged with Procurement Services. The Head of Procurement (AD Procurement Services) sits on C&V's Decarbonisation Delivery Group and the Head of Sustainability and Net Zero Carbon Management sits on our Decarbonisation Working Group.	Ms Rachel Chilcott	Ms Rachel Chilcott	14/10/2024	14/10/2024	Amber	Fully complete (Awaiting approval)		

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Risk and Regulation/ 2023/303	Internal Audit - Surgery Clinical Board - Consultant Job Plans - LIMITED	Must do	General Surgery - The General Surgery Directorate Manager should consider whether the Administrator role could be allocated to existing Directorate staff on a temporary basis, until a permanent Administrator is recruited, to ensure that monitoring of delivery of agreed sessions is undertaken. Orthopaedics - The Orthopaedic Surgery General Manager should ensure that the monitoring of Consultant activity is undertaken regularly for all Consultants, and a record is maintained to evidence all monitoring undertaken.	General Surgery Monitoring exercise complete. Includes data from other clinical boards, where activity also takes place. Orthopaedics I don't necessarily agree with the following: "we were unable to obtain evidence that monitoring is being undertaken for all Consultants on a regular basis". Monitoring is performed every week within the 6-week planning cycle. Consultants, unless on leave, will be booked for all their clinical commitments, and said schedule won't change unless there is sickness or emergency leave. If a consultant's session cannot be delivered as expected, it will be converted in something else that is of good use for the service. It is a "never event" that a consultant does not deliver their DCC despite being scheduled for them. It has happened on rare occasions in the past, and disciplinary procedures were	Mr Andrew Partridge	Mr Andrew Partridge	31/10/2023	31/05/2024	Amber	Fully complete (Awaiting approval)		
Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	Management should consider implementing a standardised template for the recording of WLI activity so that it provides clear guidance on the information required. This would also reduce the time spent on creating plans and make it easier to compare and analyse the data.	The implementation of the new WLI approval process resolves this matter.	Mrs Louise Blunsdon	Mrs Louise Blunsdon	16/10/2024	16/10/2024	Green	Fully complete (Approved)		
Risk and Regulation/ 2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	The workstream governance structure should be clearly and consistently presented in key governance documents.	Agreed - the observation is understandable. The inconsistency reflects work that was in flight when documents were provided for the audit - where the PID hadn't caught up with the sub-documents having been updated.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue		

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Risk and Regulation/ 2023/292	Internal Audit - Management of Health Board Policies	Must do	The Standing Operating Procedure which covers the Corporate Governance Team's management of the Corporate Policies should be reviewed and updated once all work on getting the policy management system fully up to date has been successfully completed.	Noted. There are various strands to the Corporate Governance Team's work in relation to putting the management of Corporate policies on a much better footing. This involves working with the Health Board's archivist and IT colleagues to put in place a more efficient policy management system. The SOP will be updated to reflect that work, in addition to any other improvements identified when the policy management system has been fully updated.	Miss Francesca Thomas	Miss Francesca Thomas	30/09/2023	18/09/2024	Amber	Fully complete (Awaiting approval)		This work is now complete as all policies have now been uploaded to AMAT, Sharepoint & the internet with updated working practices to align to this reflected in the The Policy (UHB 001) and accompanying Procedure (UHB 242).
Risk and Regulation/ 2023/303	Internal Audit - Surgery Clinical Board - Consultant Job Plans - LIMITED	Must do	Orthopaedics and General Surgery - Whilst it is acknowledged that Covid has had an adverse impact on Consultant job planning, it is an important process, and greater efforts should now be made to get Consultant job planning back on track through the undertaking of annual reviews when they become due.	Orthopaedics The current service changes have slowed down this process and we are now catching up with updating all of them on eAllocate. General Surgery Consultants were job planned between May 2022 and September 2022, the new round of job planning is currently taking place. Need to have 1 year of monitoring to be able to inform the job plan discussion. Unable to rectify appropriate start date. There was also a transition in practice for the emergency work as SDEC was opened in July last year which is why job plans weren't signed off straight away as this needed to be agreed by the consultant body and the clinical board.	Mr Andrew Partridge	Mr Andrew Partridge	31/10/2023	31/05/2024	Red	Fully complete (Awaiting approval)		
Risk and Regulation/ 2024/832	Internal Audit - LIMITED - Decarbonisation	Must do	Proposed management/accountability structures should be fully implemented as intended within the DAPs.	Governance in place, though is still new with first gathering of Delivery and Working Group members formally in November.	Ms Rachel Chilcott	Ms Rachel Chilcott	14/10/2024	14/10/2024	Amber	Fully complete (Awaiting approval)		

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Risk and Regulation/ 2024/311	Internal Audit - Alcohol Standards	Must do	Management should consider the current situation and with alcohol levels rising and an increase in alcohol specific deaths there is a need for more leaflets and information to be available for patients at the Emergency Department and across the Health Board. There is also a need to have visible signposts to websites where more advice can be sought relating to the dangers of alcohol and where they can seek further advice or intervention.	Public Health Team to identify or produce resources (leaflets, posters, scratchcards, electronic materials/screens) on alcohol and signposting for patients. Alcohol Programme Manager to identify areas for these materials to be best placed for patients.	Lauren Idowu	Mr Owen Price	31/12/2024	08/07/2024	Red	In progress		1. Not yet started.
Risk and Regulation/ 2024/308	Internal Audit - Technical Continuity	Must do	A formal documentation of the Health Board backup policy should be developed, that signposts to the detailed instructions. Once the DR site is established, the use of SureBackup and/or Veeam Health Check should be enacted.	Update and communicate new backup, restore and DR documentation when DR sites are available later in 2024.	Gareth Richards	Gareth Richards	01/04/2024	10/07/2024	Green	Partially complete (Overdue)		June 2024 No progression due to be linked to #86 "DR site has not been commissioned yet". Mar 2024 When the new DR site is fully functional and tested by CAV Networks, Backup and DR documents will be updated and communicated with relevant parties. H1 2024
Risk and Regulation/ 2024/309	Internal Audit - Estates Condition	Must do	The Board will be provided with assurances on the effectiveness of the identified actions to reduce the capital asset risks.	Agreed in principle. There is an existing agreed capital investment review that is issued to the Board, via the updates provided by the Capital Management Group, and the investment undertaken and the impact thereof on the current estate. What will be included in the future is the impact of this investment on the overall capital requirements of the estate, including understanding depreciation of the estate in the same period of the investment. This will be provided an annual basis. A programme of these updates will be agreed and formulated for the future Board agenda.	Mr Andrew Partridge	Mr Andrew Partridge	31/03/2024	04/03/2024	Red	Overdue		

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Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	Management should ensure that breaks are not being removed at the time of the shift creation, and should consider implementing a validation step within Patchwork to prevent shifts from by passing the approval process.	The enforced breaks function within patchwork has now been switched on. This function looks at the break applicable to the hours submitted via the timesheet rather than the created job. Irrespective if a service amends the break at time of job creation, this will not impact the break tracking through when the worker is submitting the timesheet.	Mrs Louise Blunsdon	Mrs Louise Blunsdon	16/10/2024	16/10/2024	Red	Fully complete (Approved)			
Risk and Regulation/ 2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	Working groups should be clearly defined, with terms of reference in place to identify memberships, governance arrangements etc. These should be distinct from normal UHB operations, to ensure the Programme receives the necessary focus and to support clear monitoring and reporting performance.	Agreed. Terms of reference were developed for workstreams and presented at the May project board during/post the audit review. Given the expectation of funding, it was prudent to plan the SOC to be efficient with time so we were relying on existing leaders to spare the time to assist and participate. In the absence of confirmed funding, there has been limited time colleagues have been able to commit alongside the ‘day-job.’ Receipt of funding would have enabled the recruitment of dedicated resource for SOFH (and SOFCS) work. Our approach did see planning progressing at differential paces and in the future needs either dedicated time from matrixed resources or dedicated resources from the workstreams assigned to the programme. To be considered as part of the governance and resource review recommended in this report.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue			
Risk and Regulation/ 2023/292	Internal Audit - Management of Health Board Policies	Must do	If all actions in the Corporate Policies Management System Plan 2022/23 have not been completed and scheduled targets have not all been met by the May 2023 deadline, then a progress update and revised target completion dates should be presented at the next available Audit Committee.	The timescales set out in the Policies Management System Plan were ambitious and very challenging. Given the current resource within the Corporate Governance team, it has been very difficult adhering to the timescales set out in the original Plan. The Head of Corporate Governance will review the Corporate Policies Management System Plan 2022/23 with the Director of Corporate Governance. The updated Plan will be presented to the Audit Committee on 4 July 2023.	Miss Francesca Thomas	Miss Francesca Thomas	30/06/2023	18/09/2024	Amber	Fully complete (Awaiting approval)		This action has now been superseeded following the appointment of a new Director of Corporate Governance in August 2024 and a new Head of Corporate Governance in October 2024.

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Risk and Regulation/ 2022/268	Internal Audit - Medical Equipment	Must do	The Medical Equipment Group should review the current arrangements in place for evidencing and verifying that appropriate training of medical equipment is taking place, particularly for equipment classified as high risk.	The recording of medical equipment training will be discussed at the next MEG to agree on the best way forward and gather evidence of best practice. The existing training on high-risk devices such as Defibrillators, Infusion Devices, POCT and US will be shared with the MEG and MDSO groups to increase awareness. ECOD have some training records on ESR which will be evidenced on as part of this action.	Mr Ed Chapman	Mr Ed Chapman	01/04/2023	10/07/2024	Amber	Partially complete (Overdue)		Implementation date moved to December 2023 EC aDoTH 10/23] Practice education meeting has been re-instated, meeting was held 09/10/23, waiting to get ToR and attendance. SBAR for staff resource not proceeded with in current financial climate, review in next FY. Initial discussions seem to indicate Allocate (Health Roster) already has the competency module. Recommend moving implementation date forward 12 months to Dec 2025 or closing. We can provide evidence of training for high risk devices, ECOD do not have records themselves as far as we are aware. Progress report 06/2023, EC (aDoTH, Med. Equip.) is working with colleagues in Clinical Engineering and senior nurses in
Risk and Regulation/ 2023/290	Internal Audit - Data Warehouse	Must do	A skills framework should be developed that identifies the required skills within the department that are needed to deliver a modern information and analytics service. This should be underpinned by a development plan setting out how skills will be brought in, either by development of staff, recruitment, or by partnering with other organisations eg Cardiff University.	Training plan for existing Informatics and BI staff is in place which will become the departments standard training pack for new starters going forward. Training will be delivered on-line via UDEMY+K65+G66	Kerry Ashmore	Kerry Ashmore	31/03/2024	08/07/2024	Amber	Partially complete (Overdue)		March 2024 - No change focus has remained on recruiting and training new starters in order to create capacity for existing staff development.
Risk and Regulation/ 2023/283	Internal Audit - Decarbonisation Final Report February 2023	Must do	In accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/ collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training.	Noted. Cardiff and Vale UHB would support the development and role out of Decarbonisation training.	Mrs Abigail Harris	Mrs Abigail Harris	20/02/2024	19/09/2024	Amber	Fully complete (Approved)		Training undertaken by staff is being monitored by the deacrbonisation team. Using existing available training material. There is an action to consider mandatory training in the draft 24/25 DAP. The team will continue to work with HEIW and the Workforce team to support delivery of decarbonisation training.

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Risk and Regulation/ 2023/280	Internal Audit - New IT service Desk System	Must do	To enable Incidents to be effectively prioritised guidance should be developed for the use of Urgency and Impact levels when logging new Incidents. This should include clear definitions for each level and when they should be used, i.e. What does High, Medium and Low Impact and Urgency mean and when should these be used. The criteria used to automatically assign priority levels should also be reviewed to ensure calls are being effectively prioritised.	Further documentation will be created to ensure that Urgency and Impact of Incidents is clarified. Additionally, the automatic criteria for call priority will be detailed and documented.	Keith Magarimbo	Keith Magarimbo	01/10/2024	10/07/2024	Amber	Partially complete (Overdue)		June '24: A priority matrix is complete and covers P1 - P5 and a prority dashboard for managers to monitor and identify priorities quickly and Senior management receive notification when a P1 or P2 has been created.
Risk and Regulation/ 2023/310	Internal Audit - LIMITED - Implementation of Health Roster System	Must do	Consideration should be given to exploring alternative ways to integrate live data from ESR to HealthRoster system ensuring that annual leave entitlements within the HealthRoster system are correct and up to date.	Whilst there is no direct interface between ESR and HealthRoster currently available (a service request is being submitted) there is an A/L entitlement report available in ESR that we can adapt and be manually uploaded into HealthRoster. The work will involve cross referencing the data between both ESR and HealthRoster, but the end achievement will be to load a monthly file into Healthroster using the manual import file in ESR.	Paul Jones	Paul Jones	31/01/2024	16/10/2024	Green	Fully complete (Approved)		System is now in place to ensure that annual leave entitlements held in Health Roster match those recorded in ESR.
Risk and Regulation/ 2023/283	Internal Audit - Decarbonisation Final Report February 2023	Must do	The same rigour and monitoring should be applied to internally commissioned/ funded initiatives to ensure the outcomes are adequately recorded/reported.	Noted, we will scope the additional opportunities across the organisation	Mrs Abigail Harris	Mrs Abigail Harris	20/02/2024	19/09/2024	Amber	Fully complete (Approved)		No funding is being managed at this time. [close action]
Risk and Regulation/ 2023/303	Internal Audit - Surgery Clinical Board - Consultant Job Plans - LIMITED	Must do	The General Surgery Directorate Manager should review the data quality issues identified and update the Allocate system as necessary.	General Surgery Rectified, there were historical consultants job plans on Allocate, including a test job plan. Job plans belonging to locums that had only just joined the HB, plus the locum job plans are specifically not fixed so that the service can maximise capacity use and backfilling. These job plans are managed within the Directorate and adhere to a 9:1 split.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Green	Fully complete (Awaiting approval)		

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Risk and Regulation/ 2024/308	Internal Audit - Technical Continuity	Must do	Ivanti should be further developed to include fields for recording of the detail of a root cause analysis and for improvement actions. A formal procedure or guide for incident handling should be developed.	Mar 2024 Root Cause is being captured as part of the normal Problem Management process. This is being enhanced with a more specific data collection post Major Incidents and Problems. These changes will be update in the Incident and Problem Management documentation. - Q1 2024	Mr Andrew Partridge	Mr Andrew Partridge	01/04/2024	10/07/2024	Amber	Partially complete (Overdue)		Mar 2024 Root Cause is being captured as part of the normal Problem Management process. This is being enhanced with a more specific data collection post Major Incidents and Problems. These changes will be update in the Incident and Problem Management documentation. - Q1 2024
Risk and Regulation/ 2024/832	Internal Audit - LIMITED - Decarbonisation	Must do	Where decarbonisation falls within the existing environmental remit of committees/ meetings, it is important that an appropriate profile is set. Terms of Reference and agendas should be reviewed to ensure that sufficient focus is provided.	Decarbonisation governance has been established as an independent entity. Requirements to review Terms of Reference has been noted and feature in C&V's draft DAP for 23/24.	Ms Rachel Chilcott	Ms Rachel Chilcott	14/10/2024	14/10/2024	Amber	Fully complete (Awaiting approval)		
Risk and Regulation/ 2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	Management should ensure that a valid reason is provided for not taking a break. Inadequate explanations should be rejected, and breaks should not be removed without a sufficient justification.	If a break is unable to be taken, the 1st tier hours approver will need to approve by updating the break to zero hours and provide a detailed reason and sign off the fraud declaration. The timesheet will then appear to the financial authoriser, tier 2, for review and final sign off.	Mrs Louise Blunsdon	Mrs Louise Blunsdon	16/10/2024	16/10/2024	Amber	Fully complete (Approved)		
Risk and Regulation/ 2024/311	Internal Audit - Alcohol Standards	Must do	Management should consider extending the alcohol screening training sessions across the wider Health Board on signs to look out for when a patient is admitted. This would help raise the profile and identify patients who attend the Health Board outside of the Emergency Department who drink in a harmful way and ensure that they are treated in the most appropriate way.	Alcohol screening training (electronic) extended across wider Health Board staff. Information on alcohol, it's impact on health and screening and treatment services to be made available and promoted to all staff and departments, waiting rooms etc.	Lauren Idowu	Mr Owen Price	31/03/2025	08/07/2024	Amber	In progress		1. Online Alcohol Brief Intervention content being developed via Public Health Wales. C&V Public Health Team are inputting. Alcohol Programme Manager will work to embed training once in post. 2. No change to implementation date. 3. None.

Risk and Regulation/ 2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	There should be a detailed review of the resources required as the UHB moves through the Programme, from SOC, to OBC and onwards, using an activity-based resource schedule. Resource schedules should be agreed with key departments and individuals to ensure risks and limitations are fully understood. Where funding bids are adjusted downwards, reporting to key forums should be clear as to the gaps this will leave in skills / capacity and the associated risks to programme delivery.	Agreed. Our plans did acknowledge the pre-requisites of the Clinical Model and Estate baseline work as early pre-requisites. The approach to understanding the estate condition has changed, with the SOC initially expected to rely on existing data. More recently, with a potential for consideration of a do minimum option, we recognise there is a need to update this data to accurately reflect current risks. When funding was looking likely to arrive, preparing to procure an external advisor was work that was decided could start. Preparing for this exercise was right at the time and was happening in parallel with planning. This procurement work is now on hold and no tender will or can be progressed without a plan being complete and committed to along with a clear line of sight to funding. The point about a low level of resource request is noted and has been a subject of ongoing internal	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue		
Risk and Regulation/ 2023/292	Internal Audit - Management of Health Board Policies	Must do	• The most appropriate structure for managing policies and procedures should be developed and applied consistently on the Health Board's website and Sharepoint. • The policies and procedures published on the Health Board's website and Sharepoint should be checked for accuracy and corrected where necessary.	As highlighted above, the Head of Corporate Governance is working with the Health Board's archivist in order to develop a more appropriate structure (including better categorisation) for the published policies and procedures. It is anticipated that once developed, this structure will be common to both the Health Board's website and SharePoint. Noted. A thorough review of the policies and procedures published on the Health Board's website and SharePoint will be undertaken to ensure accuracy as recommended.	Miss Francesca Thomas	Miss Francesca Thomas	30/09/2023	18/09/2024	Amber	Fully complete (Awaiting approval)		This action has been superseded following the appointment of a new Director and Heads of Corporate Governance in 2024. This work has been completed by the Corporate Archivist & Records Management Manager and reflected in the updated Internal Audit report on the management of UHB Policies from May 2024.

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Risk and Regulation/ 2023/290	Internal Audit - Data Warehouse	Must do	A data strategy should be fully defined, along with a supporting roadmap. This should consider the appropriateness of the warehouse for the future. We note that there is a large amount of valuable information and reporting being provided from the data warehouse. To start anew would be a resource intensive undertaking, however the warehouse may not be able to fully provide a modern analytics function. As such the capability of Jupyter workbooks should be fully assessed to ensure it is capable of meeting the demands of the organisation.	We are committed to and are working to develop a data strategy which will address the warehouse issue raised but also the wider issue of providing data to those that need it.	Mr Andrew Partridge	Mr Andrew Partridge	31/03/2024	30/05/2024	Amber	Partially complete (Overdue)		Mar '24: Data strategy being developed and led by the CCIO feeding into the data Insights work programme.
Risk and Regulation/ 2023/300	Internal Audit - Paris System	Must do	The monthly Leavers Report provided by the IT Security team should be re-instated as soon as possible. Alternatively management should liaise with Workforce colleagues to obtain a weekly leavers report. Receipt of the Leavers Report each week should be monitored.	The monthly leavers report is not an accurate source of information due to there being no link with NADEX accounts. For example, Joe Bloggs has left the organisation but there are 4 Joe Bloggs on the PARIS system, it could be impossible to determine which one. However, we do agree with the recommendations but note that they affect most digital systems in the UHB, I will work with departmental colleagues to resolve the issue department wide.	Katherine Roscoe	Katherine Roscoe	01/10/2024	16/08/2024	Amber	Unable to complete	This is outside of the control and remit of the PARIS Programme. Suggest this action be transferred to D&HI SMT to be re-allocated to the relevant persons.	Jun'24: Dependency is elsewhere within D&HI and is an ongoing piece or work for M365 team. This incentive is actively monitored by SMT.
Risk and Regulation/ 2024/832	Internal Audit - LIMITED - Decarbonisation	Must do	Potential collaboration and common utilisation of decarbonisation resource should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource.	Noted. C&V's experience of Nitrous Oxide use reduction has been shared across Welsh colleagues as an example. Green Health Wales is also being hosted by C&V.	Ms Rachel Chilcott	Ms Rachel Chilcott	14/10/2024	14/10/2024	Amber	Fully complete (Awaiting approval)		

Risk and Regulation/ 2023/303	Internal Audit - Surgery Clinical Board - Consultant Job Plans - LIMITED	Must do	Consideration should be taken to assess whether Consultant team job plans can be utilised within the two Directorates.	Orthopaedics We will try to implement this function within the Spines Team first, and then extend it to Orthopaedics. General Surgery Going forward within the next round of job planning, team job plans will be considered for managing delivery of capacity along with the annualization process. However this cannot be the only form of job planning as there are individual considerations for each job plan including those who have contracts externally to the HB e.g. Cardiff University, Welsh Government and the MoD.	Mr Antonio Roccioli	Mr Antonio Roccioli	01/04/2024	10/07/2024	Amber	Overdue		T&O From a directorate perspective, on call teams are job planned as a team, otherwise we would not be able to optimise their schedules. We don't record this anywhere at present, but we will try to roll this out in Spines first once the pilot in Medicine has ended.
Risk and Regulation/ 2023/292	Internal Audit - Management of Health Board Policies	Must do	For each new or amended policy or procedure, the Executive Lead should provide Corporate Governance with a statement indicating how staff and stakeholders have been notified and this information should be included in the Corporate Governance policies and procedures tracker.	The Corporate Governance team will strengthen its SOP so that the team routinely notify the Stakeholder Reference Group, the Local Partnership Forum and Llais (formerly the Community Health Council) once a policy/procedure has been approved and/or published. The Corporate Governance team now request a statement from the Executive Lead and/or policy author once the document has been approved and is ready for publication. The Policy Tracker has been updated to include a comment box to capture these statements, and it is already being populated.	Miss Francesca Thomas	Miss Francesca Thomas	30/06/2023	18/09/2024	Amber	Fully complete (Awaiting approval)		This action has been superseded following the appointment of a new Director of Corporate Governance and Head of Corporate Governance in 2024.
Risk and Regulation/ 2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	The team should move forward with development of a Communications Plan as soon as possible.	Agreed.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue		

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Risk and Regulation/ 2023/300	Internal Audit - Paris System	Must do	Controls should be developed to ensure that any failed interfaces from the PMS into PARIS in respect of admissions and discharges are identified.	Will work with development colleagues with the PMS and PARIS teams to ensure that a mechanism to alert of any issues with this interface is put into place.	Katherine Roscoe	Katherine Roscoe	31/10/2023	12/09/2024	Green	Fully complete (Awaiting approval)		Sept 2024 - Has been fully resolved by the use of Kafka messaging which provides the relevant staff with notifications when there is an issue. June 2024 - Ongoing piece of work Mar '24: We have already moved some interfaces to KAFKA such as the one list, which provides notifications when there is an issue with the link. As we continue to develop and make changes to existing interfaces they will be updated to use KAFKA thus enabling alerts if there are any issues.
Risk and Regulation/ 2023/300	Internal Audit - Paris System	Must do	Management should liaise with Civica with a view to moving system back-ups off-site.	We strongly agree with this recommendation, in fact it was identified during a recent hardware refresh but no suitable offsite location was found due to numerous reasons (CRI lacking capacity and Woodlands House lacking redundant power). We will use this recommendation as a springboard to address the matter urgently however, the target date will be within 6 months due to factors such as complexity, availability and financial constraints. We will work with the head of digital operations and Civica to identify a suitable offsite backup location and relocate. We will also look to identify if there are any immediate actions that we can take to mitigate the risk in the meantime.	Katherine Roscoe	Katherine Roscoe	01/04/2024	16/08/2024	Red	Overdue		Jun'24: Contract still to be finalised, once finalised we will look to move this forward with CIVICA. In the mean time we will liaise with digital ops team to determine if any offsite locations have suitable capacity. Hardware migration is completed and decommissioned. Aug'24: Application Manager in talks with Digital Ops and Civica to arrange. CRI has been identified as a suitable location but we have been told this will likely come at a cost to set up.
Risk and Regulation/ 2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	Governance forums should receive clearly distinguishable highlight / flash reports focusing on the assigned responsibilities of the reporting forum. Workstream highlight reports should be enhanced to clearly present performance information and associated risks.	Agreed.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue		

Risk and Regulation/ 2024/832	Internal Audit - LIMITED - Decarbonisation	Must do	In accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training.	Noted. Cardiff and Vale UHB would support the development and role out of Decarbonisation training.	Ms Rachel Chilcott	Ms Rachel Chilcott	14/10/2024	14/10/2024	Amber	Fully complete (Awaiting approval)		
Risk and Regulation/ 2023/310	Internal Audit - LIMITED - Implementation of Health Roster System	Must do	The review of the Rostering Procedure UHB 339 should be finalised, approved and the updated procedures should be disseminated to all relevant staff.	The e-rostering procedure was considered at the Employment Policy SubGroup (EPSG) meeting in October. The meeting me membership is trade union representatives and People & Culture Team representatives. The group did not approve the procedure as they felt it needed further review to reflect the culture that we want to create, i.e. flexibility, good work life balance, high engagement and retention. The revised procedure will include the link to the Rostering Principles, Safe Care Guidance and Nurse Staffing Framework, highlighted below. The procedure is being considered by EPSG in December 2023.	Ms Rachel Chilcott	Ms Rachel Chilcott	31/12/2023	16/10/2024	Green	Fully complete (Approved)		Following further meetings with the EPSG and further changes made the Roster Policy was published in Jan 2024 and is scheduled for review Nov 2024.
Risk and Regulation/ 2024/832	Internal Audit - LIMITED - Decarbonisation	Must do	Given the scarcity of funding, it is important that bids for funding are appropriately considered prior to submission.	C&V successfully bid for £145k.	Ms Rachel Chilcott	Ms Rachel Chilcott	14/10/2024	14/10/2024	Amber	Fully complete (Awaiting approval)		
Risk and Regulation/ 2023/310	Internal Audit - LIMITED - Implementation of Health Roster System	Must do	The review of the Rostering Procedure UHB 339 should be finalised, approved and the updated procedures should be disseminated to all relevant staff.	Nurse rostering principles with SafeCare guidance and Nurse Staffing framework agreed at Directors of Nursing meeting in August 2023 and shared with Clinical Boards, as part of the wider Workforce Sustainability Programme.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2023	16/10/2024	Green	Fully complete (Approved)		
Risk and Regulation/ 2023/310	Internal Audit - LIMITED - Implementation of Health Roster System	Must do	The review of the Rostering Procedure UHB 339 should be finalised, approved and the updated procedures should be disseminated to all relevant staff.	Rostering Sharepoint site has been developed and will be further enhanced to include procedure, principles, training documents, etc.	Ms Rachel Chilcott	Ms Rachel Chilcott	31/12/2023	16/10/2024	Green	Fully complete (Approved)		
Risk and Regulation/ 2024/832	Internal Audit - LIMITED - Decarbonisation	Must do	The same rigour and monitoring should be applied to internally commissioned/ funded initiatives to ensure the outcomes are adequately recorded/reported.	Noted, we will scope the additional opportunities across the organisation.	Ms Rachel Chilcott	Ms Rachel Chilcott	14/10/2024	14/10/2024	Amber	Fully complete (Awaiting approval)		

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Risk and Regulation/ 2023/310	Internal Audit - LIMITED - Implementation of Health Roster System	Must do	Arrangements should be put in place to ensure that rosters are created, approved and published in line with the roster timetable.	The Corporate Nursing Team (working with the e-rostering team) are producing monthly reports for Roster Managers, Senior and Lead Nurses. The reports contain information on rosters that have not been approved or not approved in accordance with the rostering timetable. Recently these reports have been sent to Clinical Board DoN requesting that more focus is placed on the importance of publishing the roster 6 weeks in advance. Compliance will be monitored monthly via the Rostering KPI dashboard.	Paul Jones	Paul Jones	31/03/2024	16/10/2024	Red	Fully complete (Approved)		Monitoring data reports are being produced by the Corporate Nursing Team and are being issued monthly to the DoNs. The e-rostering team also monitor compliance with rostering KPIs and regularly send notifications to Managers to prompt them to sign off the rosters in a timely manner.
Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	The construction risk register should be reviewed alongside the forecast outturn position, to determine: • Any remaining risks (and associated costs) which may materialise; • Whether the Contractor's forecast planned completion date (and associated one month delay) will give rise to any delay damages, and the impact on the budget position (in association with recommendation 3.2); and • Funding source/s, and appropriate approval requirements, to cover any expenditure above WG funding.	Agreed. We recognise that prior cost reporting was not up to date, noting provisional sums had not been released into contingency. This has now been rectified with the project showing an underspend. Reports will be checked more carefully for accuracy going forward. We confirm no delay damages are envisaged at this stage.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Amber	Overdue		
Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. At future projects, the contract conditions applied in managing the contract should conform with the form of contract in place. 2. The UHB should establish how delay damages will be applied at this project, should the contractor not achieve the contractual completion date. 3. The defects period end date should be corrected on Sectional Completion Certificate No. 2.	Agreed. We are seeking to establish a process whereby the contract mechanisms are formally agreed. We will discuss this with team leads to determine how this will be formally managed.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Amber	Overdue		

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Risk and Regulation/ 2023/310	Internal Audit - LIMITED - Implementation of Health Roster System	Must do	A review of the HealthRoster system should be undertaken to ensure that the user privileges for Roster Managers and Senior Management are correct and allow for appropriate segregation of duties in line with the Rostering Procedure.	HealthRoster privileges/permission have been reviewed and updated to ensure the Roster Manager cannot create and approve a roster. The new permissions hierarchy includes: first approver - Roster Manager and second approver - Senior Nurse.	Paul Jones	Paul Jones	31/10/2023	16/10/2024	Amber	Rejected (To be resubmitted)		This work is completed. We have also reviewed all Senior Nurse access who are required to cover Out of Hours support to Rostering areas.
Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. At future projects, the contract conditions applied in managing the contract should conform with the form of contract in place. 2. The UHB should establish how delay damages will be applied at this project, should the contractor not achieve the contractual completion date. 3. The defects period end date should be corrected on Sectional Completion Certificate No. 2.	Agreed. At this time, no delay damages are anticipated.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Green	Overdue		
Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. At future projects, the contract conditions applied in managing the contract should conform with the form of contract in place. 2. The UHB should establish how delay damages will be applied at this project, should the contractor not achieve the contractual completion date. 3. The defects period end date should be corrected on Sectional Completion Certificate No. 2.	Agreed.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Green	Overdue		

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Risk and Regulation/ 2023/310	Internal Audit - LIMITED - Implementation of Health Roster System	Must do	The E-Roster Team should continue to liaise with the Roster Managers and ensure that the rules and parameters within the HealthRoster system are up to date and working effectively to improve the effectiveness and uptake/utilisation of the "auto-roster" functionality.	The e-rostering team have just undertaken roster reviews with approx. 45 ward areas, this was an in-depth review which took 50 days in total. The team are working with Roster Managers daily to ensure the rules and parameters they need are built into the HealthRoster system. The aim is to build confidence in the function, change behaviours and increase the number of rosters that are created using the auto-roster functionality. The improvement will be monitored monthly through the KPI dashboard.	Paul Jones	Paul Jones	31/03/2024	16/10/2024	Amber	Fully complete (Approved)		The e-rostering team have undertaken reviews with areas that are using HealthRoster. Areas identified as suitable for SafeCare were prioritised, followed by all other nursing areas. A total of 264 roster reviews were identified: - 205 reviews have been completed - 18 scheduled to be reviewed - 27 areas yet to attend / failed to respond - 14 do not need reviewing The e-rostering team are reporting monthly key rostering metrics and focusing support on areas where improvements are required. We will continually review and monitor to ensure areas improve and comply.
Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	The UHB should liaise with NWSSP Accounts Payable to highlight the importance of project payments being made in line with contractual terms, and identify whether a solution is feasible.	Agreed. Contact will once again be made.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Amber	Overdue		

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Risk and Regulation/ 2023/310	Internal Audit - LIMITED - Implementation of Health Roster System	Must do	The E-Roster Team should continue to liaise with the Roster Managers and ensure that the rules and parameters within the HealthRoster system are up to date and working effectively to improve the effectiveness and uptake/utilisation of the "auto-roster" functionality.	The e-rostering Leads (3x band 6) are aligned to CBs to ensure that Roster Managers have the appropriate level of support to use thesystem to its full potential, including auto rostering.	Paul Jones	Paul Jones	31/03/2024	16/10/2024	Amber	Fully complete (Approved)		The e-rostering team have undertaken reviews with areas that are using HealthRoster. Areas identified as suitable for SafeCare were prioritised, followed by all other nursing areas. A total of 264 roster reviews were identified: - 205 reviews have been completed - 18 scheduled to be reviewed - 27 areas yet to attend / failed to respond - 14 do not need reviewing The e-rostering team are reporting monthly key rostering metrics and focusing support on areas where improvements are required. We will continually review and monitor to ensure areas improve and comply.
Risk and Regulation/ 2023/310	Internal Audit - LIMITED - Implementation of Health Roster System	Must do	Staff should be reminded that annual leave requests should be processed within the HealthRoster system to ensure that all requests and approvals are supported by a full audit trail.	The e-rostering team as part of the ongoing training and support to Roster Managers are reminding Roster Managers of the importance that their team need to request annual leave through the Healthroster system rather than by other mechanisms. This message is also being reinforced by the Clinical Board, DoN and the Corporate Nursing Team. The number of annual leave requests made through the HealthRoster system will be monitored monthly, if the % does not increase this will be escalated to the DoN and to NPG.	Paul Jones	Paul Jones	31/03/2024	16/10/2024	Green	Partially complete (Overdue)		We are monitoring the usage of A/L requests entered via HealthRoster system - current usage is 45% of requests made via HealthRoster for the 24/25 period. The current system - Employee Online (EOL) which staff use to make requests including A/L request - is being replaced with a new system LOOP. This is being implemented across the UHB from June 24 and aimed for completion Dec 2024. We are hoping it will make it easier for staff to make requests - as well as continuing the promotion of HealthRoster as the main input of A/L.

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Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	On completion of the project, management should undertake a review of how the design / change process has been managed, with any lessons learnt identified for application at future projects.	Agreed. The Project Director has already challenged the number of PIFS raised at this project and requested a postproject review. However, it is important to note the project remains within budget and the finished product will meet the service requirements. The approach taken was tailored to the style of the project contractor. We are also reviewing our approach to budget management with this Contractor: preparing our own estimates rather than awaiting the Contractor to cost the PMIs. This will improve our ability to make informed decisions based on greater cost certainty surrounding.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Amber	Overdue		
Risk and Regulation/ 2023/310	Internal Audit - LIMITED - Implementation of Health Roster System	Must do	Arrangements should be put in place to ensure that staff balances are being managed adequately to ensure that staff are working their contracted hours and are not owing or being owed excessive hours.	Embedding an effective rostering culture is one of the UHB's top priority and the system will support drive the efficiency. Corporate Nursing, People & Culture and Clinical Boards have worked together to reach an agreement on how we will support managers to embed effective rostering principles and achieve this priority: - Monthly e-rostering reports were piloted in October, every DoN has received a report for their Clinical Board, detailing every member of staff who has an owing time balance between 24 and 100 hours. Lead Nurses are validating this data and rostering the outstanding hours as appropriate. Progress will be monitored on a quarterly basis. - For time balances owed over 100 hours the E-Rostering Team are undertaking regular reviews of rosters. Any staff member that owes over 100 hours will be discussed and validated with the Roster Manager. Changes will be made in the system	Paul Jones	Paul Jones	31/03/2024	16/10/2024	Red	Fully complete (Approved)		Regular monthly reports are being provided by the Corporate Nursing Team of the Time Balances - the e-rostering team are working with those areas that have been highlighted with excessive time balance issues e.g. data entry errors, joiners & leavers, contract hour changes, absences not recorded correctly, etc.

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Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	The UHB and external Project Manager should support the change management process by completing the following activities in a timely manner: • approving PIFs; • accepting quotes (via PMN); and • ensuring PMNs are not issued until PIFs have been approved.	Agreed. As referenced at management response 5.1, we are implementing a new process of forecasting PIF costs internally, rather than awaiting contractor quotations. This will allow a more timely review of the change and likely budget implications, with the instruction issued once the quotation is received and agreed.	Mr Geoff Walsh	Mr Gavin Evans	31/01/2024	16/10/2024	Amber	Overdue		
Risk and Regulation/ 2023/310	Internal Audit - LIMITED - Implementation of Health Roster System	Must do	Arrangements should be put in place to ensure that Roster Managers are finalising shifts in a timely manner.	A monthly report is sent to Roster Managers to inform them how many unverified shifts they have outstanding, any outstanding shifts are escalated to the DoN 3 days and 1 day before the payroll is run. It has been agreed with the Executive Director of Nursing that any shifts that have not been verified in time will not be processed for Payroll, this has been communicated to all Roster Managers. Unverified shifts are no longer a KPI that the Health Board intends to use. The number of unverified shifts will be closely monitored by the e-rostering team and if it becomes problematic it will be escalated to DoNs, Corporate Nursing team and the EDoN.	Paul Jones	Paul Jones	31/03/2024	16/10/2024	Red	Partially complete (Overdue)		A monthly report continues to be sent to Roster Managers of all unfinalised shifts and is escalated to DoNs up to 3 days prior to the payroll being run. Shifts that are not finalised are cancelled. Despite the reports, we are still having to dedicate resources to chase the managers in updating their rosters.

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Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. The warranty arrangements for the main equipment should be confirmed by the UHB, including confirmation as to whether extended warranty cover is required: with retention of associated documentation. 2. At future projects, the risks associated with the equipment approach (e.g. storage / warranties) should be included on the project risk register to ensure visibility at Project Team / Project Board. 3. At future projects, where risks are taken in the early procurement of significant values of equipment (e.g. long periods of storage / warranty implications), these should be clearly understood and set out in the Procurement Report and Request for Approval.	Agreed. We have received verbal assurance from the Endoscopy Department that the warranty period is three years, therefore there is no risk to this expiring prior to installation.	Miss Claire Salisbury	Miss Claire Salisbury	31/01/2024	16/10/2024	Amber	Overdue		
Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. The warranty arrangements for the main equipment should be confirmed by the UHB, including confirmation as to whether extended warranty cover is required: with retention of associated documentation. 2. At future projects, the risks associated with the equipment approach (e.g. storage / warranties) should be included on the project risk register to ensure visibility at Project Team / Project Board. 3. At future projects, where risks are taken in the early procurement of significant values of equipment (e.g. long periods of storage / warranty implications), these should be clearly understood and set out in the Procurement Report and Request for Approval.	Agreed. We recognise this would be an enhancement at future projects, where applicable.	Miss Claire Salisbury	Miss Claire Salisbury	31/01/2024	16/10/2024	Amber	Overdue		

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Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. The warranty arrangements for the main equipment should be confirmed by the UHB, including confirmation as to whether extended warranty cover is required: with retention of associated documentation. 2. At future projects, the risks associated with the equipment approach (e.g. storage / warranties) should be included on the project risk register to ensure visibility at Project Team / Project Board. 3. At future projects, where risks are taken in the early procurement of significant values of equipment (e.g. long periods of storage / warranty implications), these should be clearly understood and set out in the Procurement Report and Request for Approval.	Agreed.	Miss Claire Salisbury	Miss Claire Salisbury	31/01/2024	16/10/2024	Amber	Overdue		
Risk and Regulation/ 2023/310	Internal Audit - LIMITED - Implementation of Health Roster System	Must do	Arrangements should be put in place to ensure that there is appropriate and timely oversight of the Safecare tool, and that Senior Management/Roster Managers are ensuring that Nurses in Charge are updating patient acuity data.	SafeCare has been rolled out to approximately 67 ward areas with training taking place in February and March 2023. Staffing meetings have now been introduced and take place twice daily to review staffing levels on SafeCare and to share risk across the whole of the UHB.	Paul Jones	Paul Jones	31/03/2024	16/10/2024	Red	Fully complete (Approved)		There are 98 areas that are live on SafeCare which include Mental Health, Maternity, in addition to the 35B wards (Nurse Staff Act areas). A new redeployment matrix has recently been introduced as part of a recent system upgrade to simplify the redeployment process.
Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. Capital, Estates & Facilities should develop an internal mechanism for monitoring and reporting contractor, adviser and UHB internal team performance at projects. 2. Consideration should be given to utilising the NEC Professional Services Contract alongside Framework Service Level Agreements for external advisers, where appropriate.	Agreed. We have commenced maintenance of KPIs, based on the Designed for Life Framework as a starting point, and will work on enhancing this process as it progresses. The process includes reporting to the Director of Capital & Estates, with an escalation process where needed.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Amber	Overdue		

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Risk and Regulation/ 2023/310	Internal Audit - LIMITED - Implementation of Health Roster System	Must do	Arrangements should be put in place to ensure that there is appropriate and timely oversight of the Safecare tool, and that Senior Management/Roster Managers are ensuring that Nurses in Charge are updating patient acuity data.	The Senior Nurse for the Nurse Staffing Act (Corporate Nursing) works closely with the nursing team to ensure that patient acuity is recorded accurately. We have identified that patient data is not always updated at the start of the night shift, the audit also shows this, there is a plan in place to improve this position. Reports are being generated for Senior and Lead Nurses monthly to show non-compliant areas and regular updates are provided to the Nursing Productivity Group.	Paul Jones	Paul Jones	31/03/2024	16/10/2024	Red	Fully complete (Approved)		There are 98 areas that are live on SafeCare which include Mental Health, Maternity, in addition to the 35B wards (Nurse Staff Act areas). A new redeployment matrix has recently been introduced as part of a recent system upgrade to simplify the redeployment process.
Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. Capital, Estates & Facilities should develop an internal mechanism for monitoring and reporting contractor, adviser and UHB internal team performance at projects. 2. Consideration should be given to utilising the NEC Professional Services Contract alongside Framework Service Level Agreements for external advisers, where appropriate.	Agreed - recognising this will be tailored to each project and advisors as appropriate – less complex schemes / appointments can still be managed via the SLA.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Green	Overdue		
Risk and Regulation/ 2023/310	Internal Audit - LIMITED - Implementation of Health Roster System	Must do	Arrangements should be put in place to ensure that there is appropriate and timely oversight of the Safecare tool, and that Senior Management/Roster Managers are ensuring that Nurses in Charge are updating patient acuity data.	A power-bi dashboard has been created and is updated monthly, which contains information relating to SafeCare compliance, nurse staffing level and patient acuity. The dashboard is readily available and provides ward to board overview.	Paul Jones	Paul Jones	31/03/2024	16/10/2024	Red	Fully complete (Approved)		There are 98 areas that are live on SafeCare which include Mental Health, Maternity, in addition to the 35B wards (Nurse Staff Act areas). A new redeployment matrix has recently been introduced as part of a recent system upgrade to simplify the redeployment process.
Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	At future projects, where professional services (e.g. Supervisor) are provided in-house, the duties required for the project should be clearly defined within the Project Execution Plan.	Agreed, we will incorporate this into the PEPs at future projects.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Green	Overdue		
Risk and Regulation/ 2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	External advisers should be reminded of the need to provide accurate and up to date reports.	Agreed, this will be raised with the Adviser's senior management.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Green	Overdue		
Risk and Regulation/ 2023/302	Internal Audit - Chemocare IT System Follow-up	Should do	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.	Discussions are still ongoing, as there is a lack of clarity over where alerts should come from with the position being monitored via regular discussions with suppler and IT.	Mr Andrew Partridge	Mr Andrew Partridge	31/01/2024	31/05/2024	Amber	Overdue		Mar '24: NO UPDATE

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Risk and Regulation/ 2023/302	Internal Audit - Chemocare IT System Follow-up	Should do	Finalise the review of the BCP.	Agreed. The BCP will be completed.	Mr Andrew Partridge	Mr Andrew Partridge	31/01/2024	31/05/2024	Amber	Overdue		Mar '24: NO UPDATE
Risk and Regulation/ 2024/751	Internal Audit - Risk Management and Board Assurance Framework	Should do	Clinical Boards should be informed that high risks should be escalated at the earliest opportunity to the Corporate Governance Department so that they can be reviewed and included onto the CRR if appropriate.	Assurance is provided at the Clinical Board Reviews and the Clinical Safety Group who are informed of current Extreme Risks on a monthly basis. Any new high risks raised at these meetings will be escalated to the Corporate Governance Department and included onto the Corporate Risk Register. In future all new risks and updates will be uploaded onto the new Risk Module before being presented to any meetings.	Ms Glynis Mulford	Ms Glynis Mulford	31/12/2024	19/09/2024	Amber	Fully complete (Awaiting approval)		Corporate Governance attend Clinical Board reviews where any risks 20+ are shared and any risks that could be high risk are discussed with support from CG therefore this action is complete.
Risk and Regulation/ 2023/287	Internal Audit - Nurse Staffing Levels Act Final Internal Audit	Should do	Management should ensure that all wards display the ward staffing levels to inform the patients of Nurse staffing levels for each ward. Management should ensure that the Nurse staffing levels being displayed are correct and up to date. Management should ensure that 'frequently asked questions' on the nurse staffing levels (Wales) Act 2016 are available on the wards for patients to be able to access.	A) The correct All Wales Informing Patients Poster for adults and paediatrics and Frequently Asked Questions to be sent out to all Senior and Lead Nurses and Ward Sisters and Charge Nurses. B) The All Wales Informing Patient's Poster and FAQs will also be available on the newly created Nurse Staffing Levels Act SharePoint page. C) Following the current establishment reviews, a review of all 25B wards and a selection of 25A areas will be completed to ensure current establishments on the correct posters are displayed bilingually. The availability of the Frequency Asked Questions will also be reviewed. This process will be documented and shared with the designated person. D) As part of the UHB's Ward Accreditation programme, confirmation that the correct NSA information is displayed	Miss Francesca Thomas	Miss Francesca Thomas	23/05/2023	19/09/2024	Amber	Fully complete (Approved)		A and B) The All Wales Informing Patients poster and FAQs has been shared with the Wards Sisters and Charge nurses and have been uploaded to the SharePoint. As part of the All-Wales Nurse Staffing Sub Group- these documents are being reviewed to ensure they contain information that is relevant to the patient's and the public. C) An audit was completed in July 2023 by the Nurse Staffing Levels Lead and in any areas where the information was not up to date, the ward sister/ charge nurse was contacted to ensure they had access to the correct information. Following this audit, questions have been uploaded to the Tendable audit platform which enables ward to board reporting. The questions asked are: "Are the nurse Staffing Levels displayed up to date? " Are the nurse staffing levels displayed on the ward so

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Inspection Code	Inspection Title	Recommendation Priority	Recommendation	Action	Person Responsible	Lead Person	Current Due Date	Date Last Updated	Action Rating	Progress Status	Comments/Updates
Risk and Regulation/2024/745	Internal Audit - Financial Management within Clinical Boards	Must do	Consideration should be taken by Management as to whether they want to provide additional information concerning the reported financial position by department in the monthly email that is issued to budget holders.	Finance support teams have been asked to liaise with their budget holders to review how reports are to be prepared and delivered.	robert mahoney	robert mahoney	30/09/2024	15/10/2024	Green	Overdue	
Risk and Regulation/2023/303	Internal Audit - Surgery Clinical Board - Consultant Job Plans - LIMITED	Must do	The Directorate General Manager should ensure that there is a job plan on the Allocate e-Job Planning system for all Consultants.	Orthopaedics - Missing consultants are currently being added to eAllocate, and their job plans will be signed off by 30/09/2023.	Mr Antonio Roccioli	Mr Antonio Roccioli	30/09/2023	10/07/2024	Amber	Overdue	All consultants are on eAllocate in T&O.
Risk and Regulation/2024/747	Internal Audit - Information Governance	Must do	1. Management should consider undertaking a full assessment of needs and resources to identify potential gaps and risk areas upon which capacity and resilience can be appropriately measured.	The Cardiff and Vale UHB Information Governance workforce resource since 2018, remains limited, especially in comparison with other Welsh Health Boards of a similar size. However, this capacity is being well used and core legislative functions are being performed but we accept that there are some gaps in the proactive work that we should be undertaking. To some extent, and linked to recommendation 2.1, the department has recently started work on how to improve some of these gaps including seeking funds to secure additional IG training for 3 team members. A full gap analysis will be performed during Q1 of 2024/25. This will also consider the departments resilience to ensure it can still function should any staff leave their current roles.	Mr James Webb	Mr James Webb	01/04/2024	10/07/2024	Amber	Overdue	

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Risk and Regulation/2024/748	Internal Audit - Cancer Services	Must do	Management should consider the purpose and operating arrangements of the weekly cancer tracker meetings and clarify these and the roles of those in attendance in documented terms of reference/operating arrangements.	Standard Operating Procedure and Terms of Reference documents to be created in collaboration with appropriate clinical board managers outlining the scope and purpose of the cancer tracking meetings. This document should also include a roles and responsibilities component for the relevant Cancer Services and Clinical Board staff.	Michael Eastwell	Michael Eastwell	30/05/2024	08/07/2024	Amber	Overdue	
Risk and Regulation/2024/749	Internal Audit - Patient Safety Incident Management	Must do	1. Management should review the Incident, Hazard and Near Miss Reporting Policy and Procedure and update accordingly. 2. Management should ensure that the out-of-date Incident, Hazard and Near Miss reporting Policy and Procedure are removed from the intranet and only the current policy and procedure is made available.	1. Terminology to be updated as per recommendations. Section 4.1 covers general incident reporting. A paragraph is to be added to include the role of QSE meetings in monitoring and learning from incidents. 2. Out of date policies to be removed from SharePoint – Patient Safety Team to contact Corporate Governance Team to action.	Mrs tara Cardew	Mrs tara Cardew	31/07/2024	15/10/2024	Amber	Overdue	
Risk and Regulation/2023/306	Internal Audit - Capital Systems	Must do	Project officers should ensure that returned contracts and Chair's action are signed, initialled, and dated consistently.	Guidance will be issued across the Project Management and Executive cohort to remind approvers of the importance of clearly dating formal documents when signing.	Mr Stephen Gardiner	Mr Stephen Gardiner	31/10/2023	10/07/2024	Amber	Overdue	

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Risk and Regulation/2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	There should be a review of the level of Programme governance activities required, and the viability of progressing with the aim of developing a SOC, until wider concerns over affordability / funding models have been addressed: to be approved at Board / SOFH Committee level.	Agreed. This will be informed by the outcome of the clinical review and attendance at WG IIB. Executives met with WG at the beginning of September to understand likelihood of funding. There is currently no line of sight to funding but have been invited to an IIB in on 13/11/23. Programme Boards and Project Boards have been stood down. The outcome of discussions with WG along with the Nuffield report should drive a review of next steps and Governance (including frequency) and the assistance of the Corporate Governance team will be requested. This said, communication from WG was pointing to funding before the NHS Wales cost pressures changed messaging to be less certain of funding the SOC. The SRO and PD had been keen to maintain rhythm of governance within C&V and the need for SOFH to be progressed given unsustainable estate condition. The members of the Programme Board	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue	
Risk and Regulation/2024/838	Internal Audit - Performance Reporting	Must do	Management should ensure that information/data submitted for publishing within the IPR hasundergone the relevant checks to confirm that it is accurate prior to submission to the Information team.	Agreed. The over 65's data will now be included and the age range renamed to adult mental health (18-65).	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2024	16/10/2024	Amber	Overdue	

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Risk and Regulation/2023/278	Internal Audit - Core Financial Systems (Treasury Management)	Must do	The Treasury Management (Incorporating Cash Forecasting and Bank Account Controls) Financial Control Procedure should be strengthened as follows: - The requirements of the Standing Financial Instructions, section 7.3.1 (d) Banking Procedures should be addressed; - Consideration of developing, if not included within the FCP, a separate procedure to cover the access and control arrangements of the online banking system, Bankline; and - To enhance resilience, the inclusion of the process for developing the monthly cashflow forecast, which is a key document used to inform Welsh Government on a monthly basis of the Health Board's cash requirements.	- Agreed to revise FCP to include the requirements of 7.3.1 (d) also addressed in point 2 on management actions. - Agreed FCP to be updated to include control arrangements for access, inputting and authorisation of the online banking system. - Agreed to update the process document for developing the monthly cashflow	Mrs Rebecca Holliday	Mrs Rebecca Holliday	28/02/2023	24/07/2024	Amber	Overdue	Action points 1 & 2 have been completed in full. Point 3 - Monthly Cashflow The FCP has been updated to address the points outlined in the internal report. The department has commenced a review of the cashflow process; it has become apparent that this review is quite extensive, taking into account the modernisation agenda and priority areas for improvement in the current system. Therefore, taking all these factors into account, it has been identified that cashflow modernisation/ review will be an ongoing process for the remainder of this financial year. An interim SOP has been developed as of April 2024, while the cashflow review is ongoing. The cashflow review will recommence post yearend, July 2024. July 2024 - The new "monthly cashflow" model is currently being
Risk and Regulation/2024/309	Internal Audit - Estates Condition	Must do	1.1 - The lead executive should approve the proposed approach to the surveys, recognising any benefits/limitations of the approach taken 1.2 Surveys should be carried out on the UHB estate with the results informing both an updated estates strategy and EFPMS returns	Agreed - Condition surveys were tendered in November 2023. The tenders received did not provide a competitive response. Therefore, the tender is being re-issued in Jan 2024. It is anticipated that the surveys and completion of the reports will not be achieved until July 2025.EFPMS will continue to be updated, until after the condition survey update, using informed data.	Mr Andrew Partridge	Mr Andrew Partridge	29/02/2024	04/03/2024	Amber	Overdue	
Risk and Regulation/2024/831	Internal Audit - IMTP Development Process	Must do	Management should ensure that in future plans are identified to deliver the full annual savings requirement at the point that the MDS is provided to Welsh Government.	Stronger emphasis on savings plans up front in the planning process (July - September) and increased scrutiny of the plans earlier in the process (October).	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2024	14/10/2024	Red	Overdue	

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Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1.1 Internal financial reporting should be enhanced to clearly show the forecast position against the annual CRL, and the position against the approved contingency budget. 1.2 WG PPRs should be updated to reflect the current allocation of funds across each budget area.	Agreed. This matter has already been discussed in project team meetings, and it has been agreed that papers need to be reviewed for accuracy before inclusion in agendas.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Green	Overdue	
Risk and Regulation/2024/838	Internal Audit - Performance Reporting	Must do	Management should ensure that information/data submitted for publishing within the IPR hasundergone the relevant checks to confirm that it is accurate prior to submission to the Information team.	The Information team will communicate the requirement for services to carry out relevant checks prior to submission for inclusion with the IPR document.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2024	16/10/2024	Amber	Overdue	
Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1.1 Internal financial reporting should be enhanced to clearly show the forecast position against the annual CRL, and the position against the approved contingency budget. 1.2 WG PPRs should be updated to reflect the current allocation of funds across each budget area.	Agreed. The report will be updated to reflect the current allocation of funds across each budget area.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Green	Overdue	
Risk and Regulation/2024/840	Internal Audit - Implementation of the People and Culture Plan	Must do	Management should ensure that the 2024 performance indicators are reported to the next Board and the People and Culture Committee meetings.	We will also aim to include Violence & Aggression data going forward.	Mr Robert Warren	Mr Robert Warren	30/09/2024	16/10/2024	Green	Overdue	

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Risk and Regulation/2024/831	Internal Audit - IMTP Development Process	Must do	Prior to resubmission of the IMTP and MDS to the WG the Board should undertake the following: • The IMTP/MDS data should be reconciled. • Prior to submission to the Board, it should be reviewed and signed off by an appropriate delegated authority. • The IMTP planning process should be revised to include appropriate reconciliation checks.	Reconciliation checks - Arrange for an internal team independent of the core team that input the data and write the narrative plan to review the final MDS and reconcile back to the narrative before it is submitted in February/March to SLB, Finance and Board.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2024	14/10/2024	Red	Overdue	
Risk and Regulation/2024/309	Internal Audit - Estates Condition	Must do	The Estate strategy should be updated to reflect items including performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc.	Agreed in principle - The estates strategy has constantly been reviewed, with many aspects within the document updated to provide responses to previous Board queries and the Welsh Government requests. The condition survey findings will help inform the direction of investment in relation to backlog maintenance, space utilisation, functional suitability and investment strategies. This information, along with reviewing the IMTP of clinical departments and the strategic direction of the Board will help inform the Estates Strategy.	Mr Andrew Partridge	Mr Andrew Partridge	31/03/2024	04/03/2024	Amber	Overdue	
Risk and Regulation/2024/311	Internal Audit - Alcohol Standards	Must do	The Health Board should introduce an appropriate alcohol screening tool, in order to provide a more consistent approach to noting patient information and assisting in identifying people who potentially have an alcohol-use disorder.	Consistent recording mechanism for the chosen screening tool implemented and rolled out to all relevant teams. E.g. Electronic workstation	Lauren Idowu	Lauren Idowu	30/09/2024	19/09/2024	Red	Overdue	1. This action will be undertaken by the Alcohol Programme Manager post.

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Risk and Regulation/2023/306	Internal Audit - Capital Systems	Must do	Standardised reference numbers and descriptive titles should be used for schemes across all reporting, forms, applications, and minutes. It was noted that the Procurement reference number was used in the Procurement Report and often the Request for Approval form, but thereafter, any consistency was often lost.	Standardised reference numbers and descriptive titles will be used for schemes across all reporting, forms, applications, and minutes.	Mr Stephen Gardiner	Mr Stephen Gardiner	31/10/2023	10/07/2024	Green	Overdue	
Risk and Regulation/2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	Noting the current wait for funding, it is timely to evaluate terms of reference and governance structures to ensure each forum is appropriately focused.	Agreed. This will be informed by the outcome of the clinical review and forthcoming attendance at WG IIB. The SOC production is considered a project and was being reported into the Programme Board. As the only project, it was the only Project Board. It is acknowledged that it is in the programme's early stages and the only group meeting, the Project Board was also covering more general ground by updating stakeholders on matters.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue	
Risk and Regulation/2024/750	Internal Audit - Mortality Reviews	Must do	The Health Board should attempt to: • Clear the backlog of open cases as soon as possible, ideally by its intended deadline of March 2024. • Ensure that new cases are reviewed and responded to on a timely basis.	1) Delivery of C&V scrutiny panel to review all cases referred from ME 2) Development of reporting measures to ensure timely internal responses to ME referrals.	Dr Aled Roberts	Dr Aled Roberts	30/06/2024	10/07/2024	Amber	Overdue	

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Risk and Regulation/2024/747	Internal Audit - Information Governance	Must do	Management should consider identifying appropriate IG Leads / Champions within the Health Board, and to support the IG team by promoting good information governance practice.	With the existing limited capacity, ensuring that other departments have staff with specific data protection responsibilities is desirable but we need to ensure that this doesn't adversely impact their primary roles which, in the main, are already under strain. One role that needs to be conducted is the role of a Information Asset Owner (IAO) who should be responsible for completing a Information Asset Register (IAR) for their area. It would therefore make sense to explore whether the scope of this role could be extended to also include other data protection responsibilities, such as breach reporting/management and a general IG point of contact for their department.	Mr James Webb	Mr James Webb	01/04/2024	10/07/2024	Amber	Overdue	

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Risk and Regulation/2023/303	Internal Audit - Surgery Clinical Board - Consultant Job Plans - LIMITED	Must do	2a - Orthopaedics and General Surgery Directorate management should review the current process for agreeing and signing off Consultant job plans with a view to streamlining the process. Arrangements should be put in place to ensure that all Consultants within Orthopaedics and General Surgery have up to date, signed off job plans as soon as practicably possible. Given the delays in agreeing and signing off job plans, consideration should be given to the feasibility of recording the end date of job plans as 12 months from the date they were agreed and signed off, rather than ‘ongoing’. 2b - Orthopaedics and General Surgery All job plans should include Clinical Board (service outcomes), the achievement of which should be subject to annual assessment.	2a - Orthopaedics All job plans will be signed off by the 31/10/2023, including the newly added ones. End dates will be set up so that a reminder of job plan renewal and update will be triggered after 12 months of sign-off date. Because of the recent changes in the service, numerous consultants are still in the process of signing off. 2b - Orthopaedics Outcomes and objectives will be assigned to each job plan, and will be aligned to the clinical board deliverables for the current financial year. 2a - General Surgery In General Surgery there is a process in place for job plan sign off, however not all job plans have been straightforward and have been complicated by enforced regionalisation. Start dates on the Allocate system were incorrect, this has been rectified by the project	Mr Antonio Roccioli	Mr Antonio Roccioli	31/12/2023	10/07/2024	Red	Overdue	T&O 2a - The system does not send reminders, however it will move expired job plans into the "Expired" category, which will trigger a job planning meeting. In terms of compliance, all job plans have been defined, however on e Allocate only 19/35 have been signed off. 11 awaiting clinician sign off, 5 in discussion, however will be sent for sign off soon. 2b - Specific directorate service outcomes and deliverables have been added to eAllocate for each consultant, linked too Board outcomes. Only two consultants have personal outcomes, however if no specific are added by the consultants, service outcomes will become part of their objectives.
Risk and Regulation/2024/745	Internal Audit - Financial Management within Clinical Boards	Must do	The Clinical Board Finance Teams should review the ‘reports database’ to ensure that all budget holders details are up to date and take appropriate action to remove those staff that are no longer budget holders and if applicable add the details of any budget holders that are missing. Consideration should also be given that the Financial Systems Team issue the report to each Clinical Board Finance Team on a quarterly basis for review.	The Reports database is not the only platform for availability and review of financial information and support teams follow up with primary budget holders in monthly (or more often) meetings. Finance support teams will review their distribution at the same time as they liaise with budget holders on information needs to ensure that distribution lists are appropriate and up to date.	robert mahoney	robert mahoney	30/09/2024	15/10/2024	Amber	Overdue	

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Risk and Regulation/2024/831	Internal Audit - IMTP Development Process	Must do	Prior to resubmission of the IMTP and MDS to the WG the Board should undertake the following: • The IMTP/MDS data should be reconciled. • Prior to submission to the Board, it should be reviewed and signed off by an appropriate delegated authority. • The IMTP planning process should be revised to include appropriate reconciliation checks.	Delegated Authority - Finance and Performance Committee to be given delegated authority for the MDS submission - Proposal to Director of Corporate Governance and Committee Chair.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2024	14/10/2024	Red	Overdue	
Risk and Regulation/2024/831	Internal Audit - IMTP Development Process	Must do	Prior to resubmission of the IMTP to the WG the Health Board should undertake the following: • Prior to submission to the Board, the Annual Plan/MDS should be reviewed and signed off by an appropriate delegated authority. • The annual planning process should be revised to include appropriate reconciliation controls.	Reconciliation checks - Arrange for an internal team independent of the core team that input the data and write the narrative plan to review the final MDS and reconcile back to the narrative before it is submitted in February/March to SLB, Finance and Board.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2024	14/10/2024	Amber	Overdue	
Risk and Regulation/2024/750	Internal Audit - Mortality Reviews	Must do	Ensure that the key priorities for 2024 are effectively implemented.	1 – Delivery of C&V scrutiny panel to review all cases referred from ME. 2 – Setting up a Mortality and Morbidity (M&M) Group is in progress. 3 – Making information from the Medical Examiner process available is in progress in conjunction with delivery of ME scrutiny panel. 4 – Bereavement processes T&F group in progress.	Dr Aled Roberts	Dr Aled Roberts	01/09/2024	10/07/2024	Amber	Overdue	

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Risk and Regulation/2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	1. Establish a clear and approved pay rate for junior doctors, specifying whether they should receive the full contract rate or a percentage of it. This must be reflected in the WLI procedure and communicated to all relevant staff. 2. Rota Co-ordinators and authorising officers need to ensure that all WLI sessions shift grade are correctly classified within the system, regardless of who performs the work. 3. Conduct regular audits to ensure compliance with the junior doctors WLI pay rate and to address any discrepancies promptly.	Further discussions with the AMD workforce and Medical Director are required to decide if appropriate to pay a % of the WLI consultant rate.	Hilary Sharp	Hilary Sharp	30/09/2024	16/10/2024	Amber	Overdue	

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Risk and Regulation/2024/745	Internal Audit - Financial Management within Clinical Boards	Must do	Clinical Board Finance Senior Management need to work with Heads of Services/Departments to identify deliverable savings schemes in order to meet its delegated savings target for Corporate Central Savings Themes. Where existing savings schemes are failing to deliver their planned savings in total, Finance and Senior Management need to work with Heads of Services/Departments to identify actions that can be introduced to deliver the delegated savings targets. Where it has been identified/confirmed that identified schemes will not deliver expected savings then Heads of Services/Departments should ensure that additional deliverable savings schemes are identified to address the shortfall.	The responsibility for delivery of the financial savings target is a key objective for the senior leadership team in each Clinical Board with the support and key input of the respective Finance Business Partner / Head of Finance. All savings targets for the UHB in the financial year are allocated to a Clinical Board level in the annual budget setting exercise as part of the development of the UHB financial plan. Finance Business Partners work with the Clinical Board leadership teams to continually develop savings ideas for Month 1 and then throughout the financial year. The Chief Operating Officer and Director of Finance, alongside the planning functions, ensure that the savings targets are shared and that plans are actively developed before the beginning of the financial year, and onwards into the financial year where shortfalls still exist. The delivery of the cost savings target is a fundamental, high risk, component of the financial strategy of the UHB and	robert mahoney	robert mahoney	01/04/2024	15/10/2024	Amber	Overdue	
Risk and Regulation/2022/269	Internal Audit - Development of Genomics Partnership Wales	Must do	Further work is required to ensure the Project Bank Account is established and operating in line with Welsh Government policy.	Agreed. Further discussion ongoing with Contractor to enable project bank account to be put in place for the scheme.	Mr Clive Morgan	Mr Clive Morgan	31/03/2023	30/01/2024	Red	Overdue	No updates received
Risk and Regulation/2023/306	Internal Audit - Capital Systems	Must do	The preferred method of reporting should be consistently completed on a pre-determined frequency.	Agreed. Standardised reporting arrangements are being implemented, which will be consistently applied across all UHB projects.	Mr Stephen Gardiner	Mr Stephen Gardiner	31/10/2023	10/07/2024	Green	Overdue	

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Risk and Regulation/2024/309	Internal Audit - Estates Condition	Must do	Recognising the limited progress reporting to the Board on the delivery of its Estates Strategy objectives for the period 2018-2022 and the recent (February 2023 – Board development session) red status reported against the mid-point delivery of the Estate Strategy objectives; the Board or nominated committee should receive regular updates on the delivery of the Estate Strategy and 10-year capital programme (particularly any risks/impact resulting from delay/non delivery).	Agreed in principle. The Board is updated in many areas in relation to the requirements of the estate and the funding implications thereof. The Board will be further informed of the continuing shortfall in availability of funding and the need to address ongoing financial implications of the estate at regular intervals. A programme of update reports will be agreed to be included in the future Board agendas.	Mr Andrew Partridge	Mr Andrew Partridge	31/03/2024	04/03/2024	Red	Overdue	
Risk and Regulation/2023/303	Internal Audit - Surgery Clinical Board - Consultant Job Plans - LIMITED	Must do	3a - Orthopaedics and General Surgery All Consultant job plans with more than 12 sessions per week should be approved in line with the Consultant Job planning Procedure. The approval should be evidenced on the Allocate system using the third sign off field.	3a Orthopaedics Consultants who are working on a 12 sessions job plan were authorised in previous years, and as service changes did not impact their sessional allocation, it has not been changed. However, as per the audit team request, we will action 2.1 a and b and make sure a third sign-off function is enabled. General Surgery Discussed with the CBD and the AMD for workforce, this was fed back on many occasions to the MD's office. A number of General Surgeons also have extra sessions in their job plans for external duties/responsibilities with Welsh Government, MoD and the University.	Mr Antonio Roccioli	Mr Antonio Roccioli	11/11/2023	10/07/2024	Amber	Overdue	3a Orthopaedics - this change would affect the entire organisation and possibly compliance will decrease. This function won't be enabled at present, at it showed as not bringing any added value.
Risk and Regulation/2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	The above review may include consideration of reinstatement of the SOFH Committee, or utilisation of an existing Committee, to provide periodic scrutiny and oversight of programme activities.	Agreed. This will be informed by the outcome of the clinical review and forthcoming attendance at WG IIB.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue	

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Risk and Regulation/2024/831	Internal Audit - IMTP Development Process	Must do	Prior to resubmission of the IMTP to the WG the Health Board should undertake the following: • Prior to submission to the Board, the Annual Plan/MDS should be reviewed and signed off by an appropriate delegated authority. • The annual planning process should be revised to include appropriate reconciliation controls.	Delegated Authority - Finance and Performance Committee to be given delegated authority for the MDS submission - Proposal to Director of Corporate Governance and Committee Chair.	Ms Rachel Chilcott	Ms Rachel Chilcott	30/09/2024	14/10/2024	Amber	Overdue	
Risk and Regulation/2024/841	Internal Audit - Medical Staff Additional Sessions	Must do	1. Establish a clear and approved pay rate for junior doctors, specifying whether they should receive the full contract rate or a percentage of it. This must be reflected in the WLI procedure and communicated to all relevant staff. 2. Rota Co-ordinators and authorising officers need to ensure that all WLI sessions shift grade are correctly classified within the system, regardless of who performs the work. 3. Conduct regular audits to ensure compliance with the junior doctors WLI pay rate and to address any discrepancies promptly.	3.1 would need to be addressed and approved/implemented. Bank team to provide reports to AMD workforce or representative on a quarterly basis	Hilary Sharp	Hilary Sharp	30/09/2024	16/10/2024	Amber	Overdue	
Risk and Regulation/2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	A Programme / Project -specific Scheme of Delegation should be developed.	Agreed.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue	

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Risk and Regulation/2024/748	Internal Audit - Cancer Services	Must do	Risk management and risk reporting approach for the Cancer Services Team be agreed and as a minimum consider the arrangements for: • Identifying the risk; • Analysing the risk; • Prioritising the risk; • Treating the risk; and • Monitoring / escalating the risk as appropriate	The Lead Cancer Nurse will create a unified risk register for cancer which will be governed via the Executive Cancer Board. This will be compiled in accordance with the Clinical Boards identifying, risk reviewing and unifying all relevant risks from within their individual risk registers, as well as risks identified internally from within Cancer Services. Those risks identified as most vulnerable will be reviewed at Cancer Executive Board with an expectation that remedial actions be identified and implemented at the point of presentation.	Annette Beasley	Annette Beasley	31/03/2024	08/07/2024	Amber	Overdue	
Risk and Regulation/2024/309	Internal Audit - Estates Condition	Must do	A full review should be undertaken of the Estates workforce to analyse the current position in terms of capability and capacity. Following this, a clear financial model for the revenue support needed to manage the estate should be developed.	Agreed in principle - 12 months data has been collated and reports are being run to establish the various levels of staffing required.	Mr Andrew Partridge	Mr Andrew Partridge	31/03/2024	04/03/2024	Red	Overdue	
Risk and Regulation/2024/308	Internal Audit - Technical Continuity	Must do	As part of the move to the new architecture, consideration should be given to providing more holistic management of hosted applications to maximise the resilience position, with Digital providing greater input into design. Services on physical servers should be moved into the virtual environment.	Work with the Clinical Boards, Services and Departments to migrate their servers to new OS, Hardware and introduce HA and Fault Tolerance.	Gareth Richards	Gareth Richards	01/04/2024	10/07/2024	Green	Overdue	June 2024 Good progress has been made with over 50 servers updated or replaced. Work continues to address legacy OS and Databases. This request is meeting signficant resistance due lack of application supprt or commercial implications. Progression is slower than expected as escalation to IT Director and CAV Cyber teams is often required. Completion date estimated Q4 2024 - Q1 2025

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Risk and Regulation/2024/831	Internal Audit - IMTP Development Process	Must do	It is recommended that the Strategy Development and Delivery Group Terms of Reference state: • The date that they have been approved and who approved them. • The date of next review and version number. • A clearly defined review procedure including auditable approval documents e.g. meeting minutes.	- Terms of Reference are under review and will be presented to and signed off by Senior Leadership Board. - The approval date and approving body will be noted on the new terms of reference including the date of next review. - The terms of reference will include a review procedure. - Auditable documents will include meeting papers and action and decision notes.	Ms Rachel Chilcott	Ms Rachel Chilcott	01/08/2024	14/10/2024	Amber	Overdue	
Risk and Regulation/2023/306	Internal Audit - Capital Systems	Must do	Project Issues Form's will be completed for all project changes to demonstrate compliance with delegated limits.	Agreed – the Health Board have already commenced transitioning to this approach.	Mr Stephen Gardiner	Mr Stephen Gardiner	30/09/2023	10/07/2024	Amber	Overdue	
Risk and Regulation/2024/311	Internal Audit - Alcohol Standards	Must do	Management should review the current process and consider implementing a central database that includes the records of all appropriate staff across the organisation and detailing the alcohol awareness training undertaken, the date provided and the date for renewal.	Embed alcohol training within current training schedule for relevant staff and trainees. Ensure training records centralised and kept up to date, including dates for refresher training when required and what areas the staff work in.	Lauren Idowu	Mr Owen Price	30/09/2024	08/07/2024	Red	Overdue	1. This action will be undertaken by the Alcohol Programme Manager post. 2. No changes to implementation date 3. None. 4. N/A
Risk and Regulation/2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	The workstream governance structure should be clearly and consistently presented in key governance documents.	Agreed - the observation is understandable. The inconsistency reflects work that was in flight when documents were provided for the audit - where the PID hadn't caught up with the sub-documents having been updated.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue	
Risk and Regulation/2024/309	Internal Audit - Estates Condition	Must do	The UHB should clearly defined a process for monitoring and reporting the estates condition on a periodic basis (minimum annually) including the backlog maintenance position.	Agreed in principle. The appropriate timing will be agreed with information governance and a report generated in accordance with the recommendation, on an annual basis.	Mr Andrew Partridge	Mr Andrew Partridge	31/03/2024	04/03/2024	Red	Overdue	

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Risk and Regulation/2024/309	Internal Audit - Estates Condition	Must do	The Board will be provided with assurances on the effectiveness of the identified actions to reduce the capital asset risks.	Agreed in principle. There is an existing agreed capital investment review that is issued to the Board, via the updates provided by the Capital Management Group, and the investment undertaken and the impact thereof on the current estate. What will be included in the future is the impact of this investment on the overall capital requirements of the estate, including understanding depreciation of the estate in the same period of the investment. This will be provided an annual basis. A programme of these updates will be agreed and formulated for the future Board agenda.	Mr Andrew Partridge	Mr Andrew Partridge	31/03/2024	04/03/2024	Red	Overdue	
Risk and Regulation/2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	Working groups should be clearly defined, with terms of reference in place to identify memberships, governance arrangements etc. These should be distinct from normal UHB operations, to ensure the Programme receives the necessary focus and to support clear monitoring and reporting performance.	Agreed. Terms of reference were developed for workstreams and presented at the May project board during/post the audit review. Given the expectation of funding, it was prudent to plan the SOC to be efficient with time so we were relying on existing leaders to spare the time to assist and participate. In the absence of confirmed funding, there has been limited time colleagues have been able to commit alongside the 'day-job.' Receipt of funding would have enabled the recruitment of dedicated resource for SOFH (and SOFCS) work. Our approach did see planning progressing at differential paces and in the future needs either dedicated time from matrixed resources or dedicated resources from the workstreams assigned to the programme. To be considered as part of the governance and resource review recommended in this report.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue	

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Risk and Regulation/2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	There should be a detailed review of the resources required as the UHB moves through the Programme, from SOC, to OBC and onwards, using an activity-based resource schedule. Resource schedules should be agreed with key departments and individuals to ensure risks and limitations are fully understood. Where funding bids are adjusted downwards, reporting to key forums should be clear as to the gaps this will leave in skills / capacity and the associated risks to programme delivery.	Agreed. Our plans did acknowledge the pre-requisites of the Clinical Model and Estate baseline work as early pre-requisites. The approach to understanding the estate condition has changed, with the SOC initially expected to rely on existing data. More recently, with a potential for consideration of a do minimum option, we recognise there is a need to update this data to accurately reflect current risks. When funding was looking likely to arrive, preparing to procure an external advisor was work that was decided could start. Preparing for this exercise was right at the time and was happening in parallel with planning. This procurement work is now on hold and no tender will or can be progressed without a plan being complete and committed to along with a clear line of sight to funding. The point about a low level of resource request is noted and has been a subject of ongoing internal discussions since submission.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue	
Risk and Regulation/2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	The team should move forward with development of a Communications Plan as soon as possible.	Agreed.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue	

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Risk and Regulation/2023/303	Internal Audit - Surgery Clinical Board - Consultant Job Plans - LIMITED	Must do	Consideration should be taken to assess whether Consultant team job plans can be utilised within the two Directorates.	Orthopaedics We will try to implement this function within the Spines Team first, and then extend it to Orthopaedics. General Surgery Going forward within the next round of job planning, team job plans will be considered for managing delivery of capacity along with the annualization process. However this cannot be the only form of job planning as there are individual considerations for each job plan including those who have contracts externally to the HB e.g. Cardiff University, Welsh Government and the MoD.	Mr Antonio Roccioli	Mr Antonio Roccioli	01/04/2024	10/07/2024	Amber	Overdue	T&O From a directorate perspective, on call teams are job planned as a team, otherwise we would not be able to optimise their schedules. We don't record this anywhere at present, but we will try to roll this out in Spines first once the pilot in Medicine has ended.
Risk and Regulation/2023/300	Internal Audit - Paris System	Must do	Management should liaise with Civica with a view to moving system back-ups off-site.	We strongly agree with this recommendation, in fact it was identified during a recent hardware refresh but no suitable offsite location was found due to numerous reasons (CRI lacking capacity and Woodlands House lacking redundant power). We will use this recommendation as a springboard to address the matter urgently however, the target date will be within 6 months due to factors such as complexity, availability and financial constraints. We will work with the head of digital operations and Civica to identify a suitable offsite backup location and relocate. We will also look to identify if there are any immediate actions that we can take to mitigate the risk in the meantime.	Katherine Roscoe	Katherine Roscoe	01/04/2024	16/08/2024	Red	Overdue	Jun'24: Contract still to be finalised, once finalised we will look to move this forward with CIVICA. In the mean time we will liaise with digital ops team to determine if any offsite locations have suitable capacity. Hardware migration is completed and decommissioned. Aug'24: Application Manager in talks with Digital Ops and Civica to arrange. CRI has been identified as a suitable location but we have been told this will likely come at a cost to set up.

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Risk and Regulation/2023/312	Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Must do	Governance forums should receive clearly distinguishable highlight / flash reports focusing on the assigned responsibilities of the reporting forum. Workstream highlight reports should be enhanced to clearly present performance information and associated risks.	Agreed.	Mr Andrew Partridge	Mr Andrew Partridge	04/03/2024	04/03/2024	Amber	Overdue	
Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	The construction risk register should be reviewed alongside the forecast outturn position, to determine: • Any remaining risks (and associated costs) which may materialise; • Whether the Contractor's forecast planned completion date (and associated one month delay) will give rise to any delay damages, and the impact on the budget position (in association with recommendation 3.2); and • Funding source/s, and appropriate approval requirements, to cover any expenditure above WG funding.	Agreed. We recognise that prior cost reporting was not up to date, noting provisional sums had not been released into contingency. This has now been rectified with the project showing an underspend. Reports will be checked more carefully for accuracy going forward. We confirm no delay damages are envisaged at this stage.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Amber	Overdue	
Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. At future projects, the contract conditions applied in managing the contract should conform with the form of contract in place. 2. The UHB should establish how delay damages will be applied at this project, should the contractor not achieve the contractual completion date. 3. The defects period end date should be corrected on Sectional Completion Certificate No. 2.	Agreed. We are seeking to establish a process whereby the contract mechanisms are formally agreed. We will discuss this with team leads to determine how this will be formally managed.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Amber	Overdue	

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Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. At future projects, the contract conditions applied in managing the contract should conform with the form of contract in place. 2. The UHB should establish how delay damages will be applied at this project, should the contractor not achieve the contractual completion date. 3. The defects period end date should be corrected on Sectional Completion Certificate No. 2.	Agreed. At this time, no delay damages are anticipated.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Green	Overdue	
Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. At future projects, the contract conditions applied in managing the contract should conform with the form of contract in place. 2. The UHB should establish how delay damages will be applied at this project, should the contractor not achieve the contractual completion date. 3. The defects period end date should be corrected on Sectional Completion Certificate No. 2.	Agreed.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Green	Overdue	
Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	The UHB should liaise with NWSSP Accounts Payable to highlight the importance of project payments being made in line with contractual terms, and identify whether a solution is feasible.	Agreed. Contact will once again be made.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Amber	Overdue	

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Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	On completion of the project, management should undertake a review of how the design / change process has been managed, with any lessons learnt identified for application at future projects.	Agreed. The Project Director has already challenged the number of PIFS raised at this project and requested a postproject review. However, it is important to note the project remains within budget and the finished product will meet the service requirements. The approach taken was tailored to the style of the project contractor. We are also reviewing our approach to budget management with this Contractor: preparing our own estimates rather than awaiting the Contractor to cost the PMIs. This will improve our ability to make informed decisions based on greater cost certainty surrounding.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Amber	Overdue	
Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	The UHB and external Project Manager should support the change management process by completing the following activities in a timely manner: • approving PIFs; • accepting quotes (via PMN); and • ensuring PMNs are not issued until PIFs have been approved.	Agreed. As referenced at management response 5.1, we are implementing a new process of forecasting PIF costs internally, rather than awaiting contractor quotations. This will allow a more timely review of the change and likely budget implications, with the instruction issued once the quotation is received and agreed.	Mr Geoff Walsh	Mr Gavin Evans	31/01/2024	16/10/2024	Amber	Overdue	

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Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. The warranty arrangements for the main equipment should be confirmed by the UHB, including confirmation as to whether extended warranty cover is required: with retention of associated documentation. 2. At future projects, the risks associated with the equipment approach (e.g. storage / warranties) should be included on the project risk register to ensure visibility at Project Team / Project Board. 3. At future projects, where risks are taken in the early procurement of significant values of equipment (e.g. long periods of storage / warranty implications), these should be clearly understood and set out in the Procurement Report and Request for Approval.	Agreed. We have received verbal assurance from the Endoscopy Department that the warranty period is three years, therefore there is no risk to this expiring prior to installation.	Miss Claire Salisbury	Miss Claire Salisbury	31/01/2024	16/10/2024	Amber	Overdue	

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Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. The warranty arrangements for the main equipment should be confirmed by the UHB, including confirmation as to whether extended warranty cover is required: with retention of associated documentation. 2. At future projects, the risks associated with the equipment approach (e.g. storage / warranties) should be included on the project risk register to ensure visibility at Project Team / Project Board. 3. At future projects, where risks are taken in the early procurement of significant values of equipment (e.g. long periods of storage / warranty implications), these should be clearly understood and set out in the Procurement Report and Request for Approval.	Agreed. We recognise this would be an enhancement at future projects, where applicable.	Miss Claire Salisbury	Miss Claire Salisbury	31/01/2024	16/10/2024	Amber	Overdue	

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Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. The warranty arrangements for the main equipment should be confirmed by the UHB, including confirmation as to whether extended warranty cover is required: with retention of associated documentation. 2. At future projects, the risks associated with the equipment approach (e.g. storage / warranties) should be included on the project risk register to ensure visibility at Project Team / Project Board. 3. At future projects, where risks are taken in the early procurement of significant values of equipment (e.g. long periods of storage / warranty implications), these should be clearly understood and set out in the Procurement Report and Request for Approval.	Agreed.	Miss Claire Salisbury	Miss Claire Salisbury	31/01/2024	16/10/2024	Amber	Overdue	
Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. Capital, Estates & Facilities should develop an internal mechanism for monitoring and reporting contractor, adviser and UHB internal team performance at projects. 2. Consideration should be given to utilising the NEC Professional Services Contract alongside Framework Service Level Agreements for external advisers, where appropriate.	Agreed. We have commenced maintenance of KPIs, based on the Designed for Life Framework as a starting point, and will work on enhancing this process as it progresses. The process includes reporting to the Director of Capital & Estates, with an escalation process where needed.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Amber	Overdue	

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Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	1. Capital, Estates & Facilities should develop an internal mechanism for monitoring and reporting contractor, adviser and UHB internal team performance at projects. 2. Consideration should be given to utilising the NEC Professional Services Contract alongside Framework Service Level Agreements for external advisers, where appropriate.	Agreed - recognising this will be tailored to each project and advisors as appropriate – less complex schemes / appointments can still be managed via the SLA.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Green	Overdue	
Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	At future projects, where professional services (e.g. Supervisor) are provided in-house, the duties required for the project should be clearly defined within the Project Execution Plan.	Agreed, we will incorporate this into the PEPs at future projects.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Green	Overdue	
Risk and Regulation/2024/746	Internal Audit - University Hospital Llandough Endoscopy Development	Must do	External advisers should be reminded of the need to provide accurate and up to date reports.	Agreed, this will be raised with the Adviser’s senior management.	Mr Geoff Walsh	Mr Geoff Walsh	31/01/2024	16/10/2024	Green	Overdue	
Risk and Regulation/2023/302	Internal Audit - Chemocare IT System Follow-up	Should do	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.	Discussions are still ongoing, as there is a lack of clarity over where alerts should come from with the position being monitored via regular discussions with suppler and IT.	Mr Andrew Partridge	Mr Andrew Partridge	31/01/2024	31/05/2024	Amber	Overdue	Mar '24: NO UPDATE
Risk and Regulation/2023/302	Internal Audit - Chemocare IT System Follow-up	Should do	Finalise the review of the BCP.	Agreed. The BCP will be completed.	Mr Andrew Partridge	Mr Andrew Partridge	31/01/2024	31/05/2024	Amber	Overdue	Mar '24: NO UPDATE

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Report Title:	Counter Fraud Progress Report			Agenda Item no.	4.1
Meeting:	Audit & Assurance Committee	Public	x	Meeting Date:	05/11/2024
		Private			
Status *(please tick one only)*:	Assurance x	Approval		Information	x
Lead Executive:	Catherine Phillips				
Report Author (Title):	Henry Bales				

Main Report
Background and current situation:

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

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

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

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

Recommendation:

The Board / Committee are requested to: note the report

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

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

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

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

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

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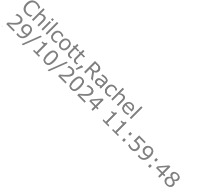
Risk: Yes/~~No~~
Fraud is a risk to all organizations. Within the NHS should fraud occur then this can have financial and reputational impacts and ultimately negatively affect patient care.
Safety: ~~Yes~~/No
Financial: Yes/~~No~~
All fraud occurring in the organization has a financial loss to the organization.
Workforce: Yes/~~No~~
Reduction of available staff during investigations and sanctions; demotivation
Legal: Yes/No
Reputational: Yes/~~No~~
Fraud is a risk to all organizations. Within the NHS should fraud occur then this can have financial and reputational impacts and ultimately negatively affect patient care.
Socio Economic: ~~Yes/~~No
Equality and Health: ~~Yes~~/No
Decarbonisation:~~ Yes~~/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Catherine Phillips	21/10/2024



NHS WALES

Counter Fraud Progress Report

17/08/2024-18/10/2024

Public

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HENRY BALES
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 on behalf of the Health Board.

This report relates to activity for the reporting period 17/08/2024-18/10/2024.

2. Progress

Infrastructure/Annual Plan

Work has continued in maintaining the Counter Fraud infrastructure in order to maintain compliance with the Counter Fraud Plan for 2024-2025, and the NHS CFA functional standards. The below activity has taken place -

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

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

Counter Fraud - Home (sharepoint.com)

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Promotion and Awareness and Educational Activity

Corporate Induction– (1) Market Place event has taken place and 20 new members of staff presented to.

Specific Fraud Awareness Talks – A session was held with four members of staff who are on the Graduate Management Programme to give them a detailed input into Counter Fraud.

E-Learning – The total number of staff who have completed Counter fraud E-Learning is now 1181, with six member of staff completing training during quarter 2.

International Fraud Awareness Week (IFAW) – preparations are underway for IFAW which will run between 17th – 23rd November 2024.

Prevention

Local Bulletins/Alerts – (0)

IBURN (intelligence bulletin) – (2)

1- CV fraud alert relating to an individual that is believed to be applying for employment across government departments making false representations within their application. Checks were conducted showing no applications made to the organisation by the individual. NWSSP recruitment made aware.
2- Cyber scam relating to a third-party supplier to an NHS Scotland organisation. Third-party supplier had been compromised and this led to a number of NHS email addresses also being compromised. As a result, there was a risk to NHS organisations that have had dealings with this company. Alert issued to relevant teams (Cyber Security and Finance for awareness).

FPN (Fraud Prevention Notice issued by CFA) – (0)

Local Proactive Exercise (LPE) – There is currently one LPE being undertaken into procurement (due diligence and contract management) as prescribed through a national exercise from the NHS Counter Fraud Authority.

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National Fraud Initiative

The process has commenced for the submission of data to the next NFI programme (2024-25). This data will be released for matches to be reviewed approximately 20th December 2024.

Referrals

During this reporting period there have been a total of 19 referrals made to the team. All of these referrals have been investigated and there has not been a requirement to promote any to formal investigation. One referral that had been received in the previous period was upgraded to a formal investigation (INV/24/02109).

Investigations

A summary of the investigations for 2024-25 is provided below. At the time of reporting 8 investigations remain open and are being investigated by the team. The investigations that have been closed during this period have been highlighted on the table. Investigations of note will be subject to update in private session.

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/23/00079	Staff Overpayment	CARRIED OVER - 10/01/2023	18/04/2024	CCJ awarded for full amount.
INV/23/00096	Overpayment of Salary - Non-Starter	CARRIED OVER - 12/01/2023	18/04/2024	CCJ awarded for full amount.
INV/23/00113	Suspected Overtime Fraud	CARRIED OVER - 13/01/2023	18/04/2024	Subject dismissed following disciplinary hearing, Repayment made.
INV/23/00825	Salary Overpayment for Sick Pay	CARRIED OVER - 02/05/2023		
INV/23/01634	Salary Sacrifice Vehicle – Payments not made	CARRIED OVER - 03/08/2023		
INV/23/01696	Overpayment	CARRIED OVER - 14/08/2023	08/07/2024	Payment plan commenced to repay overpayment.
INV/23/02002	Theft of Controlled Drugs	CARRIED OVER - 15/09/2023		
INV/23/02207	Working Elsewhere whilst sick	CARRIED OVER - 12/10/2023	31/05/2024	Subject interviewed under caution, no fraud found, internal disciplinary outcome of Verbal Warning due to breaches in policy/procedure.

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INV/23/02421	Money missing suspected stolen	CARRIED OVER - 26/10/2023		
INV/24/00102	Working Elsewhere whilst sick	CARRIED OVER - 16/01/2024		
INV/24/00336	Overpayment	CARRIED OVER - 09/02/2024		
INV/24/00462	Working elsewhere whilst sick	CARRIED OVER - 21/02/2024		
INV/24/00505	False Sickness	CARRIED OVER - 29/02/2024	11/06/2024	Subject was dismissed from employment at a disciplinary panel. Case not progressed criminally.
INV/24/00548	Overpayment	CARRIED OVER - 05/03/2024	08/07/2024	Repayment made in full
INV/24/00660	Optician CPD Claims	CARRIED OVER - 14/03/2024	07/06/2024	No further Action
INV/24/00876	Allegation of selling prescription medication	09/04/2024	10/04/2024	No offences identified
INV/24/00909	dishonesty to obtain special paid leave	09/04/2024	07/06/2024	Disciplinary process followed - two days leave returned via final payroll
INV/24/01037	Working for agency whilst off sick with UHB	22/04/2024	22/08/2024	Subject interviewed, no fraud found, procedure not followed, internal disciplinary matter.
INV/24/01016	Obtaining free prescriptions when not entitled	23/04/2024	07/05/2024	Measures taken to prevent any future issues, no fraud identified.
INV/24/01024	COVID SCAM CALL to member of Public	23/04/2024	23/04/2024	No counter fraud issues, advice passed
INV/24/01064	Allocation of shifts for own gain	25/04/2024	30/04/2024	No fraud identified, internal process issues identified recommendations made.
INV/24/01117	Altered prescription presented at pharmacy	30/04/2024	07/05/2024	Altered prescription presented, not dispensed, unable to prove who presented/altered prescription.
INV/24/01240	Duplicate claim for Optometry Services	15/05/2024	07/06/2024	Insufficient evidence to progress
INV/24/01254	Fraudulent email asking for payment to be made	16/05/2024	20/05/2024	No financial loss, prevention measures put in place. Referrer suitably advised
INV/24/01314	Secondary care whilst not ordinarily resident	23/05/2024	07/06/2024	Enquiries completed, no offences identified.
INV/24/01389	Working elsewhere whilst sick	30/05/2024	30/05/2024	Enquiries completed no agency shifts completed whilst on sick leave. No fraud identified.

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INV/24/01426	Fraudulent email asking for payment to be made	03/06/2024	05/06/2024	No financial loss, prevention measures put in place. Referrer suitably advised
INV/24/01454	Fraudulent email asking for payment to be made	06/06/2024	07/06/2024	No financial loss, prevention measures put in place. Referrer suitably advised
INV/24/01461	Fraudulent email asking for payment to be made	07/06/2024	17/06/2024	No financial loss, prevention measures put in place. Referrer suitably advised
INV/24/01513	Duplicate GOS claims for patient by suppliers	13/06/2024	04/07/2024	No fraud identified. Advice Given.
INV/24/01514	Two claims for GOS in short space of time	13/06/2024	04/07/2024	Advice letter sent. Lack of controls in place, no offence provable. Risk work completed, steps underway to improve system.
INV/24/01515	Two claims for GOS in short space of time	13/06/2024	04/07/2024	Advice letter sent. Lack of controls in place, no offence provable. Risk work completed, steps underway to improve system.
INV/24/01516	Two claims for GOS in short space of time	13/06/2024	04/07/2024	No issues identified.
INV/24/01509	Pharmacist dispensing cheaper drugs claiming for expensive	14/06/2024	18/06/2024	Transferred to CFS Wales
INV/24/01637	Duplicate claim for Optometry Services	26/06/2024	04/07/2024	No Issues Identified.
INV/24/1661	Fraudulent email asking for payment to be made	28/06/2024	01/07/2024	No financial loss, prevention measures put in place. Referrer suitably advised
INV/24/01743	Procurement / Theft Issues	08/07/2024	22/08/2024	No offence identified, process not followed, referred back to directorate.
INV/24/01970	Two claims within one month at two opticians	02/08/2024	22/08/2024	No offences identified - recommendations made to improve procedure
INV/24/01971	Two claims in one day for acute eye issues	02/08/2024	22/08/2024	No offences identified - recommendations made to improve procedure
INV/24/01972	Inflated travel expenses claims	02/08/2024		
INV/24/02109	Two claims for eyesight test	21/08/2024	22/08/2024	No offences identified - recommendations made to improve procedure

3. Significant Salary Overpayments

There have been 7 significant salary overpayments reported for this period. All of these have been reviewed by the counter fraud team and none have required escalation to formal criminal investigations.

NB. The new All Wales Salary Overpayments Policy requires that the Counter Fraud team review all significant salary overpayments prior the employee being informed of the issue. The Counter Fraud team have a five-day window to carry out an initial assessment of the surrounding circumstances and decide whether the matter will be formally investigated as a financial crime.
A digital dashboard has been developed and implemented to assist with the monitoring of salary overpayments, their causes and the departments where they occur. This dashboard is accessible to the Finance and Counter Fraud teams and should assist in providing timely and accurate data in relation to any problem areas.

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