GUIDANCE NOTES

Internal Audit Recommendations / Actions Log

October 2017

Red - Implementation date passed management action not complete

Orange - Action not on target for completion by agreed/revised date

Yellow - Action on target to be completed by agreed/revised date

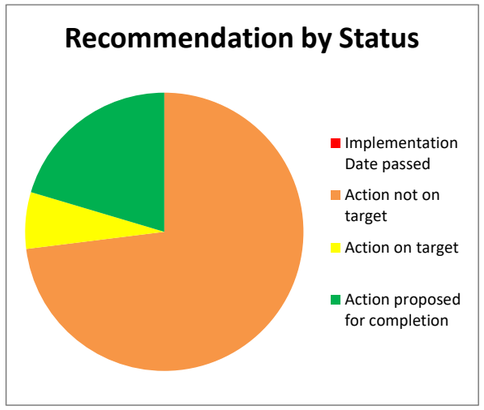
Ref	Date added	Issue	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Original Agreed Implementation Date	Revised Implemen-tation Date	Status	Progress	Actions Completed	Issues Arising This Period
Reference No	Date Added to log		Recommendation details taken from Internal Audit Report.	Assigned in the IA report	Management Action details taken from Internal Audit Report.	Executive Lead	Date will be inlcuded here.		Please use appropriate 'Fill Colour' in accordance with the key above.	Executive lead should make a judgement on current progress (delete as appropriate): Improving No Change Declining	**This will contain specific actions that have been taken towards addressing the issue e.g.** • A schedule of all academic staff that provided sessional work/service for the organisation and seconded individuals from other health bodies is in place.	**This should be used to give a summary of any issues that have occurred since the last meeting/update and the actions have been taken to mititgate them e.g.** • No issues arising in the period; or • Work was delayed due to..... The issue has been discussed in the senior management team and this will be dealt with as a matter of priority.....

Next Steps & Expected Milestones
This section should be used to identify the next steps that will be taken to achieve the recommendation. Realistic milestones should also be provided that can be reported upon and measured in future updates. These milestones must relate to the agreed implementation date, or where this is not achievable appropriate justification should be provided. Do not duplicate narrative provided in other columns E.g. The service is on target to meet the agreed implementation date and will: • Prepare a schedule of all academic staff that provide sessional work/service for the organisation by November 2017..... or • The agreed implementation target of May 2017 will not be achieved due to..... We are addressing this by.....

Appendix 1

Cwm Taf Morgannwg

Internal Audit Recommendations / Action Log - [h] 2019



Recommendations by Priority & Status					
Priority	TOTAL	Implementation Date passed	Action not on target	Action on target	Actions Completed
High	**48**	0	39	2	7
Medium	**80**	0	57	7	16
Low	**24**	0	15	1	8

Progress	
Total Recommendations	
New Recommendations	
Improving	19
No Change	4
Declining	

Recommendations by Executive Lead & Status					
Executive Lead	Total	Implementation Date passed	Action not on target	Action on target	Actions Completed
Director of Corporate Governance	**4**	0	2	1	1
Director of Finance	**31**	0	16	6	9
Director of Operations	**67**	0	52	0	15
Director of Finance/Director for People	**5**	0	3	0	2
Director of Nursing	**3**	0	3	0	0
Director of Planning & Performance	**20**	0	13	3	4
Director for People	**16**	0	16	0	0
Medical Director	**6**	0	6	0	0

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Yellow - Action
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Continuing Healthcare (January 2019)													
CHC 02	Jan-19	Reasonable	Following the publication by Welsh Government of a revised CHC national framework, management should review Health Board procedure documents and forms used in the CHC process to ensure all aspects remain relevant and aligned to the national framework. Consideration should be given to having a single document within the Health Board that signposts users to the relevant guidance such as the framework, the FCP, and to the relevant forms that need completing. Management should also provide refresher training to relevant staff within directorates and extending training to local authority counterparts, to ensure that staff are fully aware of any revisions to the framework and fully understand their responsibilities for the aspects of the process that they are responsible for.	Medium	Welsh Government are in the process of finalising the revised CHC Framework for early 2019. Cwm Taf UHB plan to review all documentation in the line with the new CHC Framework to ensure consistence of application and prevent duplication. A joint training programme between health and social care will be an essential element of embedding the new framework.	Director of Nursing	Lead Nurse for CHC and NHS Funded Nursing Care	01/07/2019	01/10/2019 This should be within three months of implementation of the new framework (due to be published on July 2019). April 2021 July 2021		In progress	May 2021 Further Update - No change in position - Due to Covid 19 the Welsh Government has delayed the publication of this document until Summer 2021. March 2021 Update: Further update - Due to Covid 19 the Welsh Government has delayed the publication of this document until Summer 2021.	March 2019 update - Awaiting publication of new Framework in order to draft policy and organise training programme. March 2020 Update - Welsh Government has confirmed this week that the launch of the new Continuing Healthcare Framework will be delayed from 1 April 2020 until later in the year. November 2020 Update - We are unable to update our paperwork in line with the new CHC Framework until it is launched. We have not been provided with a date from WG as to when this will happen. January 2021-Update: The change required to update procedure documents and training plan used for our internals CHC process is integral to/ dependent on the new Welsh Government (WG) Framework which at the time of audit was planned for launch but this been delayed on at least 2 occasions. Recent, WG feedback before Christmas was the launch of the framework was further delayed and that they wish to revisit aspect of the policy and there would be further delay until Spring of 2021. We are therefore unable to action this one remaining action from the IA outcomes as WG are key to releasing the Framework; as soon as the Framework is released the revised assessment process will be implemented across CTM UHB however, we will continue to follow the current CTM UHB assessment process which is in line with the current WG Framework until the new framework from WG has been released for implementation.. We recognise that this is not a sustainable response to an action which is well over due for completion however, we have been awaiting WG release of the Framework for over 18 months; we will be expecting an update at the next CHC Leads Meeting on 09.02.21 which includes Welsh Government Membership. This would be an All Wales position. March 2021 Update: Further update - Due to Covid 19 the Welsh Government has delayed the publication of this document until Summer 2021.
IT Systems (March 2019)													
IT 01	Feb-19	Reasonable	The organisation should develop an overarching BCP / DR process. This should consider all the systems and use a business impact analysis to prioritise the systems for recovery. The business (Directorates / Departments) should be involved in the process and should be consulted in order to define appropriate RTO / RPOs.	Medium	The organisation will look to develop an overall BCP/DR plan for ICT services. This would require senior management within ICT and the Civil Contingencies Manager to drive this with the co-operation of the various stakeholders within the Health Board. This should be overseen by the Digital Strategy Group. July 2019 Update: Quotes for two suppliers were soliicited and the lower cost supplier has recently been retained to assist with this activity. A detialed plan will be forthcoming once the supplier is on site. We currently estimate to complete this action in October.	Director of Planning & Performance	Assistant Director of ICT	Apr-19	March 2020 December 2020 July 2021		In progress	May 2021 - the member of the Cyber Security team responsible for this work has not been available for over a month which has lead to no progress being made. The member of staff is set to return in the second week of May 2021.	October 2019 Update - Senior management are in discussions around BCP/DR plans relating to infrastructure and ICT service affecting systems. Incident process flow diagrams are being drafted to provide visibility on the work flow when an incident occurs. This will be reviewed and completed in readiness for DHSSG. June 2020 Update - No Further Progress - Revised completion date of December 2020. August 2020 Update: Distaster Recovery plans have been created for infrastructure services such as DHCP services, on site mail exchnage services and file storage. Initial work has commenced between ICT governance and the Head of Systems to address clinical systems planning. A template has been produced and is to be agreed for all DR plans. The new Cito system has produced a comprehensive DR and BC plans. November 2020 Update - No further progress made since the August update. January 2021 - Progress made in terms of getting individual system recovery plans produced, DHCP, Hyper-V, CITO, all underway or complete. No Overarchign plan as yet,and BIA to be defined in readiness for NISD giving us which order the applications would need to be recovered in March 2021 - Ongoing. Documents for File services, Kaspersky and Solarwinds now also complete with overarching document started. Regular meetings booked for various technology applications

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IT 02	Feb-19	Reasonable	As part of the review process for DR plans, the identified weaknesses should be addressed, with up to date configurations included, along with all relevant contact names and numbers. The plans should also consider the RTO / RPO needed by the user departments and instructions should be complete. Hard copies of the plans should be stored so they are accessible in the event of network loss.	Medium	Management Respponse: ICT will address the identified weaknesses including contact details and the availability of hardcopy. In addition, ICT will consult with the department regarding their RTO / RPO requirements which will be factored into the updated DR plans.	Director of Planning & Performance	Assistant Director of ICT	Apr-19	January 2020 December 2020 December 2021		In progress	May 2021 - Although the member of the Cyber Security team has not been available (as stated in IT01), progress has been made on infrastructure systems. A meeting has taken place with Systems Managers responsible for the Pathology system and progress is being made in this area.	July 2019 Update: This will be part of the review process in Finding 1. October 2019 update - Senior management are reviewing contact names and numbers so they are located on hard copy and digital copy in the event of a major incident. Departments are being communicated with Civil Contingency in terms of user based advise and training in the event of their own DR plans in accordance to ICT service delivery. June 2020 Update - No further progress - revised completion date of December 2020. August 2020 Update - work is progressing as per response for IT01. November 2020 Update - No further progress made since the August update. January 2021 - Weaknesses are being noted and also addressed as we find them during this process. As an example, we've recently found DHCP service didnt have certain IP Ranges available in High Availability, so changes have been been raised to rectify. Instead of Hard Copies, our plan is to host on Secure Data Vault which we would use in event of DR. March 2021 - Further issues found during production of solarwinds DR document. A number of devices missing from Solarwinds, now added and monitoring enabled for them. SPOF also identified.
IT 03	Feb-19	Reasonable	As part of the process for reviewing IT DR plans, contact should be made with departments to ask them to establish their required RTO (the time for which they could acceptably work without the IT service being considered). This process should then push departments into developing their own plans for service provision without IT. The plans should consider varying scenarios covering lengths of outage. e.g. 1hr, 4hr, 1day etc. and also the different aspects of IT e.g. network loss, system loss etc.	Medium	Management Response: The Civil Contingencies Manager to review the BC plans within each Department and put mitigations in place as required, addressing the varying scenarios as recommended.	Director of Planning & Performance	Assistant Director of ICT	Apr-19	April 2020 December 2021		In progress	May 2021 - no progress has been carried out on this recommendation.	July 2019 Update: ICT, NWIS and the Civil Contingencies Manager ran a half day major incident scenario on 24 June. NWIS are going to provide feedback on the our response which we will use to update the DR plans. Engagement with departments will start in September. Note that the recent loss of a national datacentre has also tested our resilience and the learning from this event will be included in the revised DR plans. October 2019 update - Civil Contingencies Manager has advised that he has asked all Directorates to produce their ICT recovery plans with some Directorates asking for further advice. No completed plans have been received to date. ICT are working with Civil Contingency on meeting with departments to undertake an exercise around their DR plans and to raise awareness on what services ICT deliver in the event of a disaster. June 2020 Update - Due to the current COVID-19 outbreak focus has been placed elsewhere. Within the Datacentres ICT have now had implemented a resilient third room based at PCH to provide resilience for major systems. THis is at the PCH Switchroom which although is on the ground floor at PCH it is in a different fire zone to the main datacentre at PCH. Revised completion date of December 2020. August 2020 Update - Work is progressing as described in IT01. November 2020 Update - No further progress made since the August 2020 update. January 2021 - This is being included in each systems DR plan, and will be collated once we have a list list. March 2021 - no further update
Mandatory Training (March 2019)													

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MT 02	Feb-19	Reasonable	Assurances should be sought that individuals working on behalf of the Health Board, but that are not direct employees, are participating in mandatory training relevant to the role that they are providing. A means of monitoring the training compliance of such staff groups should be put in place. An action plan should be developed in relation to bank staff that includes cleansing the data in ESR and establishing a process to ensure this group of staff participate in training. Monitoring of compliance rates should be undertaken.	High	For agency workers, the UHB's providers manage compliance as part of their contractual obligations. To ensure the UHB is sighted on compliance, at the point of candidate submission the agency is required to submit a number of personnel documents, including a mandatory training certificate. Candidates' documents are reviewed upon presentation. Any gaps in compliance are identified, discussed with the booking department and a risk assessment and a waiver form completed if the level of risk is deemed to be acceptable. For Bank Staff, an action plan is being developed to resolve identified issues, which includes:- • Arrange ESR accounts for all bank workers to access e-learning modules. • Validate and cleansing the staff bank register (commenced). • Validate ESR training records for existing bank staff. Issue of remuneration to be considered as part of this work. • Consider an agreed penalty for non-compliance (e.g. restriction from duties, possible de-registration in line with All Wales Terms of Engagement. • L&D CSTF Strategy to include Bank workers March 2019 progress to date- the ability to receive paper payslips ceased in January 2019. All new starters are immediately set up with NADEX accounts. Validation of the e-system has been completed 360 accounts closed. A Validation of the paper files to be undertaken – due to start mid-March. Bank staff have been contacted to provide evidence of training undertaken outside of CTUHB – this is being received and will be uploaded onto a data load for ESR SBAR is being developed in readiness for Exec catch up for consideration/discussion and approval	Director for People	Learning & Development Manager	Jan-20	January 2020 March 2021 July 2021		In progress	May 2021 - A paper was submitted to the People & Culture Committee citing a series of recommendations of how compliance might be improved. Recommendations were approved this month and I am in the process of setting up a Compliance Steering group and examining how recommendations can be implemented.	October 2019 update - see above June 2020 Update - See above July 2020 Update - see above. December 2020 UPDATE: This work has not progressed due to change of senior leadership in the L&D team and other pressures within the team. JANUARY 2021 UPDATE: no update available. APRIL 2021: New senior leadership now in place within the L&D team - this specific action to be reviewed to ensure a practical solution, taking into account training already received by bank staff as part of induction and standard training. Actions to be completed by July 2021.
Patient Experience (April 2019) Reasonable Assurance													
PE 03	Apr-19	Reasonable	A more detailed action plan should be developed to support the achievement of the actions outlined under each of the six ambitions. This should include responsible officers and timescales for completion. This will allow easier monitoring of the actions over the life of the Patient Experience Plan.	Medium	The patient experience plan is being revised and will include a detailed implementation plan displaying timescales and leads.	Director of Nursing	Assistant Director of Nursing & Peoples Experience	Jun-19	September 2020 March 2021 September 2021		In progress	May 2021 Update Due to the changes in ILG structures and the governance teams together with the transisition of PTR over to Corporate Governance during the summer of 2021. The Patient Experience Plan will be reviewed once this transisition has occured and in conjunction with Engagement and communication leads to create a People's Engagement Strategy.	July 2020 Update - see above. November 2020 Update - Due to the changes in structure and the governance teams now being embedded here, a new Patient Experience Plan will need to be pulled together in the new year. January 2021 Update - The Patient Experience Plan will be reviewed in March 21 and if required, updated March 2021 Update - The HB is scoping a joint People's Experience and communication Strategy. This will be joint piece of work with the Head of People's Experience, Director of Corporate Governance, and Assistant Director of Communications and Engagement
Risk Management (June 2018)													
RM 03 Follow up	Apr-19		Updated Recommendation - The Ophthalmology risk register should be reviewed and updated. A review of the updated risk register should be a standing agenda item for ENT Heads of Service meetings.	Medium	Updated Management Response - A review of all Directorates Risk Registers has been planned which will capture ophthalmology service. Chris Beadle will lead the work from the Datix system and will work with the Head and Neck Directorate the Assistant Director.	Director of Operations		Jul-19	September 2020 March 2021 June 2021		Completed	May 2021. The Ophthalmology Directorate is no longer within the H&N Directorate (which no longer exists). The Ophthalmology Service is now subsumed into the Surgical CSG within Bridgend ILG where it is subject to scrutiny and risks are included in the appropriate register. Further review in June 2021 to ensure that this has happened successfully.	31/7/20 The five health board wide opthalmolgy risks are currently sat on a risk register that has not been allocated to ILGs. The appropriate allocation and urgent review of these risks will have been completed by 14/8/20 and moving forward will be reviewed as part of the ILG Q&S meetings. 31/7/20 New FUNB risk opened 17/9/19 which is reviewed regularly and updated as the opthalmology FUNB work progresses. 31/7/20 Move to ILG structure and COVID. January 2021 - the Ophthalmology Directorate is moving to the Bridgend ILG and further work will be undertaken when this is transfer is complete - in parallel with work already underway. Next report will ne in March 2021. March 2021 Update - Issues within Ophthalmology have been ongoing for some time. Service now hosted by the Bridgend ILG following a transfer from RTE. Extensive involvement from Executive – Royal College Review planned and (as reported in ILG / COO Performance Meeting on 24 Feb 2021) new hosts scoping situation.
Mobile Phones (May 2019) Reasonable Assurance													

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MP 01	May-19	Reasonable	The Health Board should introduce a formal policy and procedure that outlines the organisational approach to, and management of, Health Board provided mobile phones.	Medium	Management Response: The Health Board accepts that a policy is needed. ICT will produce the policy, with reference to, and superceding, existing controls and procedures that are in place. July 2019 Update: The draft policy has been produced and will be reviewed and approved at the July DSSG meeting. From there it will be sent to executive catch up for approval.	Director of Planning & Performance	Assistant Director of ICT	Jun-19	July 2019 April 2021 August 2021		In progress	May 2021 - The tender document has been released and is aiming for a go live date of 1st Aug 2021	August 2019: Policy was approved at DSSG From there it will be sent to executive catch up for approval. - still pending - Sept 2019 June 2020 Update - No updates received, however, will be reviewed again in line with the new mobile phone contract that is being prepared for tender. July 2020 Mobile signal survey undertaken in collaboration wth looking at the suppliers and how we improve the mobile contract to provide a better service. August 2020 Update - Coverage review underway, and first draft of mobile phone contract released. November 2020 - ICT ITT Specification completed and passed to procurement. Review of survey completed with Vodafone who have agreed to implement changes to try and improve levels of service. Aiming for completion and migration to tender winner before April 2021. January 2021 - Tender document final changes being made from comments recieved on last draft. Due to be released within the next two weeks. March 2021 - Tender document completed and with Procurement.
MP 02	May-19	Reasonable	Documentation should be stored electronically to allow for easy referral to forms if necessary. This would allow for more historical forms to be accessed easily.	Medium	Management Response: The Health Board has recently procured an electronic document management system for the scanning and storage of medical records. This system can be used for administrative documents as well. However, this is currently outside the scope of the project as funded in the business case (December 2018). ICT will write a proposal for expanding the scope of the project to include corporate documents. July 2019 Update: A project manager has been allocated to this task. Scoping of the activity is now underway and a project brief will be tabled at the September Digital Strategy Steering Group.	Director of Planning & Performance	Assistant Director of ICT	Jul-19	September 2019 February 2021 April 2021		In progress	May 2021 - DPN system has gone live further discussions are required to define the process.	August 2019 - Project Brief drawn up and circulated to the SRO for agreement. Once finalised it will be discussed at the Project Portfolio Management Board. June 2020 Update - Delays to the DPN project mean that there has been no progress in scannig the documentation. This and other scanning projects are currently on hold. July 2020 Project is progressing looking at the 2 issues of preformance and scanning before UAT commences. August 2020 Update: Position remains the same as June 2020. November 2020 Update - System currently in testing and providing positive responses. Desktop equipment for end users also currently being deployed approximatley 80% complete. January 2021 - Project aims to go live in Feb 2021. All equipment purchased for the project currently at 97% deployed. March 2021 - Project now aims to go live Mid March 2021. All equipment purchased - deployment now at 99% completed.
Directorate Review Surgery Management Arrangements (July 19) - Reasonable Assurance													
SMA 06	Jul-19	Reasonable	Management should work with consultants to understand what the barriers are to ensuring that job plans are agreed in good time. Actions from this exercise should be implemented to improve job plan sign-off. Management should work with consultants to ensure that job plans are discussed and agreed by all relevant parties ahead of the job planning period. Advice should be sought from other directorates where job plans are completed in a timely manner and a forward work plan should be developed to ensure planning takes place in a timely manner and the CBM should continue to monitor the ongoing status of job plans within the directorate.	High	A plan to undertake consultant job plans that are out of compliance has been developed and this will be monitored through CBM. The major barrier to undertake consultant job plans is Directorate Manager and Clinical Director capacity. The COO has recently agreed an interim Deputy Directorate Manager to increase management capacity in the Directorate.	Director of Operations	Directorate Manager	Ongoing	February 2021 June 2021 July 2021		In progress	May 2021. The CSG now has a process in place of reviewing job plans and this will continue to be a focus in the coming months. A further update will be available in July 2021 and the position is monitored via the CSG Reviews with the senior RTE ILG Team. It remains a challenge given recent events and issues with the Allocate System need to be worked through.	October 2019 update - Consultant job plans ongoing. Interim deputy directorate manager not in post and directorate capacity remains problematic. June 2020 Update - The job plans are ongoing, further progress was made prior to COVID and work will also be undertaken to reflect the changes in responsibility as the result of the ILG implementation. Progress is dependant on implementing a directorate management structure in the RE ILG Surgical and Anaesthetic Directorate. July 2020 Update - Improvements being made and plans being updated to reflect the ILG structure. November 2020 Update The Clinical Service Group is challenging in terms of size and the number of senior staff to manage the process, however the Manager is working on a timetable to manage the Job Plans. An update will be provided in February 2021. January 2021 Update - The focus required by managing covid 19 has meant that there has not been as much management focus as the Directorate would have chosen. However, job plans are being undertaken as a routine matter in the work of the Directorate and as planned an update will be provided in February 2021. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. Any urgent job planning matters that cannot wait are managed through the Service Group by the General Manager and the Clinical Director on an ad hoc basis as needed. March 2021 Update - As a result of the lack of a Deputy SGM (since at least October 2019) this work has not progressed as fast as would have been liked. The SGM has instigated a process to speed up the process of carrying out job planning, any urgent matters are managed by the SGM and the Clinical Director. The following will be available by the end of April 2021: ☐ A plan to progress ☐ Numbers of consultants seen and job plans completed
Directorate Review Radiology Management Arrangements (July 19) - Reasonable Assurance													

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RMA 02	Jul-19	Reasonable	All Radiology specific policies and procedures should be documented in a central record and assigned an 'owner' responsible for ensuring their assigned policies and procedures are maintained up to date. All directorate specific policies and procedures should be made available to all directorate staff via SharePoint.	Medium	Currently moving forward with a new SharePoint site for Radiology – linking with Karl Carpenter (Digital Services Manager) and maintenance of this will be part of the remit of a Superintendent Radiographer post currently being advertised within the Health Board.	Director of Operations	Directorate Manager	Dec-19	October 2020 March 2021 June 2021 August 2021		In progress	May 2021 Update - A test site was set up in March 2020 and the process of reviewing all policies started in June 2020 led by Dr Ally Yates. The appointment of the Head of Radiography post will take place imminently and this will aid implementation - this post is going out for advertisement in July 21. A plan outlining expected completion dates will be worked on by the meeting in June 2021. Covid-19 has meant that this process has lost momentum.	March 2020 Update - Test site created by E-Business team. Awaiting further direction from Directorate. July 2020 Update - Work continues led by Dr Ally Yates, Consultant Radiologist to review all policies and procedures. Radiology has its own 'policy for making policies' based on the Health Board version. As policies are being renewed they are being put in to the new format and agreed although formal governance meetings in Radiology have drifted during Covid. With regard to the Sharepoint site a quick dummy site with some new features was developed but no further progress has been made. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - A test site was set up in March 2020 and the process of reviewing all policies started in June 2020 led by Dr Ally Yates. The appointment of the Head of Radiography post will take place imminently and this will aid implementation. A plan outlining expected completion dates will be worked on by the meeting in June 2021. Covid-19 has meant that this process has lost momentum.
RMA 05	Jul-19	Reasonable	1. Suitable arrangements to cover the Head of Radiology role should be put in place as a matter of urgency. 2. Senior management posts should be included in future succession / workforce plans.	High	1. Agree the previous Head of Radiography has gone on a 2 year secondment. A new Head of Radiography needs to be appointed, this will done via a HR process as part of restructuring required for the new Cwm Taf Morgannwg UHB. 2. Agreed the Quality Lead Role for Radiology is included in our IMTP investment as our number one priority.	Director of Operations	Directorate Manager	Sep-19	October 2020 March 2021 August 2021		Part Completed	May 2021 Update - Clinical medical site leads are now in place and the recruitment for the Head of Radiography position which will replace the superintendent positions and work across all CTM will commence in the next month.	Quality Manager Role approved substantively. Still no progress with the Head of Radiography role due to organisational changes to ILG model. July 2020 update - The 'Head of Radiology' is the Professional Head (a Radiographer) rather than the Directorate/General Manager. We still do not have a formally appointed professional head for Radiology although Paul Johnston has continued to undertake the role. The Quality lead role was approved and advertised with no suitable applicants. It remains a priority but is on hold for discussion regarding management structures with the newly appointed General Manager. November 2020 Update - Point 2 - Reviews around the structure of the senior management and clinical leaders within the CSS CSG took place with the ILG directors in the last two weeks and the proposal is being costing and worked up for agreement. One off funding for an external management consultant to come and look at the workforce structure within pathology has been agreed for 2020/21 and this will be sourced in the next month. The intention of this piece of work is to identify what the structure of pathology needs to look like to be realistic and effective. This piece of work may require some careful mediation and support from WOD is being sourced. November 2020 Update Point 1 After a recent round of recruitment into the ILG, a Clinical Director for Radiology has now been confirmed across CTWUHB. A Clinical Service Group Manager for Clinical Support Services has also recently been recruited and supports the group from a managerial perspective. Agreement has just been reached within the ILG to recruit to a HCP Head of Radiology in the next couple of months and is just going through the process of JD, Finance agreement and selection processes. It is anticipated that this post will be an internal only appointment and is in relation to the Senior Superintendent positions January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus -

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RMA 09	Jul-19	Reasonable	The Directorate should ensure that all staff are provided with the opportunity to undertake their mandatory training. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for noncompliance with a view to providing support where necessary.	Medium	Agree with the findings however would point out that training allocated to staff on ESR has been done poorly and with no consultation with the Directorate. Directorate is in close consultation with Learning & Development but progress is very slow from L&D.	Director of Operations	Directorate Manager	Dec-19	October 2020 March 2021 August 2021		In progress	May 2021 Update - Mandatory training continues to be reported however learning subjects on ESR are still allocated poorly. Site leads have now been asked to put together plans for ensuring that staff are able to access stat man training wihtin a reasonable timeframe. Plans are expected to be in place by 1 June Current workforce gaps due to covid and shielding have made it difficult to release staff to carry out training. Where it is possible, staff are being supported to do so and this will be extended now.	L&D are still working on this as they are aware of the issue not just in Radiology. July 2020 Update - Mandatory training continues to be reported however learning subjects on ESR are still allocated poorly. This has been raised on a number of occasions as it leads to incorrect statistics regarding the percentages for competency. Most recently raised at our clinical meeting and Workforce taking forward with learning and development. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. March 2021 Update - Mandatory training continues to be reported however learning subjects on ESR are still allocated poorly. This has been raised on a number of occasions as it leads to incorrect statistics regarding the percentages for competency. Most recently raised at our clinical meeting and Workforce taking forward with learning and development. The issue is being discussed with Business Partners and a plan is being developed – it will be available at the next Audit Meeting Current workforce gaps due to covid and shielding have made it difficult to release staff to carry out training. Where it is possible, staff are being supported to do so.
Data Quality Patient Pathway Appointment Process (October 19) - Limited Assurance FOLLOW UP AUDIT UNDERTAKEN IN JANUARY 2021													
DQ 01	Oct-19	Limited	1. Directorate Managers need to: ☐ Remind consultant, medical and nursing staff of the need to complete outcome forms for all patients seen. ☐ Remind outpatient receptionists of the importance of inputting outcome forms on WPAS in a timely manner. ☐ Remind Medical Secretaries to check that outcomes that have been input on WPAS align to outcomes as per dictated letters. Where necessary additional training should be requested to ensure that all staff are aware of their responsibilities in completing the above steps correctly. 2. Management should engage with the two directorates where the electronic outcome form was trialled to understand why it has been adopted in one area and not in the other. Following the conclusion of this engagement the Health Board should consider trialling the electronic outcome forms within all Directorates. 3. Consideration should be given as to how data can be captured to allow the calculation and monitoring of the proportion of patients whose outcome is not recorded on WPAS. **Updated Recommendation - 1. Clinical Service Group Managers need to:** **☐ Remind consultant, medical and nursing staff of the need to complete outcome forms for all patients seen.** **☐ Remind outpatient receptionists of the importance of inputting outcome forms on WPAS in a timely manner.** **☐ Remind Medical Secretaries to check that outcomes that have been input on WPAS align to outcomes as per dictated letters.** **All staff need to be made fully aware of the implications of not recording the outcome**	High	We fully agree with all the recommendations and will incorporate this into our action plan. We intend to secure additional resource to assist in the monitoring and implementation of this action plan. A forum will be set up to oversee this work stream and detailed action plan. A process of 'cashing up' at the end of every clinic is required to ensure clinic and administration staff have processed the patients using the outcome form and WPAS. This process needs to include the initiation of diagnostic tests and request forms being processed to cut down on 'dead time' waits for diagnostics. This process needs to be mandated and managed by the clinic manager. Temporary administration and nursing staff need to undertake mandatory training in cashing up clinics. The Assistant Director of Scheduled Care together with the Assistant Director of Performance and Information will engage with the two directorates where the electronic outcome form was trialled to understand why it has been adopted in one area and not in the other. Following the conclusion of this engagement the Health Board will consider trialling the electronic outcome forms within all Directorates. An appointment with no outcome registered report needs to be circulated in order that administration managers can act on patients who have no outcome, validating the patient's position on the pathway. All staff need to understand the implications of failure to comply. Weekly reports need to be circulated to services including consultants with non-compliance addressed by relevant professional leads. **Updated Management Response - These recommendations are accepted, though the ownership at ILG level will be through the Hospital Service Managers.**	Director of Operations	ILG Acute Service Managers/Assistant Director of Performance & Information	Mar-20	Feb-21		In progress	May 2021 Update - Operational pressures have meant that an update has not been possible this month – a full update will be available at the next meeting. Nothing further to report this month.	December 2020 Update - There has been limited progress in taking action to address the previous recommendations. The onset of Covid-19 clearly impacted on the UHB's ability to deliver elective activity, as it concentrated all its efforts in responding to the pandemic. As a consequence, the UHB lost the momentum it had built up through the establishment of a Planned Patient Flow Project to take forward both the recommendations of the Internal Audit report, as well as the those of the Delivery Unit report arising from their supportive intervention on waiting list management. As has been rightly pointed out by our Internal Audit colleagues, the PID did not make reference explicitly to two of the actions from their report (Findings 4 & 5) and whilst the PPF Project may not have been the right forum for aspects of Finding 4 (temporary secretaries), it should have made explicit reference to the action, especially given the focus on training. Finding 5 (watch list functionality) is not something that the UHB can amend and whilst we were seeking a response from NWIS regarding what might be feasible and over what timescale (current thinking is that this may well not be technically feasible), it is not documented within the PID as it should. IA colleagues have noted that a number of changes have occurred within the Health Board, as a result of turnover and ownership of the agreed actions within the report has not been clearly transferred to individuals now responsible for this area, which is accepted. My WPAS Team are still sending out regular reports to relevant departments requesting errors to be rectified and whilst the volume of errors reduced, this was linked to reduced activity during Covid-19, as opposed to any improvement, as noted by IA colleagues. We have not been able to focus on this over the last ten months and now have to restart our work through the new

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DQ 02	October 2019	Limited	1. Directorate Managers and their teams should review the report of patients recorded as being on a closed pathway to ensure that they are on the correct pathway. Day-case and inpatients should be moved back to an open pathway so that they receive the required treatment on a timely basis. 2. Analysis should be undertaken of the cases where the pathway has been incorrectly closed to identify if they are common to one directorate, department or person. Where necessary, further investigation should be undertaken to why these errors are routinely occurring and further training provided. 3. Consideration should be given to escalating the incorrectly closed pathway reports to ensure Service Group Managers and more senior staff within the Health Board are made aware of the ongoing issue. **UPDATED RECOMMENDATION - We have re-raised our original recommendations:** **1. Within each of the Directorates/ Clinical Service Groups, analysis should be undertaken of the cases where the pathway has been incorrectly closed to identify if they are common to one department or person. Further training should be provided within the respective areas.** **2. The incorrectly closed pathway reports should be escalated to ensure that Service Group Managers and more senior staff within the Health Board are made aware of the ongoing issue.**	High	We are fully in agreement with the recommendations and will incorporate this into the action plan response (see above). Recommend clinic outcome letters are an opportunity to validate patient outcomes, a SOP will detail the actions to be taken to achieve this. Where staff are unable to achieve the required standards, a performance monitoring process will be instigated. Agree there is a need for a regular monitoring report to be tabled at Directorate meetings for improvement purposes. **UPDATED MANAGEMENT RESPONSE - We agree with the recommendations, noting that the draft Data Quality** **Assurance Framework and the additional training material developed offer an opportunity to ensure staff are accountable for their actions and this will need to be reinforced through the new operating model. The Performance & Information Directorate will regularly carry out analyses to target additional training towards specific Directorates and/or individuals and escalate concerns to the ILG Hospital Service Managers. This will commence in the new year, with a regular process in place by the end of January 2021.** **The same risk regarding two instances of core operational systems having to be used by all ILGs applies.**	Director of Operations	ILG Acute Service Managers/Assistant Director of Performance & Information	Mar-20	Jan-21		In progress	May 2021 - nothing further to report this month.	December 2020 Update - See above response. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months.
DQ 03	Oct-19	Limited	Directorate Managers need to ensure that Medical Secretary training is consistently applied including completion of the Referral to Treatment test. Refresher training should be provided on a regular basis in line with PDR requirements and targeted to those employees who are identified as having a higher numbers of input errors than expected. Where problems remain, consideration should be given to applying the appropriate Workforce and OD policy to manage the situation. **UPDATED RECOMMENDATION - The performance monitoring tool suggested by management at the time of our original audit should be developed as a means to identifying areas that need focused intervention.** **Clinical Service Group managers should request WPAS team training for those areas or individuals identified as having a higher numbers of input errors than**	Medium	A performance monitoring tool will be developed to identify areas of focusedintervention with direct performance monitoring for the Directorate teams. **UPDATED MANAGEMENT RESPONSE - The updated recommendations are accepted and as per the previous recommendation, will be addressed through a performance management process initiated through the Performance & Information Directorate.** **The same risk regarding two instances of core operational systems having to be used by all ILGs applies.**	Director of Operations	ILG Acute Service Managers/Assistant Director of Performance & Information	Mar-20	Feb-21		In progress	May 2021 Update - Nothing further to report this month,	December 2020 Update - See above response. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months.
DQ 04	Oct-19	Limited	Service General Managers together with Directorate Managers should consider reviewing the process for using temporary Secretaries within the Health Board to ensure that all receive WPAS training ahead of commencing in a role. **UPDATED RECOMMENDATION - Management should produce a risk assessment to determine the feasibility of Temporary Secretaries assisting in managing Waiting List (WL) data.**	Medium	Temporary secretaries should not be used to manage Waiting List (WL) data input unless fully trained and long term temps. We will carry out a risk assessment to determine the feasibility of this followed by agreed implementation when feasible. These personnel should be used for letter backlogs and typing. Administration managers must ensure staff are fully trained. **UPDATED MANAGEMENT RESPONSE - ILGs have a responsibility to make temporary secretaries known to the WPAS** **team once employed and are not to be given access to WPAS for pathway management until such time as they have been trained.** **The same risk regarding two instances of core operational systems having to be used by all ILGs applies, arguably though a greater challenge for temporary staff supporting clinical Directorates.**	Director of Operations	ILG Acute Service Managers/ Clinical Service General Managers	Mar-20	February 2021 March 2021		In progress	May 2021 - nothing further to report this month.	December 2020 Update - See above response. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months.

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DQ 05	October 2019	Limited	The process for monitoring patients who are awaiting diagnostic investigation results should be reviewed to ensure all Medical Secretaries are utilising a standard approach that is user friendly and does not restrict access, thus allowing visibility to other staff members. **UPDATED RECOMMENDATION - A review of the watch list process should be undertaken and following that guidance produced that ensures all Medical Secretaries are using a standard approach that is user friendly and does not restrict access, allowing visibility to other staff members.**	Medium	A review of this process and guidance will be carried out, potentially with external support to assist and add pace to the review. Consistent guidance and emphasis on use will then be provided. Management teams will ensure that locally held spreadsheets are not replacing the mandatory addition to the formally report QL. Request internal audit re-assessment of this in next year's audit plan. **UPDATED MANAGEMENT RESPONSE - A technical assessment on the potential upgrading of watch list functionality to facilitate performance management of Medical Secretaries will be commissioned.**	Director of Operations	Assistant Director of Performance & Information/ Assistant Director ICT	March/April/May 2020	February 2021 March 2021 August 2021		In progress	May 2021 Update - Nothing further to report this month.	December 2020 Update - See above response January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months.
Consultant Job Planning (October 19) - Limited Assurance													
CJP 01	October 2019	Limited	1. The Health Board should develop an approach to ensure that all consultants and SAS doctors have an up to date job plan that is reviewed on an annual basis. In developing their approach, the Health Board should consult with consultants, SAS doctors and their line managers to identify the barriers that are currently preventing the timely completion and sign-off of job plans. 2. The Health Board should ensure that there are sufficient resources available so that job plans follow the 'lock down' process where the job plans are not formally signed-off in good time. The Approach should be consistently applied across all sites.	High	1. Job planning does not necessarily require a face to face review if the plan agreed the previous year remains satisfactory. That said personal and organisational objectives need to be agreed for the year and can be signed off if non-contentious. 2. Job plan compliance is a standard agenda item at the Clinical Business Meeting (CBM) held with each directorate. The HR business partners are present at the CBMs to understand what if any barriers there are to job planning. The data is also reported through Finance Performance and Workforce Committee via the Board. 3. We acknowledge that there are many job plans which are out of date and /or not signed-off and this will be addressed by either through refreshed directorate training or Medical Director intervention. 4. Likewise, refreshed training is to be rolled out to Princess of Wales to ensure a consistent approach.	Medical Director	Acting Workforce Operational Lead	Mar-20	March 2021 December 2021		In progress	May 2021 Update - there is no further change to the March update	January 2020 Update - Currently there is a gap in training and knowledge of the system in the new areas of CTM. This has started being addressed with training in POW for clinical directors (CD), directorate managers (DM) and assistant directorate managers (ADM) on the 19 December 2019. It has been identified by users of the system, that they feel there is no access to guidance on how to use the system after the training. A standard operating procedure (SOP) will be developed in conjunction with Allocate for users to be able to access when there are questions about how to use the system post training. Allocate have provided a user guide that will be adapted into a CTM specific SOP. There is a need for a spread of responsibility for job planning outside the current CD/DMs tasked with its completion. It is particularly relevant in the areas such as medicine where there is a high amount of medics to job plan for. This is to be supported in the training provided and needs to be factored into each directorates plan on deciding the amount of trained staff needed to have sufficient capacity to meet the demand. July 2020 update - Job planning has been placed on hold for the duration of the Pandemic. We are currently in a situation where very limited job planning activity is being undertaken. This means that compliance is deteriorating. Training was and has been completed in all of the ILGs, though there was very limited engagement even though there was a wide set of staff and medics contacted to let them know the training was being run. An SOP has been developed in conjunction with the guides inside eJP and will be shared with users for comment. The wider spread of responsibility is still desirable, however due to the lack of engagement with the training and the changing structures within the UHB due to the development of the ILGs, it is hard to determine currently who the additional persons involved should be. November 2020 Update - a) The produced job planning compliance report is now distributed via the WOD packs to the ILG management teams monthly. In addition to this, the medic leadership

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CJP 02	Oct-19	Limited	1. The notes section in the Allocate system should be used to record reasons for deviations from the standard Welsh Government consultant's contract and guidance. For example, where there are more or less than 10 weekly sessions in total, or there are more than 3 weekly SPA sessions. 2. A plan should be developed to ensure all PoW consultants and SAS doctors' job plans are reviewed and updated as soon as is practicably possible to align with the new Health Board's objectives. 3. Staff carrying out job plan reviews should ensure that all SPA activity is sufficiently detailed, that Health Board outcomes are linked to IMTP objectives, and that meaningful Service or Directorate outcomes are recorded in all job plans. This may be achieved by providing tailored training to staff responsible for conducting job plan meetings and reviews. 4. Health Board guidance should be provided detailing how breaks should be factored into timetables.	High	1. Clinical sessions which exceed the contractual norm are relevant as determined by the business area, based on clinical requirements. This will also have implications for continuity and safety of clinical care. The additional sessions are also more cost effective for the Health Board as opposed to agency locums. The reasoning behind additional clinical sessions needs to be clear in the job plan. This will be emphasised as part of the updated training package. 2. As soon as the Health Board's operating model and subsequent objectives agreed, all Health Board objectives will need to be revisited through the annual job planning cycle. In the interim, existing job plans for Doctors in PoW will rollover into the next cycle. 3. The appropriate recording of SPA activity and linking to subsequent Health Board outcomes will be highlighted in the reviewed Health Board training material. 4. The Health Board is very clear about the rest break requirements under EWTD. The reason why breaks are not necessarily included is due to the flexibility required for the individual, as all job plans are variable and negotiated in accordance to service need. The requirement to take rest breaks will be further emphasised in the updated job planning training.	Medical Director	Acting Workforce Operational Lead	Nov-19	March 2020 April 2021 May 2021 August 2021		In progress	May 2021 Update: This was due to be approved in collaboration with the LNC in May, unfortunately this did not happen due to further work being felt needed to be undertaken on the document during discussion in the meeting. This has now been rolled over to the next LNC for approval with the amendments in August 2021.	January 2020 Update - Recording of reasons for differences to guideline amounts of direct clinical care and supporting professional activity splits is variable. Differences to guidelines are acceptable and allowed, but training will need to be provided and referenced in the SOP to ensure the reasons for differences are captured in future. There is some historical differences between sites on the split, this will have an agreed approach for all sites from January onwards for new job plans. June 2020 Update - SPA/DCC split guidance – This was developed between medical workforce, Vijay Singh and Sarah Spencer. It is currently awaiting review at the LNC before wider distribution. Due to Covid19 this has stalled due to no LNCs taking place. July 2020 Update - No chnage to the position. September 2020 Update - The Deputy Medical Director and Assistant medical Director revisited the guidance developed by Dr V.Singh. This was matched and referenced against other organisations policies as well as taking royal college guidance into consideration. This has now been brought to final draft in preparation to be taken to the LNC. This will be shared at the next LNC in November before roll out to the UHB. November 2020 Update - a) There has been a delay in full roll out of incorporating all of the Bridgend ILGs job plans into eJP with updated CTM objectives, thus is due to the onset of the pandemic and pausing of job plan reviews with most staff. This will be picked up and moved forwards when business as usual returns to the ILG. b) The operating model for the UHB is now in place and this has been incorporated into the eJP software to match the new structure. c) SPA and DCC guidance has been developed by the AMD for Medical Workforce. This underpins the application of SPA within the job planning process and will be reflected in the notes in eJP. The implementation date should be extended due to complication from the pandemic. It is likely to take an
CJP 03	Oct-19	Limited	Staff conducting job planning meetings and annual review meetings should ensure that all job plans include personal outcomes that are sufficiently detailed and measurable, and in line with personal outcomes and targets agreed as part of the annual review process. Progress against personal outcomes should be monitored and recorded in line with the Health Board's guidance.	High		Medical Director	Acting Workforce Operational Lead	Nov-19	March 2021 December 2021		In progress	May 2021 Update - No further update to provide	January 2020 Update - The report links the need for personal outcomes to be in the Job plans. This is contrary to what the organisation had seen what Job plans are for. There should be a record of clinical outcomes recorded and referenced, but personal outcomes are for the appraisal and validation process rather than job planning. July 2020 - No change, work has stalled around this due to Covid19. November 2020 Update - Guidance is currently being developed by the AMD for Medical Workforce. No extension needed. January 2021 Update - Personal outcomes are part of appraisal and validation process rather than job planning currently. As part of the job planning training, clear personal outcomes will be factored into the process and now recorded in new job plans. The training that has been rolled out across the UHB covered this. The updated SPA/DCC guidance on this is awaiting comment from the LNC. As previously mentioned, the LNC has not met recently due to the pandemic and dates for the next meetings have not been arranged as of yet. The completion date has been revised to December 2021. March 2021 Update - Personal outcomes are part of appraisal and validation process rather than job planning currently. As part of the job planning training, clear personal outcomes will be factored into the process and now recorded in new job plans. The training that has been rolled out across the UHB covered this. The updated guidance on this was shared with the LNC in February 2021 and a number of amendments were suggested. These have been taken on board, worked into the document where appropriate and will be shared with the LNC at the next meeting in April.

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CJP 04	October 2019	Limited	1. An exercise should be undertaken to match the number of sessions from job plans to the payroll for all current consultants and SAS doctors to identify any discrepancies and any potential over or under payments to staff. All discrepancies should be investigated. 2. The current process for updating the payroll with changes to salaries arising from job plan changes should be reviewed to ensure it happens in a timely manner when a plan is signed-off or proxy signed-off. 3. A process should be established for notifying the payroll section of all new job plans and job plan changes for PoW based consultants and SAS doctors. 4. The job planning guidance refers to recording all information in relation to the plan in the e-job plan (Allocate), therefore where plans are created outside of the system, the Allocate system should be updated to reflect this.	High		Medical Director	Acting Workforce Operational Lead	November 2019/April 2019	February 2020 March 2021 May 2021 July 2021		In progress	May 2021 Update: Allocate have subsequently returned to the UHB believing they have found a solution to the different calculation being produced. All the ACT plans are now being re-entered to eJP using this new information. However a paper has been written outlining the cost associated with the difference, if the change suggested does not work to align the job plan sessional calculation.	January 2020 Update - There is a difference between Allocate and manual Anaesthetics, critical care and theatres (ACT) SAS doctor calculations in regards to session amounts. This is due to ACT using a manual calculation for their sessional data, because there is a belief that Allocates software is not producing the correct data in this area. There are discrepancies between some of the data in the organisation in regards to payments. So a whole organisation review will be undertaken to see how wide spread this is by medical workforce to identify the extent of it. June 2020 Update - Discrepancies in payments/job plans – An organisational review was undertaken. Outside of ACT, only 2 Medics had 'incorrect' salary amounts according to their job plans. ACT has discrepancies due to the Allocate software not calculating the sessional allowance for their work rotas correctly. Allocate have been unable to correct this thus far. July 2020 - No change. Allocate still unable to correct. November 2020 - a) The exercise for matching the sessions against payroll is complete and any discrepancies have been rectified. b) Payroll will only now be informed to change pay for staff with completed and up to date job plans on eJP. The salary is then matched to the session data in eJP. No extension needed. January 2021 Update - Allocate have had an initial meeting with Workforce and Anaesthetics, Critical Care & Theatres (ACT) to investigate why there is a difference in the sessional calculations being produced by eJP to the internal systems used by ACT. They are returning with their findings at the end of January and will give a way forwards to solve the problem. The completion date has been revised to March 2021. March 2021 Update - Workforce have met with Allocate and Anaesthetics, Critical Care & Theatres (ACT) to investigate why there is a difference in the sessional calculations being produced by eJP to the internal systems used by ACT.
CJP 05	Oct-19	Limited	1. Directorates should ensure that all 'Additional Duty' hours are authorised in advance of being worked. Authorisation should incorporate confirmation that a check has been carried out to ensure consultants are not already scheduled (according to the job plan) to work during proposed Additional Duty hours. Furthermore, the check should encompass ensuring that working the additional shift does not mean the consultant is then working 'back to back' shifts or cancelling DCC sessions to undertake the shift. 2. A single standard claim form should be used for ADH claims. Any system utilising electronic claim forms should contain the same data and claimant declarations as manual paper claim forms. Claimants should be required to confirm that they have not cancelled planned DCC sessions to undertake ADH.	High	The Health Board are currently reviewing the ADH process with a view to driving all ADH arrangements through an e-system, as part of the development on an internal locum bank model. This model will address each of the recommendations noted.	Medical Director	Acting Workforce Operational Lead	Apr-20	May 2020 September 2021		In progress	May 2021 Update: A paper has been submitted to management board for approval of the approach to gather the information for the rate card. The Medic bank will be launched without a rate card, but the software solution Patchwork in place. What this will allow the Health Board to do, is see in real time what rates are being paid for ADHs in every area. This will then allow the development of a rate card based on that data, that will better justify and evidence why rates have been selected.	January 2020 Update - There has been a check completed this month on ADH payments and amount of ADH being worked in the organisation. This data is being used to harmonise rates across the HB and to develop a bank system. The standardised ADH rate and bank solution will be in place by the new financial year. June 2020 - An ADH rate card has been produced for all specialties and sites. A sign off process has also been produced. This is still manual in nature though. A project team has been setup to introduce the 'electronic' Medic bank, but due to C19 this has stalled. July 2020 Update - A paper has been submitted to the Management board for approval of the Bank project. A result is being awaited from this to move forwards with. Once agreed and in place, the bank adress all outstanding issues. November 2020 Update - a) An electronic solution to ADH shifts being made available is being implemented within the UHB. This begins its initial roll out in the Bridgend ILG the end of November 2020. This will allow for accurate recording, auditing and allocation of ADHs. This will eventually be the only method that ADHs can be worked, so therefore ensuring there is clear visibility of all future ADHs being undertaken within the UHB. No extension needed. January 2021 Update - A revised standardised rate card has been produced in collaboration between medical workforce, finance, the AMD for Medical Workforce and the Medical Director. This is now under review to ensure it fits in with comments received about the last version from the ILGs. A financial control procedure has been produced and approved. Within this is confirmation of a standard rate card development for payment of ADHs. Following publication of the ADH rate card, it was determined that further work was required on it, to review the proposed rates, following extensive feedback from Medical colleagues and the LNC.
Pathology Compliance (January 2020) - Reasonable Assurance													

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PC 01	Jan-20	Reasonable	An inventory of non-capital assets should be developed by Clinical Haematology detailing their assets, which fit under the definition of the inventory as detailed within the FCP. Inventories should be reviewed to ensure that they hold all of the relevant information as laid out in the Health Board's FCP.	Medium	An inventory of non-capital assets will be developed for Clinical Haematology in line with the FCP.	Director of Operations	Directorate Manager	Apr-20	September 2020 March 2021 May 2021 July 2021		In progress	May 2021 Update - This will be picked up as a priority and reported on at the end of June 2021. Service Manager to lead on this, but delayed due to UKAS and nurse manager absence. Will be completed by end Jun 21	June 2020 Update - Not Started: on hold due to COVID-19 pressures, target date has been amended to September 2020. September 2020 Update - The Clinical Haematology services will be repatriated from the WWIC to Ward 15 (PCH) and Tirion Centre (RGH) at the end of September 2020. After a period of settlement we aim to complete this work by the end of October 2020. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. March 2021 Update - This will be picked up as a priority and reported on at the end of April 2021. Service Manager to lead on this
PC 03	Jan-20	Reasonable	Whilst it is appreciated that determining the number of tests that will be required to be provided in a year may not be possible, where services are being provided by the Health Board to other health boards in Wales and income is generated as a consequence, SLA's should be in place and approved in line with the Scheme of Delegation.	Medium	SLA's to be developed for work received in line with scheme of delegation.	Director of Operations	Directorate Manager	Apr-20	September 2020 March 2021 May 2021 August 2021		In progress	May 2021 Update -SLAs are being reviewed and approved via CSGM with clinical input from individual services. UKAS inspection approved work already done on these.	SLA's currently in development with assistance of Quality Team. June 2020 Update - In Progress: Departments that generate income are currently developing SLA's, however this is likely not to be compelted bt April due to other comittments relating to COVID -19. Target date has now been amended to September 2020. September 2020 Update - SLA's with C&V and with Harp funeral directors have recently been scrutinised and reviewed. C & V now signed and Harp Funerals ceased. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. March 2021 Update - This will be picked up as a priority and reported on at the end of April 2021. Service Manager to lead on this
Digitisation (January 2020) - Reasonable Assurance													
DIG 01	Jan-20	Reasonable	The organisation should seek to increase the level of resource into key areas of the project.	High	Work is now under way to fill the vacant training, testing and system supportroles, via a combination of agency and substantive staff. The individual responsible for the 4 work-streams (Project Manager) has a dual role but this is in two consecutive stages; as project manager prior to go-live, becoming Cito Systems Manager on go-live. The substantive roles being recruited now are the Cito system support staff, working to the Cito Systems Manager. Each of the 4 work-streams has a manager, all of whom report to (or work with) the Project Manager. The majority of the project management work will have been completed by go live, therefore the overlap of project management and system management work is not anticipated to continue beyond the short term	Director of Operations	Programme Manager	Dec-19	September 2020 March 2021 May 2021		In progress	March 2021 Update - The band 6 post did not attracted staff of sufficient experience. The decision was made to employ a band 5 for one year to build the e forms and to fund a rebanding of a technical post in infrastructure to cover DPN. The go live is now 18th March due to a delay in NWIS time when they were pulled into a COVID issue that required resolving. An update will be available at the next meeting of the Committee.	July 2020 Update - Shortlisting under way for substantive staff. Go-live decision pending Project Baord August. ECMG approval of revised costs required at August meeting. September 2020 Update Recruitment ongoing for substantive posts; interviews to date have been unsuccessful. Posts revised and interviews are scheduled shortly. External contractors are now funded and will be engaged appropriately before go-live. Project resourced as required. December 2020 Update - 2/12/20. Update:1 Band 4 now in post. Band 6 re-adveertised again; being shortlisted this week. External contractors to be engaged Jan 21 - resourced as required. ILG Clinical and Operational Leads now being engaged, Clinical Assurance Group to be revived. July 2020 Update - Contractors recruited (since terminated). Recruitment commenced - ongoing. Plan for re-engagement of contractors developed, for implementation when we have a confirmed go-live date. July 2020 Update - Covid disruption to project progression. January 2021 Update There has been some progress - though covid has caused significant disruption.
DIG 01	Jan-20	Reasonable	The organisation should seek to increase the level of resource into key areas of the project.	High	Work is now under way to fill the vacant training, testing and system supportroles, via a combination of agency and substantive staff. The individual responsible for the 4 work-streams (Project Manager) has a dual role but this is in two consecutive stages; as project manager prior to go-live, becoming Cito Systems Manager on go-live. The substantive roles being recruited now are the Cito system support staff, working to the Cito Systems Manager. Each of the 4 work-streams has a manager, all of whom report to (or work with) the Project Manager. The majority of the project management work will have been completed by go live, therefore the overlap of project management and system management work is not anticipated to continue beyond the short term	Director of Operations	Programme Manager	Dec-19	01/01/2021 May 2021		In progress	March 2021 Update - The band 6 post did not attracted staff of sufficient experience. The decision was made to employ a band 5 for one year to build the e forms and to fund a rebanding of a technical post in infrastructure to cover DPN. The go live is now 18th March due to a delay in NWIS time when they were pulled into a COVID issue that required resolving. An update will be available at the next meeting of the Committee.	There has been some progress - though covid has caused significant disruption.
DIG 01	Jan-20	Reasonable	The organisation should seek to increase the level of resource into key areas of the project.	High	Clinical Assurance Group – participation by clinical staff remains a challenge, despite attempts to expand this by the Chief Clinical Information Officer and Chief Clinical Nursing Officer. Members who are unable to attend are however sent notes and items under discussion, for information. The new Medical Director is currently being engaged on 16/10/19 and both he and the Chief Operating Officer will be asked to encourage clinical involvement with the project.	Director of Operations	Programme Manager	Oct-19	01/01/2021 May 2021		Completed	May 2021 Update - This is now complete - the go live was achieved as planned and the Board is in place. Focus going forward will be th edevelopment of the eforms and a software developer will be appointed imminently.	March 2021 Update - The band 6 post did not attracted staff of sufficient experience. The decision was made to employ a band 5 for one year to build the e forms and to fund a rebanding of a technical post in infrastructure to cover DPN. The go live is now 18th March due to a delay in NWIS time when they were pulled into a COVID issue that required resolving. An update will be available at the next meeting of the Committee.

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DIG 02	Jan-20	Reasonable	The anticipated go live date should be assessed and restated to an achievable, reasonable date. The project should seek to ensure appropriate resources are provided. Communication should commence, with information on the project being made available to staff on the website.	High	NWIS participation in integration and data migration work is now being provided and this is progressing well. The go-live date has now been re-assessed by the Project Team and Project Board and postponed for two months. The Princess of Wales phase of the project has been deferred for two years, due to clinical concerns about separate ICT systems. This has deferred an element of the project work. These decisions were made with Executive approval (COMPLETED) As outlined above in Finding 1, additional resources are now being sourced for the Project Team, both short-term requirements and substantive staff. As outlined above in Finding 1, communication materials are being developed for imminent publication and dissemination.	Director of Operations	Programme Manager	Oct-19	August 2020 March 2021 April 2021		Completed	May 2021. The project went live as planned. Communication has been maintained via sharepoint and in association with the Communications Team -also mentioned in the CEO blog.	July 2020 Update - Plans in place to progress one technical issues resolved an go-live date confrmed. September 2020 Update - Oct 20 Update - Go-live date currently under review due to ongoing technical issues. Decision to set go-live date expected by early November. Resources secured, as above. December 2020 Update - Go-live date currently under review due to ongoing technical issues. Decision to set go-live date expected by early November. Resources secured, as above. Go live expected Feb 21. Comms work ongoing, to be issued shortly. Website under revision, communication to go ut to Champion Users shortly. July 2020 Update - NWIS support, Comms support achieved. July 2020 Update - Covid Disruption to project progression. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. March 2021 Update - Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. Covid 19 activity has meant that this is not available at present but will be at the next meeting of the Committee.
DIG 04	Jan-20	Reasonable	The DR process for CITO should be formally set out and tested prior to go live.	Medium	The disaster recovery process is automatic. Cito will be run on 2 servers at PCH,for resilience and load balancing. These are located in different areas of the hospital and have dual power supplies. Back-up tapes are transferred frequently to secure, fire-proof storage at a second site (KHHP). If the PCH servers fail, there is an automatic failover to the RGH server. This also has dual power supplies and back-up tapes. This is described in various documents but will, as recommended, be collated into one document and tested.	Director of Operations	Programme Manager	Dec-19	September 2020 March 2021 April 2021		Completed	May 2021. This is now complete. A task and finish group has compleetd this work.	July 2020 Update - Work was ongoing but clinical involvement paused. Re-convene clinical work on business continuity. Complete disaster recovery documentation. July 2020 Update - Covid Disruption. September 2020 Update - Work has progressed and is ongoing to document and test the DR process. December 2020 Update; Business Continuity and DR procedures developed further - out for comments by Project Board. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. March 2021 Update - Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. This has not been possible - an update will be available in April 2021.
IG Arrangements Community & Mental Health (January 2020) - Reasonable Assurance													
IGCMH 01 (a)	Jan-20	Reasonable	The records management strategy and policy should be reviewed and updated accordingly to incorporate changes in legislation, the impact of the boundary change and the future vision for records management within the Health Board. Once reviewed and approved staff should be made aware of the revised policy and strategy.	High	The Health Board needs to review and implement a current records management strategy with a regular review date. There is an Information Governance policy in place which sets out legal obligations. A revised Records Management Strategy and Policy needs to be developed and approved by the ICT & Information Governance Committee being established in January 2020.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk Head of Information Governance	Sep-20	March 2021 July 2021		In progress	Update May 2021: The Records Management Procedure - COMPLETE - Approved at the Management Board on the 19th May 2021. The Records Management Policy is scheduled for approval at the Digital & Data Committee on the 8th July 2021.	October 2020 Update - The September deadline needs to be pushed back to March 2021 as we have not reviewed / updated the records policy during the last few months due to the COVID position. November 2020 Update - In Progress – policy being drafted benchmarking with other Health Boards in Wales to ensure a consistent approach. Review will be led by the Information Governance Team in conjunction with the Health Records team in relation to patient records. The policy will be received at the Information Governance Group in December and will seek approval by the Digital & Data Committee thereafter. March 2021 Update: Records Management Policy currently at consultation stage and comments being sought from Medical Records and Clinical Audit colleagues. Draft will be received at the Information Governance Group in April 2021 to endorse for approval at the following Digital & Data Committee in July 2021.
Medical Equipmant and Devices Follow Up (February 2020) - Reasonable Assurance													

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MED FUP 03	Feb-20	Reasonable	While we understand that currently, the department does not have the resources to undertake a reconciliation of equipment that has been loaned to wards, consideration should be given to undertaking periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system.	Medium	1. Band 2 Equipment library Job Description is now matched – to be uploaded and advertised on TRAC to appoint staff. This will then enable periodic checks between the equipment available in the library and the equipment recorded as being on loan on the system to be undertaken. 2. Continued use of partial RF-ID system to be utilised with confirmation that data connection to RAM 5000 can be completed. 3. SON to be submitted to Capital for increased RF-ID system coverage for RGH (£244.8K), early indication from Capital is that a more detailed business case will be required as roll out to other sites is also required.	Director of Operations	Assistant Director of Facilities	Apr-20	September 2020 April 2021 July 2021		Part Completed	3. May 2021 Update - For phase 1 equipment has arrived but further work is needed for implementation such as addressing wi-fi connectivity issues at POW, addressing new ICT issues with scanning large amounts of equipment in one area via handhelds, mapping locations into the system at PCH, and final installation of oxygen cylinder tracking and bed store equipment at RGH. This work is scheduled to begin in May / June 2021. Due to this the target date has been moved to 31/07/2021. It should be noted that now in place is that any new equipment is now being tagged as part of the RF-ID system and this will continue moving forward. (PJ WG 12/05/2021).	1. April 2020 Update - B2 equipment library post - advertised – undergoing shortlisting. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 2. April 2020 Update - RF-ID –limited area in use – no further work done - however attempting to obtain further funding through technology funds from Welsh government in meanwhile. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 3. April 2020 Update - RF-ID –limited area in use – no further work done - however attempting to obtain further funding through technology funds from Welsh government in meanwhile. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 1. July 2020 Update - Interviews held. Recruitment checks in progress for successful candidiate (WG 02/06/2020). Start date confirmed as 20/07/2020 (WG 16/07/2020). 3. July 2020 Update - Business case to be developed for submitting to Capital/Finance to support phased approach to implementation on each site, with request from Finance to be revenue neutral. (WG 09/06/2020). 3rd draft of business case paper to be finallised with various options and costs for funding (WG 16/07/2020). 3. September 2020 Update - SON submitted to Capital and DOF on 30/07/2020, awaiting prioritisation and decision on funding. WG advised that target date has been amended to reflect this update, date amended to 31/03/2021 (DW 28/08/2020). 2. July 2020 Update - Identified costs in IMTP, some work performed by supplier for COVID equipment tracking for mapping sites. Equipment that is tagged will now update 'Last known location' field on RAM each night in background process if within areas with antennae or by using hand held device. Complete (WG 09/06/2020). 1. Role now in place. Complete (WG 28/08/2020) January 2021 Update - Additional hand-held devices have now been ordered and delivered. Further work is in progress by the supplier to implement the site mapping for the devices to be functional on PCH and POW sites. Further purchase orders are to be submitted for additional works and installation, presentation to be provided at next
Nurse Agency Usage (April 2020) - Reasonable Assurance													
NAU 01	Apr-20	Reasonable	1. Clarity should be provided as to whether the Staff Bank Policy Induction Checklist (Appendix C) should be completed or the more recently revised 'Ward induction checklist for bank and agency workers'. 2. Ward Managers / the Nurse in Charge should be reminded of the importance to complete the induction checklist to ensure that new agency nurses are appropriately orientated and provided with relevant health and safety overview of the ward they are due to work on.	High	Induction check list to be reviewed and agreed by Heads of Nursing. Ward Managers & Senior Nurses to receive updated check list that must be completed for all new Bank and agency nurses. Updated Bank/Agency Nurse Induction Checklist to be included into the revised Staff Bank policy.	Director for People	Head of Corporate Nursing	March 2020/April 2020/August 2020	February 2021 June 2021		In progress	APRIL 2021: Amendments came back via policy infrastructure, which will be incorporated into the policy draft for approval. This will be taken through the Health Board's policy group by Jun-21. Revised implementation date provided.	November 2020 Update - The Bank Policy is being updated during December 2020/Januay 2021. The updated policy will consist of a review and update of all the bank and agency forms. January 2021 update - Policy has been completed and is awaiting review by policy sub groups.
NAU 02	Apr-20	Reasonable	1. The Bank / Agency Nurse Quality Monitoring Form should be reviewed to ensure it is fit for purpose and provides a suitable means for the routine monitoring of the quality of work provided by agency staff. 2. Ward Managers should be reminded of the need to complete the quality monitoring form and returning it to the Bank office as a means of formally evaluating the performance of agency nurses and aiding and informing any future acceptance or rejection of potential agency nurses in the event of query or concern. 3. The Clinical Incident Reporting for Agency Staff flowchart and the Staff Bank Policy should be reviewed to ensure consistent guidance for managing and monitoring issues relating to the quality of	High	Revised Clinical Incident Reporting flowchart to be placed into the Staff Bank Policy. Bank / Agency Nurse Quality Monitoring Form will be reviewed to ensure it is fit for purpose and amendments made for updated policy in August 2020. The cross-referencing of patient experience and agency use data is something that we will look into. In the first instance we will need to see if data in relation to patient experience can be obtained from colleagues in the Health Board and we will look to see if meaningful reports can be produced. In the mean-time we will continue to review specific concerns that have been raised via our routine processes.	Director for People	Head of Corporate Nursing	Aug-20	October 2020 February 2021 June 2021		In progress	APRIL 2021: See above for policy amendments. Remaining recommendations delayed due to the pandemic but will be taken forward in the same timeframe as the policy approval. Revised implementation date provided.	July 2020 Update - The policy will be written in September 2020, which will coincide with the change in recruitment processes for staff bank workers. Roll out and publication of the policy will be completed by end of October 2020. November 2020 Update - The Bank Policy is being updated during December 2020/Januay 2021. The updated policy will consist of a review and update of all the bank and agency forms. July 2020 Update - Due to outbreak of covid-19 and consequent pressure on staff bank to recruit additional bank workers to support exsisting and new HB services has meant a delay in starting this policy. January 2021 Update - No further chnage/update

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NAU 03	Apr-20	Reasonable	1. The Staff Bank Policy should be reviewed and updated as necessary to reflect current practice, process and systems in place within the Health Board. The policy should more explicitly reference the engagement and management of agency nurses as opposed to just focussing on Bank staff. 2. Where other relevant policies exist, such as the Rostering Policy, these should be cross-referenced within the Staff Bank Policy. 3. Where procedures are developed to supplement existing policies, reference should be made to the overarching policy and if necessary, the policy should	Medium	The Staff Bank Policy will require updating to include the Collaborative Bank project which is due to commence in April 2020. The updated version will include appropriate references to the UH Rostering Policy. The updated policy will include: ☐ The updated 'Booking Bank & Agency Nurses - Procedures for Ward Managers' ☐ The new Request for Thornbury Nurses proforma. ☐ The updated e-datix reporting algorithm The following documents will be recirculated to Heads of Nursing. ☐ The updated The updated 'Booking Bank &	Director for People		March 2020/April 2020/August 2020	October 2020 February 2021 June 2021		In progress	APRIL 2021: See above for policy amendments. Remaining recommendations delayed due to the pandemic but will be taken forward in the same timeframe as the policy approval. Revised implementation date provided.	July 2020 Update - The policy will be written in September 2020, which will coincide with the change in recruitment processes for staff bank workers. Roll out and publication of the policy will be completed by end of October 2020. November 2020 Update - The Bank Policy is being updated during December 2020/Januay 2021. The updated policy will consist of a review and update of all the bank and agency forms. July 2020 Update - Due to outbreak of covid-19 and consequent pressure on staff bank to recruit additional bank workers to support exsisting and new HB services has meant a delay in starting this policy. Jan 21 update - Policy has been completed and is awaiting review by policy sub groups.
NAU 04	Apr-20	Reasonable	1. A review of the Temporary Nursing & Midwifery Staffing Decision Checklist (Appendix 5) contained within the Roster Policy should take place to ensure all aspects remain relevant. Consideration should be given if the checklist needs to be completed for every shift filled by an agency employee or if one checklist could be completed covering all agency shifts needed on a week's	Medium	Appendix 5 in the Roster Policy will be replaced with the updated 'Booking Bank & Agency Nurses -Procedures for Ward. Heads of Nursing to ensure the checklist is re-circulated to Ward Managers and Senior Nurses emphasising the importance of the completion of the check list for all new bank and agency nurses to the ward areas/department.	Director for People	Head of Corporate Nursing	April 2020/May 2020	August 2020 February 2021 June 2021		In progress	APRIL 2021: The Rostering Policy has been updated and is currently in the system for approval. A new Rostering Group has been established with Senior Nurses to ensure appropriate and consistent rostering practice across the Health Board. The Rostering Policy will be approved within the same timeframe as the Bank Policy. A revised implementation date has been provided.	Appendix 5 has been sent through to the workforce polict review group for the change to be made to the roster polocu it is in the agenda for the aug meeting. November 2020 Update - The Bank Policy is being updated during December 2020/Januay 2021. The updated policy will consist of a review and update of all the bank and agency forms. Jan 21 update - Policy has been completed and is awaiting review by policy sub groups.
Cyber Security Follow Up (June 2020)													
CSFU 03	Jun-20	Reasonable	**Original Recommendation** - A formal patch management procedure should be developed that sets out the mechanisms for patching / updating all items within the Health Board. **Updated Recommendation** - A formal patching strategy and SOP should be developed for the patching process that sets out the mechanism and processes for this.	Medium	**Original Management Response** - Formal patching strategy is being put in place and will be submitted to Digital Strategy Steering Group (DSSG) in June. **Updated Management Response** - A formal patching strategy and SOP are currently being worked on and should be ready to publish by July 2020.	Director of Planning & Performance	Assistant Director of ICT	Jun-19	July 2020 December 2020 May 2021 July 2021		In progress	May 2021 - there has been a delay in completing the procedure due to work pressures, date has been extended to July 2021	**Current Position** - We note that the process for patching has been amended, with a rota in place for patching of servers. We also note that the Health Board has purchased the Ivanti patch management solution to help improve the patching process. However, at present there is no strategy as stated in the initial management response, and no standard operating procedure (SOP) in place for the patching process. Based on the progress made and the evidence that we reviewed we consider the original recommendation to be partially implemented and have reclassified the remaining elements as Medium priority. July 2020 update - DT & AE drafting patching policy, summary of patching completed but yet to be finalised and produced as SOP. Expected to be finalised by end of August 2020. August 2020 Update - Due to the pressures of Covid 19 and the resources required for the roll out and ongoing maintenance of Microsoft 365, the timescale has been reset to December 2020. January 2021 - work is continuing on the patch management procedure. March 2021 - a draft procedure is in progress and will be presented to the RAGCSB to review at the April 2021 meeting.
CSFU 04	Jun-20	Reasonable	**Original Recommendation** - A formal, resourced plan for the removal of old software and devices should be established. **Updated Recommendation** - The remaining areas of old software should be identified and formally reported to the DSSG / committee, noting where software cannot be easily removed and the associated risk. Linked to this a formal plan for removing /updating old software within the resource constraints should be defined.	Medium	**Original Management Response** - The existing plan will be updated and brought to DSSG for formal approval in June. **Updated Management Response** - A formal risk analysis and remediation strategy is currently being developed which will be presented to the DHSSG by September 2020.	Director of Planning & Performance	Assistant Director of ICT	Jun-19	September 2020 November 2020 May 2021 August 2021		In progress	May 2021 - the RAGCSB did not meet in April due to members being unavailable. A Head of End User Computing (EUC) has been appointed and is discussions with Dell on procuring their services to update end of life software (specifically Windows 7). The Head of Server Management recently had a meeting with various Clinical Systems Managers and a plan is in progress of removing/replacing end of life operating systems.	**Current Position** - Work to remove old software is part of the general procedures. As new systems are brought on line the older servers are removed so the process is largely led from the bottom up rather than top down and there is no formalised plan to remove old versions of software. We note that old versions of key software such as Java / Windows Server / Windows are still used as they are supporting a vital component of the service and as such the Health Board has removed and updated as much as possible without updating these core applications themselves. We note that there is ongoing work to reduce the risks associated with old software, with older versions of Firefox being removed from desktops. We further note that initial discussions are ongoing over the use of Kapersky to block unofficial and old software within the Health Board. Based on the progress made and the evidence that we reviewed we consider the original recommendation to be partially implemented and the remaining elements remain as Medium priority. August 2020 Update - Work has commenced within the infrastructure team, to address the server operating systems to ensure that all servers are on at least Server 2016 operating systems. An end user device sub group has been formed and will have its first meeting this month to discuss a astrategy of ensuring that Windows operating systems are on the most up to date version. The timescale has been set back to November 2020. January 2021- work is continuing within the working groups to ensure that outdated software is addressed. March 2021 - a formal report and remidiation strategy and will be presented to the RAGCSB to review at the April 2021 meeting.

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CSFU 05	Jun-20	Reasonable	**Original Recommendation** - The organisation should provide additional resource for a minimum defined period to allow for the data communications team to improve network security. **Updated Recommendation** - Work should continue to improve the network security of the Health Board. Following the firewall audit, the firewall rules should be amended to increase the security position.	Medium	**Original Management Response** - Data communications security will be addressed by the new posts discussed in finding 2. **Updated Management Response** - The firewall audit has been received and confirmed as accurate. Work has commenced in addressing the recommendations highlighted in the audit. The Cyber team have received the Cisco Implementing Advanced Cisco ASA Security and will be addressing the firewall rules starting in June 2020.	Director of Planning & Performance	Assistant Director of ICT	Jul-19	June 2020 December 2020 March 2021 July 2021		In progress	May 2021 - a meeting has taken place with SICL and the firewall configuration files have been provided as part of the review process. Work on the firewall rules is continuing. In March ICT procured software called Skybox for a one year as a Proof of Concept. Once installed and configured the software will enable ICT to address more complex firewall rules and help manage the administration more effectively. The new Solarwinds environment is now up and running.	**Current Position** - As noted above, resources have been provided for cyber security and one of the posts is within the server team. The current position with the firewall is that the rules have not been changed to restrict access from NHS Wales, however in order to improve the security of the Health Board, a company has been engaged to undertake a firewall audit. The purpose of this is to look at the firewall configuration and rules, which will form the basis of the control moving forward. We note that control over changes to the firewall rules is moving to the cyber security team with training for the cyber security team booked with Cisco in order to do this. The process for changing the firewall rules has been improved with a standard form in place for requests, which are channelled through the cyber team for approval before being discussed and agreed at the Change Advisory Board (CAB). January 2021 - work is continuing on addressing the rules on the Firewalls where the bulk of the work should be completed by the end of February 2021. Additional hardware and software licenses have been procured for the upgrade of the Solarwinds network and performance management environment. A date has been set for the updrade to be completed by Friday 12 February. Based on the progress made and the evidence that we reviewed we consider the original recommendation to be partially implemented and the remaining elements remain as Medium priority. July 2020 update: Firewall project to restart in August with gradual handover of firewall rules from Data Comms to Cyber Security Team. Training scheduled between Data Comms Team and Cyber Team to begin handover. We have an additional temporary resource within Cyber Security Team also looking at networking areas and Solarwinds. August 2020 Update - work on the updating of software versions on each firewall is now complete along with configuring each firewall as per recommendations. There has been an isue in auditing the rules on each firewall due to a licensing issues with Solwarwinds. The ICT Department have requested a quote from the supplier on
Head & Neck Compliance (August 2020)													
HNC 01	Aug-20	Reasonable	1. Staff identified as requiring scheme of delegation training as part of their role should complete the on-line training module in ESR as soon as practically possible. 2. Consideration should be given as to whether any other staff within the directorate would benefit from scheme of delegation training, to ensure there is a consistency in training requests across the directorate.	High	Agreed this will be resolved in the NEW ILG structures The action will be as follows: • The staff requiring scheme of delegation training will be contacted individually and required by the Service Group Manager to complete the training by the end of August 2020. • Advice will be taken from Finance Partners regarding which staff would benefit from scheme of delegation meeting – with a particular focus on band 7 staff. • Issue will be raised in the CSG governance meeting and an email sent to all senior staff in the Directorate (from band 7 up) outlining the paramount	Director of Operations	Service Group Manager	Aug-20	March 2021 May 2021		In progress	May 2021. The Head and Neck Directorate no longer exists, and so consideration will be given by the next meeting to how to explain this to auditors and propose a change in the management actions. For reassurance in the meantime, CSGs now managing these specialties have been contacted and though actions are sometimes slow as a result of covid 19 implications, the services are being subsumed into new arrangements in each ILG. The actions recommended are usually monitored locally by the CSG meeting with the ILG and then at ILG Performance Review Meetings with the COO.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. Following the changes to the structure connected with the RTE ILG, discussion is ongoing with the new Associate Service Group Director to decide an agreed way to take this matter forward. March 2021 Update - Management actions have been stalled by the demands of covid 19 but remain valid. The Ophthalmology aspect of Head & Neck Service has moved to the Bridgend ILG and will join the ILG's arrangements. Update at the next Committee meeting.
HNC 02	Aug-20	Reasonable	Heads of Department within the Head & Neck Directorate should be reminded of the requirement to complete and maintain an inventory of non-capital assets in line with Financial Control Procedure 11, where applicable.	High	Action will be: • The Heads of Service who did not complete the inventories will be contacted individually and required by the Service Group Manager to ensure that they understand the importance of this issue and asked to produce a compliant inventory by the end of September 2020. • Issue will be raised in the CSG Governance meeting and an email sent to all senior staff in the Directorate (from band 7 up) outlining the paramount importance of this issue.	Director of Operations	Service Group Manager	Oct-20	March 2021 May 2021		In progress	May 2021. The Head and Neck Directorate no longer exists, and so consideration will be given by the next meeting to how to explain this to auditors and propose a change in the management actions. For reassurance in the meantime, CSGs now managing these specialties have been contacted and though actions are sometimes slow as a result of covid 19 implications, the services are being subsumed into new arrangements in each ILG. The actions recommended are usually monitored locally by the CSG meeting with the ILG and then at ILG Performance Review Meetings with the COO. Within RTE, staff have been communicated with recently with a requirement to address this recommendation and in Bridgend the matter is being subsumed into existing management arrangements.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. Following the changes to the structure connected with the RTE ILG, discussion is ongoing with the new Associate Service Group Director to decide an agreed way to take this matter forward. March 2021 - Management actions have been stalled by stalled by the demands of covid 19 but remain valid. The Ophthalmology aspect of Head & Neck Service has moved to the Bridgend ILG and will join the ILG's arrangements.

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Ref	Date added	Assurance rating	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Status	Progress	Updates during this period/Latest Update	Previous Updates
HNC 03	Aug-20	Reasonable	Given the value of items that pass through the audiology department, management should review the current arrangements for managing stock in all departments and then consider drawing up a desktop procedure for the management of stock, which is applied to all departments. The procedure should cover as a minimum: • Ordering and receipting. • Minimum and maximum stock levels (if practical). • Security and access to stock. • Ongoing spot checks. • Annual stock take.	Medium	Actions will be: • The Service Group Manager will see the Head of Audiology personally to emphasise the importance of this issue – including its financial implications for the Directorate as a whole. • The Head of Audiology will be required to improve this situation as part of his PADR and also asked to identify a plan with milestones.	Director of Operations	Head of Audiology	Sep-20	March 2021 May 2021		In progress	May 2021. The Head and Neck Directorate no longer exists, and so consideration will be given by the next meeting to how to explain this to auditors and propose a change in the management actions. For reassurance in the meantime, CSGs now managing these specialties have been contacted and though actions are sometimes slow as a result of covid 19 implications, the services are being subsumed into new arrangements in each ILG. The actions recommended are usually monitored locally by the CSG meeting with the ILG and then at ILG Performance Review Meetings with the COO. Further, Audiology colleagues across the UHB have met to focus on stock control. Stock is kept securely in Audiology and there are plans to carry out more regular stock takes and the minimum and maximum stock levels, including preparation of standing orders for hearing aid orders. Battery provision will be picked up centrally, with colleagues at shared services are working on this on an all wales level.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Head of Audiology has set up a meeting to discuss stock control across the sites and draft a procedure. Anticipated this will be completed by end of April 2021.
HNC 04	Aug-20	Reasonable	Budget holders should review all budgets with the Finance Business Partner to identify any 'historical' budgets that are no longer applicable and make the necessary adjustments as part of the budget setting process for 2020/2021 financial year.	Medium	Action will be: • Working with Finance Partners, all budget holders will be required to complete reviews of budgets.	Director of Operations	Budget Holders	Oct-20	March 2021 May 2021		In progress	May 2021. The Head and Neck Directorate no longer exists, and so consideration will be given by the next meeting to how to explain this to auditors and propose a change in the management actions. For reassurance in the meantime, CSGs now managing these specialties have been contacted and though actions are sometimes slow as a result of covid 19 implications, the services are being subsumed into new arrangements in each ILG. The actions recommended are usually monitored locally by the CSG meeting with the ILG and then at ILG Performance Review Meetings with the COO. Financial matters are picked up across the Board by CSG meetings with Business Partners and then with the ILG Team. This is further reviewed in the monthly Performance Review meetings with the COO.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Management actions have been stalled by stalled by the demands of covid 19 but remain valid. The Ophthalmology aspect of Head & Neck Service has moved to the Bridgend ILG and will join the ILG's arrangements.
HNC 05	Aug-20	Reasonable	Management should ensure that any additional payments due to staff are correctly recorded and authorised on the monthly pay returns and that all payments are in compliance with Agenda for Change.	Medium	Action will be: • Directorate Support Manager will be required to put in place a system that ensures appropriate payments. This will be audited every three months.	Director of Operations	Service Group Manager	Aug-20	March 2021 May 2021		In progress	May 2021. The Head and Neck Directorate no longer exists, and so consideration will be given by the next meeting to how to explain this to auditors and propose a change in the management actions. For reassurance in the meantime, CSGs now managing these specialties have been contacted and though actions are sometimes slow as a result of covid 19 implications, the services are being subsumed into new arrangements in each ILG. The actions recommended are usually monitored locally by the CSG meeting with the ILG and then at ILG Performance Review Meetings with the COO. There are checks in place across CSGs to ensure that a full check is made of all additional payments.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Management actions have been stalled by stalled by the demands of covid 19 but remain valid. The Ophthalmology aspect of Head & Neck Service has moved to the Bridgend ILG and will join the ILG's arrangements.
HNC 06	Aug-20	Reasonable	All budget holders should be reminded of their responsibility to review all monthly financial information sent to them and contact Finance to rectify any errors.	Low	Actions will be: • Working with Business Partners, meetings will be arranged monthly to review financial reports. They will need to be attended by Heads of Service.	Director of Operations	Service Group Manager	Sep-20	March 2021 May 2021		In progress	May 2021. The Head and Neck Directorate no longer exists, and so consideration will be given by the next meeting to how to explain this to auditors and propose a change in the management actions. For reassurance in the meantime, CSGs now managing these specialties have been contacted and though actions are sometimes slow as a result of covid 19 implications, the services are being subsumed into new arrangements in each ILG. The actions recommended are usually monitored locally by the CSG meeting with the ILG and then at ILG Performance Review Meetings with the COO. There are checks in place across CSGs to ensure that a full check is made of all payments, and in RTE as an example, the CSG Manager meets Finance colleagues twice a month.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Management actions have been stalled by stalled by the demands of covid 19 but remain valid. The Ophthalmology aspect of Head & Neck Service has moved to the Bridgend ILG and will join the ILG's arrangements.
Health & Safety Management (Agust 2020)													

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HSM 01	Aug-20	Reasonable	1) It should be ensured that training data in relation to PoW and another Bridgend based staff is input into ESR and included in any performance data reported. 2) Where compliance rates are low in particular areas, management should work to understand what the barriers are that stop staff completing the training. In addition, advice should be sought from those areas that are performing well in order for best practice and ideas to be shared. 3) All Executive Directors should undertake training to the level required as part of their role and ESR records should be updated accordingly. 4) Consideration should be given to the Violence and Aggression training report submitted to the Security and Violence Operational Group and the need for additional resources to meet the current training gap.	High	Actions to address each item are listed below. 1. It should be ensured that training data in relation to PoW and another Bridgend based staff is input into ESR and included in any performance data reported. At the time of audit Cwm Taf Morgannwg University Health Board (CTMUHB) was in the process of aligning ESR Competency data between the old Cwm Taf University Health Board and the Bridgend region of Abertawe Bro Morgannwg University Health Board. The work is now completed and all Competencies at Level 1 have now migrated on to the ESR system for staff in the Bridgend region and performance data is reported. 2. Where compliance rates are low in particular areas, management should work to understand what the barriers are that stop staff completing the training. In addition, advice should be sought from those areas that are performing well in order for best practice and ideas to be shared. Statutory and Mandatory Training has previously been monitored via Directorate Clinical/Corporate Business Meetings within the Health Board. This monitoring will continue and form part of the improvement work of the newly established Integrated Locality Groups (ILGs). A group has recently been established under the Director of Nursing to review the current training requirements for all Statutory and Mandatory Training for all Nurses employed within the UHB. This will help identify the main issues that are	Director for People	Head of Health, Safety & Fire	Mar-21			Part Completed	This work is currently on hold due to the current Covid-19 epidemic and a completion time is not currently predictable.	
HSM 02	Aug-20	Reasonable	The Health and Safety policy should be reviewed and where necessary updated to reflect any changes required due to the merger between Cwm Taf and Princess of Wales Hospital, and to reflect the current Health and Safety reporting arrangements within the Health Board.	Medium	In April 2019 the Bridgend region of the former Abertawe Bro Morgannwg University Health Board merged with Cwm Taf University Health Board. Each organisation had in place their own individual Health and Safety Polices and under TUPE arrangements it was decided to allow the organisation 12 months to align these policies. A newly drafted Health and Safety Policy for Cwm Taf Morgannwg University Health Board has been developed. The Policy once approved will be signed by the Chief Executive communicated to all staff through the Health Board's Intranet Training	Director for People	Head of Health, Safety & Fire	Sep-20	May-21		In progress	APRIL 2021: This policy is coming to the next Health, Safety & Fire Committee for approval. Revised implementation date provided.	
HSM 03	Aug-20	Reasonable	Management should review the Health and Safety Co-ordinator resource and the alignment of work in order to ensure sufficient coverage of the service areas.	Medium	In light of the recent structural changes implemented within Cwm Taf Morgannwg UHB, a review of Health and Safety Coordinator support to each new Integrated Locality Group has been undertaken. It is planned to have 2 Health and Safety Coordinators in each new ILG. There is a current deficiency for 1 Health and Safety Coordinator post in the Bridgend ILG and this is currently being considered through a	Director for People	Head of Health, Safety & Fire	Aug-20	Jun-21		In progress	APRIL 2021: SBAR in draft articulating revised resource requirements, to be taken through Health Board management structures in May and June 2021. Revised implementation date provided.	
HSM 05	Aug-20	Low	The pathway on the intranet to the Health and Safety Policy should be made easier in order to ensure easy access for all staff.	Low	The New CTMUHB Health and Safety Policy (once ratified) will be placed under the Risk Management Policies section of the Health Board's intranet pages. A link to this will also be provided clearly on the Health Board's Health and Safety Webpages.	Director for People	Head of Health, Safety & Fire	Sep-20	Jun-21		In progress	APRIL 2021: Once the policy is approved in May, a new interactive area on the intranet will be developed. The interactive intranet page is currently 2/3rds complete, and will be available to launch by the end of June 2021. A revised implementation date has been provided.	
HSM 06	Aug-20	Low	The templates currently being used to undertake annual Health and Safety reviews should be reviewed to ensure they are accurately reflecting the Health and Safety issues within each department.	Low	The Health and Safety Team are developing an audit package for use across the CTMUHB. The package will provide assurance to ILGs and the Board that policies and procedures are being followed in all Service Group Wards and Departments. Once completed, the audit package will be presented to the Health, Safety and Fire Committee for approval.	Director for People	Head of Health, Safety & Fire	Jan-21	Jul-21		In progress	APRIL 2021: An audit tool is being developed, taking learning from the social distancing audit tool developed. The package itself is developed, and by July we will have determined the key areas to be examined via the audit tool. This will be complete and ready to use by the end of July. A revised implementation date has been provided.	

Directorate Review Acute Medicine & A&E (July 2020)

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DRAM 01	Aug-20	Reasonable	A detailed review of all risks currently recorded on DATIX should be undertaken in order to ensure all entries are accurate, remain relevant and have been consistently scored. Where possible a more streamlined register should be in place that facilitates comprehensive monitoring of at least the high scoring risks at the CBM and QSRGG.	Medium	The establishment of the Integrated Locality Groups has prompted a thorough review of the risk registers for each of the clinical service groups. The CSG are now focused on one acute site and the register should therefore be smaller and easier to manage, with regular review of the risks via the governance groups. This work has started but not yet completed due to delays in appointments to the ILG supporting structures.	Director of Operations	General Manager	Sep-20	December 2020 April 2021		Completed	May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on RRs. They are now subject to the ILG processes that are part of the new operating model and are monitored by the CSGs and their Patient Care Business Partners, via ILG internal meetings and then via ILG Performance Review with the COO.	November 2020 Update - The establishment of the Integrated Locality Groups prompted a thorough review of the risk registers for each of the clinical service groups. The RTE ILG Clinical Services Group for Medicine is now focused on one acute site and the register is smaller and easier to manage, with regular review of the risks via the governance groups. This work started in April 2020 and is now nearing completion although it should be noted that there were delays due to the impact of the COVID pandemic and timing of key appointments to the supporting structure. January 2021 Update RTE ILG risk register for the medicine CSG has been reviewed and updated. RTE ILG January 21 Update - The establishment of the Integrated Locality Groups prompted a thorough review of the risk registers for each of the clinical service groups. The RTE ILG Clinical Services Group for Medicine is now focused on one acute site and the register is smaller and easier to manage, with regular review of the risks via the governance groups. This work started in April 2020 and is now nearing completion although it should be noted that there were delays due to the impact of the COVID pandemic and timing of key appointments to the supporting structure. March 2021 Update - Final timing for the completion of this work will be reported by the end of March 2021.
DRAM 02	Aug-20	Reasonable	Following the review of the risk register, there should be clear evidence of review and monitoring of at least all high scoring risks at the CBM and QSRGG.	Medium	The risk register for each site will be reviewed and updated for each acute site by September 2020 as per finding 1. Once this work is completed the process for review and monitoring will be established via the ILG and service group governance structures.	Director of Operations	General Manager	Sep-20	December 2020 April 2021		Completed	May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on RRs. They are now subject to the ILG processes that are part of the new operating model and are monitored by the CSGs and their Patient Care Business Partners, via ILG internal meetings and then via ILG Performance Review with the COO.	November 2020 Update - The risk register for the Medicine CSG, once completed as set out above, will be subject to regular review and monitoring via the ILG and service group governance structures. RTE. January 2021 Update - RTE ILG - regular discussion on high level risks at the monthly performance review meetings with the ILG directors. ILG January 21 Update - The risk register for the Medicine CSG, once completed as set out above, will be subject to regular review and monitoring via the ILG and service group governance structures. March 2021 Update - Final timing for the completion of this work will be reported by the end of
DRAM 03	Aug-20	Reasonable	1. The Health Board Executive Team should review the contents of the current draft version of the CBM terms of reference with a view to updating content particularly around business and membership and to ensure the format of the meetings will work with the new operating model. The revised Terms of Reference should then undergo a formal approval process for use in all CBMs as soon as possible. 2. Officers who form the core membership of both the CBM and the QSRGG should attend at each meeting or send a representative where appropriate. This ensures that key messages can be cascaded to all relevant teams within the directorate. 3. The terms of the reference for the QSRGG should be reviewed, updated and finalised. The review should include a review of the structure diagram outlining the key groups in the directorate, to ensure it captures all groups	Medium	1. Each ILG has put in place revised governance arrangements and the CBM are no longer part of the model. The newly established governance arrangements have been subject to robust review and discussion with the executive directors (COMPLETED) 2 & 3 The format of the governance groups is now being reviewed to ensure that it is aligned to the ILG model. Once membership has been agreed, attendance will be monitored to ensure that the groups are quorate. The reviews will capture the supporting structure on each acute site.	Director of Operations	ILG Directors/ General Manager	Sep-20	December 2020 April 2021		Completed	May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on RRs. They are now subject to the ILG processes that are part of the new operating model and are monitored by the CSGs and their Patient Care Business Partners, via ILG internal meetings and then via ILG Performance Review with the COO.	Action 1 has been completed. March 2021 Update - 2 & 3 The format of the governance groups is now being reviewed to ensure that it is aligned to the ILG model. Once membership has been agreed, attendance will be monitored to ensure that the groups are quorate. The reviews will capture the supporting structure on each acute site." Final timing for the completion of this work will be reported by the end of April 2021.
DRAM 04	Aug-20	Reasonable	1. A review of the policies and procedures saved to the intranet should be undertaken to ensure there is a central repository of all documents and all documents that are listed are still relevant, with all out of date policies reviewed and updated where necessary. 2. Where there are common policies across a number of departments, to avoid duplication and possible inconsistencies, consideration should be given to having a set of directorate wide policies with one copy saved and clear information on the lead area for the policy including who is responsible for	Medium	The review of policies and procedures needs to be undertaken on each acute site and it is acknowledged that this is an area of concern with focussed attention needed over the next 6 months. There also needs to be clear guidance from the ILG on the process for the approval of policies and procedures in the new operating model.	Director of Operations	ILG Directors/ General Manager	September 2020/December 2020	Apr-21		In progress	May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a key risk for old policies –and this will be a challenging piece of work to undertake with all the other priorities. Both Directorates do, however, confirm that the new policies that were developed as a result of changes involving covid 19 have been stored in one place and are accessible.	November 2020 Update - The planned review has been delayed due to the COVID pandemic and the timely appointment to the CSG supporting structure. RTE ILG January 2021 Update - The planned review has been delayed due to the COVID pandemic and the timely appointment to the CSG supporting structure. March 2021 Update - Final timing for the completion of this work will be reported by the end of April 2021.

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DRAM 07	Aug-20	Reasonable	In line with Health Board targets, all staff should be subject to a PDR on an annual basis with copies of PDRs accessible should managers be absent.	Medium	It is acknowledged that every member of staff should have an up to date PDR in place and this will need to be addressed by the CSG general managers and other members of the leadership team such as the Senior Nurses on each of the acute sites.	Director of Operations	General Manager & Senior Nurses	Dec-20	01/12/2020 September 2021		In progress	May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a key risk –and this will be a challenging piece of work to undertake with all the other priorities. Both Directorates do, however, confirm that this remains on the agenda and in MC there has been work done on the priorities for the CSG which will all be reflected in the PDRs. Given the backlog and the challenge, the likely date has been changed to September 2021. Where urgent cases arise they will be managed proactively – and the issue is monitored at ILG and COO level.	November 2020 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that this has been difficult during the COVID pandemic. RTE ILG January 21 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that improvement has been difficult during the COVID pandemic. System issues also remain with the e-rostering system and the ESR system not sharing information. March 2021 Update - This will be an area for focus in the future – further action will be completed asap.
DRAM 08	Aug-20	Reasonable	1. All information contained on self-certification forms, RTW forms and ESR should correspond. Comprehensive and accurate documentation in relation to each episode of sickness should be maintained to allow the proper management of sickness within the directorate and accurate reporting. 2. It should be ensured that self-certification and return to work forms are fully completed in a timely manner following the employee's return.	Medium	It is acknowledged that this position is not acceptable and this will need to be addressed by the CSG general managers and other members of the leadership team such as the Senior Nurses on each of the acute sites.	Director of Operations	General Manager & Senior Nurses	Dec-20	01/04/2021 September 2021		In progress	May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a key risk –and this will be a challenging piece of work to undertake with all the other priorities. Both Directorates do, however, confirm that this remains on the agenda and in MC there has been work done on staff training to undertake this process, and both MC and RTE are dealing with issues with the Allocate IT system. Given the backlog and the challenge, the likely date has been changed to September 2021. Where urgent cases arise they will be managed proactively – and the issue is monitored at ILG and COO level.	November 2020 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that this has been difficult during the COVID pandemic. RTE ILG January 2021 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that progress has been difficult during the COVID pandemic. Review of the consultant requirements for mandatory training has highlighted the need for some changes that will improve the position. March 2021 Update - System issues also remain with the e-rostering system and the ESR system not sharing information. This will be an area for focus in the future – further action will be completed asap.
DRAM 09	Aug-20	Reasonable	The directorate should ensure that all staff record their mandatory training in ESR and all staff are provided with the opportunity to undertake their mandatory training. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for non-compliance with a view to providing support where necessary.	Medium	It is acknowledged that every member of staff should be provided with the opportunity to undertake their mandatory training and this will need to be addressed by the CSG general managers and other members of the leadership team such as the Senior Nurses on each of the acute sites.	Director of Operations	General Manager & Senior Nurses	Dec-20	Aug-21		In progress	May 2021 Update - In both RTE and MC this remains a key area of risk - there will be a further update in August 2021.	November 2020 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that this has been difficult during the COVID pandemic. RTE ILG January 2021 Update - demand and capacity plans will be reviewed as part of the development of the IMTP for 2021-23 although it must be acknowledged that the COVID pandemic has had a significant impact of both elements and the long terms plans will need to be planned carefully following the COVID pandemic period. March 2021 Update - The position is monitored via the monthly ILG performance review meetings although it must be acknowledged that progress has been difficult during the COVID pandemic. Review of the consultant requirements for mandatory training has highlighted the need for some changes that will improve the position.
DRAM 12	Aug-20	Reasonable	Management should ensure that the directorate's demand and capacity plan is updated on a periodic basis to reflect any issues that arise for any of the specialties. The updated plan should then be formally reviewed at the CBMs.	Medium	Demand and capacity planning remains a challenge for each of the service groups and further action is needed to ensure that robust plans are in place and subject to regular review. It should however be noted that the establishment of the ILG operating model and the COVID-19 pandemic response has delayed progress in this area during 2020. It will now need to be a priority to ensure that we fully understand the position and the actions needed to return to normal working and	Director of Operations	ILG Directors/ General Manager	Sep-20	Dec-20		Part Completed	May 2021. All CSGs have been involved in extensive and detailed D&C planning as part of resetting and the IMTP and the plans are complete. They will be monitored monthly at CSG / ILG level and again at the ILG / COO Performance Review meetings on a monthly basis.	RTE ILG January 2021 Update - demand and capacity plans will be reviewed as part of the development of the IMTP for 2021-23 although it must be acknowledged that the COVID pandemic has had a significant impact of both elements and the long terms plans will need to be planned carefully following the COVID pandemic period. March 2021 Update - This will be an area for focus in the future – further action will be completed by the time of the next meeting.
DRAM 13	Aug-20	Reasonable	An inventory of non-capital assets should be developed for each department within the directorate, detailing their assets, which fit under the definition of inventory as detailed within the Financial Control Procedure.	High	It is accepted that this area needs attention and this will need to be prioritised by the CSG general managers during 2020-21 once supporting staffing structures are in place.	Director of Operations	General Manager	Apr-21	01/05/2021 August 2021/April 2022		In progress	May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a key risk – and both MC and RTE recognise that it will take time to be complete. The CSG Manager in MC has recently sent out information to staff and anticipates an earlier resolution than RTE but it is recognised in both areas.	RTE ILG January 2021 Update - action has been delayed due to the COVID pandemic and this area will need to be addressed in 2021-22. March 2021 Update - This will be an area for focus in the future – further action will be completed asap.
DRAM 14	Aug-20	Reasonable	1. Management should ensure that all staff are aware of the contents of Patients Property and Money Financial Control Procedure and their responsibilities to comply with it. Consideration should be given to some form of monitoring to ensure compliance. 2. In the meantime, a separate property book should be obtained for use in the major injury unit and disclaimers should be present within wards and departments to make it clear to patients about their responsibility for	High	This is accepted as poor practice and communication will be sent to all wards and departments to outline the required actions to ensure compliance with the Financial Control Procedure.	Director of Operations	Senior Nurses Medicine	Jul-20	01/04/2021 August 2021		In progress	May 2021 Update - For RTE this remains a challenging area and there have been a number of claims - mostly for patients bringing large amounts of cash into hospital following admission for covid 19. The area is one of focus for Senior Nurses who have been tasked with improving understanding and awareness and a review is ongoing. In MC this is not regarded as so much of a risk and normal property book procedures are ongoing.	November 2020 Update - Communication has been sent to all wards and departments (July 2020) to outline the required actions to ensure compliance with the Financial Control Procedure. This area remains a challenge and the position has been exacerbated during the COVID pandemic with increased patient movement between wards in line with the IPC guidelines. RTE ILG January 2021 Update - Repeated communication has been sent to all wards and departments to outline the required actions to ensure compliance with the Financial Control Procedure. This area remains a challenge and the position has been xacerbated during the COVID pandemic with increased patient movement between wards in line with the IPC guidelines.
Medical & Dental Rostering (July 2020)													

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MDR 01	Aug-20	Limited	The Health Board should continue to move to using a single medical and dental rostering system that would allow efficiencies in usage, especially where links can be made to other Health Board systems such as consultant job planning. This will also enable the Workforce Development team to provide consistent support across the Health Board.	High	Allocate Health Roster has now been rolled out for the whole of the UHB with the exception of ACT and PoW ED. In particular, the rollout was extended to Princess of Wales (PoW) medics during April and May. ACT currently use a separate rostering product called CLW and have for many years. This is also the case in a number of Health Boards and Trusts as the rostering features have been specifically designed for Anaesthetic rosters. Historically, and prior to the transfer on 1 April 2020 POW Emergency Department have used a separate rostering product. For ED POW and ACT to move over to Health Roster, the additional functionality needed would require the purchase of 2 additional modules from Allocate. The 2 modules are Medic on Duty (MOD) and Activity Manager (AM). In addition, this would require further discussions with Consultants and directorate colleagues as their current processes are considered to be perfectly suitable and adequate for their rostering arrangements and would not be a priority. The link of eJob Planning to health roster is the ultimate gold standard and is fully supported. For this to be possible it requires the purchase of the additional e-rostering products, to allow for the interface and indeed for all business areas to be using the Activity manager. In order to roll out Activity Manager effectively, the rostering team would be required to revisit all ILGs to ensure Health Roster is being used effectively for annual leave, study leave and sickness. This will be	Director for People	Head of Workforce Productivity & E-Systems	June 2020/December 2020	Apr-22		Part Completed	January 2021 Update - Allocate Health Roster has now been rolled out for the whole of the UHB with the exception of ACT and the POW Emergency Department (ED). This work has stalled due to the impact of the Pandemic.	
MDR 04	Aug-20	Limited	1) The Health Board should develop a rostering policy specific to medical and dental staff. To ensure consistency and no conflict or duplication, consideration should be given to any other related policies and future financial control procedures such as medical variable pay. The policy should also give clear guidance on the alignment between the roster development process, consultant job plans and service demands. 2) The current set of HealthRoster 'how to' guides should be reviewed to ensure they are comprehensive and can be used in all areas of the Health Board as HealthRoster is rolled out. It should be ensured that any procedures or guides created align to the roster policy and cover both the use of the system to create rosters and the use of the system by medical and dental staff to manage their time. For example, booking annual leave and making amendment requests. 3) For areas where the roll out of HealthRoster is not imminent, separate 'how to' guides on that system should be developed. The guides should include the step by step process for creating the rosters and also guides for users of the	High	A rostering policy will be developed in a collaboration with the ILGs to ensure they are bought into the guidance. Sitting alongside this a separate 'medical establishment' project which will identify the funded posts in each of the ILGs. This is critical to inform the true and accurate development and recording of rosters. There are user guides on how use Health Roster within the Allocate Health Roster system so further guidance would not be relevant. If there is a requirement to refine this guidance, following feedback from Super Users, only then will the Allocate guidance be further developed.	Director for People	Head of Workforce Productivity & E-Systems	Sep-20	Dec-21		Part Completed	January 2021 Update - Intital scoping and collection of documnetation has been completed. This work will commence again after the pandemic.	

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MDR 05	Aug-20	Limited	Annual leave and sick leave should be recorded on Health Roster which interfaces with ESR for Consultants and Middle Grade staff, thus allowing sickness to be managed appropriately.	High	The addition of PoW (excluding ED and ACT) to Health Roster has already moved a significant way towards achieving consistent recording of absences. The next phase however is to meet with each business area to ensure absences are being recorded on the system, which in turn feeds into ESR. There is a reliance on directorate colleagues in the ILGS to administer the system however regular checks and reporting may also expose where the data is not being inputted. This would be an ongoing exercise and could not be a one-off meeting with the directorate rota administrators and would be reliant on additional rostering	Director for People	Head of Workforce Productivity & E-Systems	Sep-20	Dec-21		In progress	APRIL 2021: Work delayed during the pandemic, revised implementation dates provided.	January 2021 Update - PoW being added to Health Roster has greatly improved the capability to record leave and sickness pan UHB. It has become apparent however, that during the pandemic limited recording of leave & sickness has happened on Health Roster in medic areas. This needs to be visited and understood why this has gone on, as the same has not happened for Nursing areas. This is an area that will now require additional support to the roster managers and training to the Medics using the systems to enable the system to be used to a fuller extent.
MDR 06	Aug-20	Limited	Management should ensure that there are processes in place for monitoring the rosters including reviewing aspects such as ensuring medical and dental staff are undertaking the correct hours and working in line with the job plans.	High	The monitoring of hours worked against the planned rota is the responsibility of the Directorate and Roster managers. Workforce will provide KPI data to the Directorates through the ILG Medical Workforce Efficiency meetings setting out time frames for requesting leave, sickness data and study leave. The comparison of agreed job plans against rota is again a matter for the ILG Directorates as noted above.	Director for People	Head of Workforce Productivity & E-Systems	Nov-20	Dec-21		In progress	APRIL 2021: Work delayed during the pandemic, revised implementation dates provided.	January 2021 Update - This project work will has stalled due to Covid 19 and will commence after the pandemic. KPIs will be buiolt into the Rostering policy for medics addtionally.
MDR 08	Aug-20	Limited	1) Management should ensure that on granting annual and study leave to staff, that consideration is taken to ensure there is enough Consultants in place to cover all shifts and they are not all granted leave at the same time. 2) The process for requesting and approving annual and study leave should be clearly set out in departmental procedure notes so that all are clear on the expectation of the department	Medium	A policy has recently been finalised covering study leave entitlements across CTM. This clarifies how much is available and how to record it via the Health Roster system. This policy is awaiting ratification by the LNC. Once all areas are using Health Roster fully, rules can be set on the roster to ensure the correct amount of staff are permitted to be off per day/Week.	Director for People	Head of Workforce Productivity & E-Systems	Nov-20	Dec-21		In progress	APRIL 2021: Work delayed during the pandemic, revised implementation dates provided.	January 2021 Update - Policy is awaiting sight and approval at the LNC. Dates for the LNC have not been released for this year yet had the last meeting was cancelled due to the pandemic pressures.
MDR 09	Aug-20	Limited	Management should ensure when they are producing the rosters that the SPAs and DCC session align to the agreed job plans.	Medium	If the Medic on Duty and Activity Manager modules are purchased and integrated into the process, this can automate the upload of the Job Plan into HealthRoster. This will demonstrate whether or not there is a reflection of the agreed job plan. However, this does need to be enforced and managed by each of ILG management teams, not by Workforce. ILG management will need to ensure that actual job plans reflect what is shown on the Roster	Director for People	Head of Workforce Productivity & E-Systems	Dec-20	Dec-21		In progress	APRIL 2021: Work delayed during the pandemic, revised implementation dates provided.	January 2021 Update - This work will not take place until the pandemic is over, due to the current main focus within both the Departments and eRostering being maintenance of current service.
Head & Neck Management Arrangements (August 2020)													
HNMA 02	Aug-20	Limited	1. The Directorate should ensure that a central database is created that records all applicable policies and procedures for all departments that constitute the Head & Neck Directorate. The database should include as a minimum the name of policy/procedure, applicable department, lead person, approval date, review date and committee/meeting responsible for formally approving policy if applicable. 2. Management should also ensure that the information is accessible to all applicable staff including agency workers.	High	The Service Group Manager will work with the Heads of Department to ensure that a dedicated page is established on the intranet site. Thought will be given to nominating a number of more junior staff to come up with proposals and lead the process and develop a communication plan.	Director of Operations	Management Team Ophthalmology	No Date Indentified	March 2021 June 2021 August 2021		In progress	May 2021. The Head & Neck Directorate no longer exists and a proposal arround how this is handled will be made to Auditors. In the meantime, a check has been made across the areas where the policies sit and thus far, the new policies that were developed as a result of changes involving covid 19 have been stored in one place and are accessible.	January 2021 Update Progress has been made across the UHB with the development and review of Risk Registers. January 2021 Update - Following a follow up review undertaken by Internal Audut the following update was provided: Our recommendation in relation to policies and procedures remains open at the current time. Progress against this recommendation is monitored via the internal audit tracker. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Governance arrangements were followed up by Audit due to its limited assurance rating and a report went to the December Audit Committee. Covid 19 has hampered progress in this area. An update on progress will be available by the end of March 2021 –this recommendation open and progress will be monitored. In the Bridgend ILG, the requirements are being explored and a report will be available by the end of June 2021.

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HNMA 06	Aug-20	Limited	1. All episodes of sickness should be recorded on ESR. Comprehensive and accurate documentation in relation to each episode of sickness should be maintained to allow the proper management of sickness within the directorate and accurate reporting. 2. It should be ensured that self-certification and return to work forms are fully completed. 3. All information contained on self-certification forms, RTW forms and ESR should correspond. 4. Absence management prompts should be monitored and where periods of absence result in a prompt being breached, the appropriate action should be	High	Working with colleagues in WOD the Directorate will start an education programme for all staff management issues – with joint workshops as has happened in other areas (for example, Mental Health). This will start a journey for the Directorate towards compliance. Since receipt of the report the detail has been shared with the Heads of Service and improvements have been made which will be qualified if a re-review takes place. Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service.	Director of Operations	Service Group Manager	Oct-20	March 2021 April 2021 September 2021		In progress	May 2021. The Head & Neck Directorate no longer exists and a proposal arround how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. Colleagues from WOD work closely within all CSGs and provide important support where it is needed. These issues are monitored via internal ILG processes and then via the Performance Review with the COO. At present issues with ESR and Health Roster are the focus of work and as a result the date will be September 2021.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021 –this recommendation open and progress will be monitored.
HNMA 07	Aug-20	Limited	1. In line with Health Board targets, all staff should be subject to a PDR on an annual basis. 2. PDR documentation should be fully completed, with meaningful objectives agreed by the manager and employee. The document should be signed by both parties and ESR with the date the PDR took place. 3. Copies of PDRs can be accessed to be undertaken in Manager's absence.	High	The report has been shared with all Heads of Services and improvements have been made in the specialty area of Dental Services. The new management arrangements for the RTE ILG are in the process of being resolved and in line with the new workforce performance management ILG structure, the detailed improvements will be made. Further, this issue will be highlighted to the Bridgend and RTE ILG when it takes over management responsibility for this service.	Director of Operations	Service Group Manager	Oct-20	March 2021 April 2021 August 2021		In progress	May 2021. A check has been made across the old Cwm Taf Directorates and a review has been taken on this issue. This does remain a risk given the size of the challenge and is monitored through internal ILG Meetings and the ILG Performance Review with the COO.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021 –this recommendation open and progress will be monitored.
HNMA 09	Aug-20	Limited	The Directorate should ensure that all staff record their mandatory training in ESR and all staff are provided with the opportunity to undertake their mandatory training. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for non-compliance with a view to providing support where necessary.	Medium	This has been raised with the Heads of Service. The new management arrangements for RTE ILG are in the process of being resolved and in line with the new workforce performance management ILG structure, the detailed improvements will be made Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service.	Director of Operations	Service Group Manager	Oct-20	March 2021 April 2021 August 2021		In progress	May 2021. The Head & Neck Directorate no longer exists and a proposal around how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. These issues are monitored via internal ILG processes and then via the Performance Review with the COO.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021 –this recommendation open and progress will be monitored.
HNMA 10	Aug-20	Limited	1 Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period. 2 Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Directorate Manager and Clinical Director to resolve any problems in a timely manner and ensure plans get signed off.	Medium	The management team agree with this recommendation, and the lack of compliance has been as a result of COVID restrictions. The Clinical Director and the Service General Manager will work to complete this work by the end of September 2020.	Director of Operations	Clinical Director/ Service General Manager	Sep-20	01/03/2021 August 2021		Part Completed	May 2021. The Head & Neck Directorate no longer exists and a proposal around how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. These issues are monitored via internal ILG processes and then via the Performance Review with the COO.	January 2021 Update The CSG Manager and Director are undertaking job planning across their areas. Issues are discussed and agreed as part of CSG normal business - the status has been changed to yellow to reflectthis. January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - As a result of the lack of a Deputy SGM (since at least October 2019) this work has not progressed as fast as would have been liked. The SGM has instigated a process to speed up the process of carrying out job planning, any urgent matters are managed
HNMA 11	Aug-20	Limited	1. All relevant records (paper and electronic) in relation to annual leave should be accurately completed and retained to ensure managers are aware of leave that has been granted and prevent staff taking more leave than they are entitled to. 2. The annual leave entitlement recorded on paper records or other systems should be reconciled to ESR at the start of each year to ensure opening balances are correct. Where necessary any differences should be investigated, including the variations identified	Low	Working with colleagues in WOD the Directorate will start an education programme for all staff management issues – with joint workshops as has happened in other areas (for example, Mental Health). This will start a journey for the Directorate towards compliance. Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service.	Director of Operations	Service Group Manager	Oct-20	March 2021 April 2021 August 2021		In progress	May 2021. The Head & Neck Directorate no longer exists and a proposal around how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. These issues are monitored via internal ILG processes and then via the Performance Review with the COO.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021
HNMA 13	Aug-20	Limited	Workforce Reporting within the Directorate Integrated Governance Business Meetings should be expanded to provide information on a departmental level. This would allow any areas of concern to be highlighted and the Directorate could then determine what action needs to be undertaken and responsible officer.	Medium	The Heads of Service have the reports for their areas and understand the HR issues in their departments. The Heads of Department will work with Business Partners to improve the situation.	Director of Operations	Heads of Service & Business Partners	Nov-20	March 2021 April 2021 August 2021		In progress	May 2021. The Head & Neck Directorate no longer exists and a proposal around how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. These issues are monitored via internal ILG processes and then via the Performance Review with the COO.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021.

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HNMA 14	Aug-20	Limited	Management should ensure that all relevant correspondence/documentation relating to the IMTP process is retained if future access is required.	Low	The Service Group Manager will ensure that this is in place in the next round of IMTP planning and submission.	Director of Operations	Service Group Manager	Dec-20	March 2021 April 2021 August 2021		In progress	May 2021. The Head & Neck Directorate no longer exists and a proposal around how this is handled will be made to Auditors. In the meantime, a check has been made on the arrangements where these services are now held. These issues are monitored via internal ILG processes and then via the Performance Review with the COO.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - Covid 19 has hampered progress in this area. Limited action can be proved to have taken place. An update on progress will be available by the end of April 2021.
Pathology Directorate Follow Up Review (Managerial Arrangements) (October 2020)													
PDFU 04	Oct-20	Reasonable	**Updated Recommendation** - All policies and procedures should be reviewed on a regular basis to ensure that they are current and up to date.	Low	**Updated Management Response** - There are a significant number of policies and procedures within Pathology, document review is monitored monthly through the Pathology scorecard and significant improvements have been made. Pathology will be implementing an electronic quality management solution within the next few months, this will automatically alert staff when documents are due for review, which should result in further improvements. There will also be a visual metrics dashboard which will show the status of document review for each	Director of Operations	Service Leads	Jan-21	Aug-21		In progress	May 2021 Update - Operational pressures have meant that an update has not been possible this month – a full update will be available at the next meeting.	Jan 2021 - work is ongoing with service leads and quality manager. March 2021 Update - Covid 19 implications have slowed the process and this area will be a focus for the rest of the year. Work is ongoing with service leads and quality manager.
PDFU 05	Oct-20	Reasonable	**Updated Recommendation** - Managers should ensure all staff receive a PDR on an annual basis. Where necessary an action plan should be developed, and consideration given to obtaining assistance from other departments within the directorate to ensure compliance rates can be improved.	High	**Updated Management Response** - 1. Service managers to provide an action plan with target dates for completion of outstanding PDRs. 2. Compliance at 9/9/20 is 56.3%.	Director of Operations	Service Managers	Oct-20	01/06/2021 August 2021		In progress	May 2021 Update - Operational pressures have meant that an update has not been possible this month – a full update will be available at the next meeting.	Jan 2021 - limitations with increased covid activity and workforce gaps has slowed progress - but is being continued where it will fit within parameters without affecting patient care. March 2021 Update - This area will be a focus for the coming year.
PDFU 06	Oct-20	Reasonable	**Updated Recommendation** - The Directorate should ensure all staff are reminded (and provided with support when needed) to complete core module training in line with Welsh Government's expectations. When reasonably practicable (following the Covid-19 crisis) staff should be afforded the opportunity and time to complete mandatory training.	Low	**Updated Management Response** - Managers to provide time to complete mandatory training for staff wherever possible to improve compliance.	Director of Operations	Service Managers	Ongoing	01/03/2021 August 2021		In progress	May 2021 Update - Operational pressures have meant that an update has not been possible this month – a full update will be available at the next meeting.	January 2021. Implication of covid have meant that this has not been able to receive the appropriate management focus - this will be remedied in the next two months. An update will be provided in March 2021. March 2021 Update - A number of staff were able to access all elearning during covid pandemic and original social distancing strategies - ongoing, but unable to access F2F courses as yet through the Training Department. Work on elearning supporting during covid, but access to F2F courses is limited due to covid response.
PDFU 07	Oct-20	Reasonable	**Updated Recommendation** - When consultant job plans are re-established following the Covid-19 crisis, the Directorate should ensure these are completed in a timely manner. A control system should be established to ensure Consultant Job Plans are reviewed prior to expiration and monitoring should take place at an appropriate group within the directorate.	Medium	**Updated Management Response** - Review of overdue consultant job plans to take place. A system will be developed to alert consultants when job plans are due for review.	Director of Operations	Clinical Service Group Manager	Nov-20	May-21		Part Completed	May 2021 - No further update provided	January 2021 Update - A number of staff were able to access all elearning during covid pandemic and original social distancing strategies - ongoing, but unable to access F2F courses as yet through training dept. Jan 2021 - work on elearning supporting during covid, but access to F2F courses is limited due to covid response. March 2021. Covid 19 has slowed action here. It is anticipated that an update will be available in May 2021.
PDFU 09	Oct-20	Reasonable	**Updated Recommendation** - It should be ensured that RTW forms are fully completed, including details of previous sickness episodes, to determine if the current absence has resulted in a prompt being hit. Where a prompt has been hit a record should be made of the action taken, including if no action is taken, with an explanation as to why discretion was applied in this instance.	Medium	**Updated Management Response** - Managers to ensure that sickness continues to be appropriately monitored and managed within their service areas.	Director of Operations	Service Managers	Ongoing	01/05/2021 August 2021		In progress	May 2021 Update - Operational pressures have meant that an update has not been possible this month – a full update will be available at the next meeting.	Jan 2021 - CSGM and Deputy CSGM are working with WOD and training to pilot new leadership and management course modules across all band 7 and above workforce. Rigorous support package being developed to aid all supervisors and managers to facilitate better sickness monitoring and absence reviews. March 2021 Update - CSGM and Deputy CSGM are working with WOD and training to pilot new leadership and management course modules across all band 7 and above workforce. Rigorous support package being developed to aid all supervisors and managers to facilitate better sickness monitoring and absence reviews.
Medical Agency Usage (October 2020)													
MAU 06	Oct-20	Reasonable	Following the review of required attendees for the Scrutiny Group, it should be ensured that the remit of the group is clear, there are regular meetings taking place and all relevant staff are in attendance.	Low	The Scrutiny group structure and cohort is currently being revised to ensure it falls in line with the new locality based structures. Representation will be sought from each ILG from a director (or nominated deputy), finance, procurement, workforce and speciality perspective. Current talks are ongoing as to whether to hold three separate meetings per locality or one CTM meeting. A new terms of reference will be developed for this meeting, it has been agreed that this will be chaired by the Medical Director or Deputy Medical Director in their absence.	Medical Director	Assistant Director of Workforce Productivity & Efficiency	Feb-21	Jun-21		In progress	May 2021 Update: The scrutiny group has been incorporated into the new Workforce Strategy Group (WSG). The draft ToR have been developed for this group and it is predicated that it will be launched in June, once the ToR are ageed by all interested parties.	November 2020 Update - Discussions around the structure of the Scrutiny group going forward are yet to be finalised. Revised terms of reference will be finalised in January 2021.
Risk Management (February 2021)													

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RM21 01	Feb-21	Reasonable	Management should ensure that all risks that are scored 15 or more are escalated up to the Organisational Risk Register to enable the Executives to view all risks within their areas. Management should also ensure that all risks recorded on the Rhondda Taf Ely (RTE) ILG Risk Register and the RTE Surgery CSG Risk Register are aligned and all risks scoring over 15 are escalated to the ILG Risk Register	High	ILGs are committed to undertaking a review of all risks within the three locality groups. This work has been significantly impacted by the impact and response to the Covid-19 pandemic with operational focus quite rightly directed to clinical service provision. This work is still planned, however the timeline for this is dependent on the Covid19 pandemic response and the impact of post Covid recovery of planned care. The work will be approached as follows: 1.1 Review of risks and Clinical Service Group (CSG) risk registers ensuring it continues to be embedded in the ILG via a standing agenda item for the CSG and ILG Quality, Safety & Experience meetings. 1.2 ILG Heads of Quality & Safety will continue to work with CSG's to both rationalise and standardise the CSG risk register. 1.3 Through the delivery of dedicated monthly training slots ensure that CSG's have awareness/training in the Service to Board Escalation process and align their risk management approach to the recently revised Health Board Risk Management Strategy.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk	Oct-21			In progress	Update May 2021 - On track for October 2021 implementation date. The Assistant Director of Governance & Risk meets monthly with the Heads of Quality & Safety within ILG's and will be advised if there is any impact to this timeframe.	Update March 2021 - On track for October 2021 implementation date. The Assistant Director of Governance & Risk meets monthly with the Heads of Quality & Safety within ILG's and will be advised if there is any impact to this timeframe.
RM21 03	Feb-21	Reasonable	Whilst we acknowledge that compiling a Training Needs Analysis is a new task that has been included on the Risk Management Improvement Plan, Management need to ensure that all departments and staff are provided with training on the new Risk Management Strategy, and the use Datix to record risks, as soon as possible. This will help ensure consistency of approach across the organisation.	Medium	A training needs analysis will be undertaken early in 2021. In the interim monthly risk training sessions via Microsoft Teams has been scheduled with an open invite for staff across ILG's to attend.	Director of Corporate Governance/ Board Secretary	Assistant Director of Governance & Risk	Apr-21	Jul-21		In progress	Update May 2021 Training Needs Analysis currenrly being finalised within the Task and Finish Group. Will be shared with the Health Board once the training packages that align have been developed.	Update March 2021 A revised date is requested as the Assistant Director of Governance & Risk is now part of a small Task and Finish Group with other NHS Organisations in Wales to develop a risk training needs analysis that ensures a consistent approach across NHS Wales and avoids duplication. A first draft of a TNA has been developed and will be shared with the Health Board in due course. The trainining packages to support the TNA are being worked through by the group.
CAMHS Management Arrangements (February 2021)													
CAMMAN 01	Feb-21	Limited	1. CAMHS should undertake a mapping exercise that identifies all of the groups and committees that currently exist. The remits, attendees and frequency of meetings for all groups should be reviewed, along with the relationship and flow of information between the groups, to identify if there is any overlap or gaps in the current governance arrangements. Consideration should be given to simplifying the current arrangements. 2. Once a mapping exercise has been completed, a structure diagram that shows the inter-relationship between each of the key committees and groups within the Clinical Service Group and how these feed upwards into the ILG's governance arrangements should be documented. A brief summary of each group's purpose should also be added to the diagram where a formal ToR does not need to exist for a particular group.	Medium	CAMHS meeting structure & ToRs for Quality and Business meetings to be reviewed and simplified. ☐ Business Meeting (SMT) created (COMPLETE) ☐ Quality and Safety meeting ToR to be reviewed and signed off at next meeting. ☐ Meeting structure at LMT level to feed into these two key meetings. ☐ Performance meetings are in place monthly with LMTs. These do not require a Tor & feed directly into the Business Meeting (SMT) (COMPLETE) ToRs will be updated to reflect attendees, quoracy requirements, and frequency of meetings. ToR for Locality meetings will cover all three areas to ensure consistency. All formal meetings will be minuted including who was in attendance, the key agenda items discussed, decisions made and points for future action (COMPLETE) Actions from other groups that appear to have remained open for a number of years will be reviewed, addressed and closed.	Director of Operations	Clinical Service Group Manager	Mar-21	May-21		Completed	May 2021 Update - CAMHS meeting structure & ToRs for Quality and Business meetings to be reviewed and simplified. • Business Meeting (SMT) created, • Quality and Safety meeting ToR reviewed and signed off, • Meeting structure at LMT level to feed into these two key meetings. • Performance meetings are in place monthly with LMTs. These do not require a Tor & feed directly into the Business Meeting (SMT) ToRs have been updated to reflect attendees, quoracy requirements, and frequency of meetings. ToR for Locality meetings cover all three areas to ensure consistency. All formal meetings are minuted including who was in attendance, the key agenda items discussed, decisions made and points for future action. Actions from other groups that appear to have remained open for a number of years are reviewed, addressed and closed.	March 2021 Update - Update will be abailable in May 2021

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CAMMAN 02	Feb-21	Limited	1. In conjunction with a mapping exercise, the Terms of Reference for all current groups should be reviewed. Where it is deemed that a group remains relevant, the ToRs should be brought up to date including attendees, quoracy requirements, and frequency of meetings. Where one type of meeting is to be held in each of the three service areas (CTM, Swansea Bay, Tier 4), consideration should be given to having a single ToR that covers all three areas and ensures consistency. 2. When reviewing each group and assessing the need for its existence, the name of the group should be agreed and consistently applied on documents such as their Terms of Reference, the structure diagram, group agendas and	High	Quality meetings – plan as per Finding 1 ToR to be completed A new performance meeting structure is in place with the Bridgend ILG	Director of Operations	Head of Nursing	Mar-21	May-21		Completed	May 2021 Update - Complete	March 2021 Update - Update will be abailable in May 2021
CAMMAN 03	Feb-21	Limited	Future meetings should be held in line with the frequency stated in their ToR and only cancelled as a last resort. Where named attendees cannot be present at a meeting, deputies should attend in their place.	Medium	Meetings will be held in line with the frequency stated in their ToR and only cancelled as a last resort. Where named attendees cannot be present at a meeting, deputies will attend in their place (COMPLETE) Local meetings being held to be mapped re frequency, including hosted services. Frequency of SMT is now monthly with updated ToR (COMPLETE)	Director of Operations	Service Improvement Manager	Mar-21	May-21		Completed	May 2021 Update - Complete	March 2021 Update - Update will be abailable in May 2021
CAMMAN 04	Feb-21	Limited	1. Comprehensive and meaningful records should be retained of each meeting including who was in attendance, the key agenda items discussed, decisions made and points for future action. 2. It should be ensured that any actions that remained open during the January 2020 Clinical Business Meeting have either been completed or have been transferred to the new Service Group Performance Review meeting or another appropriate group or committee. Furthermore, actions from other groups that appear to have remained open for a number of years should be addressed.	High	CAMHS meeting structure & ToRs for Quality and Business meetings to be reviewed and simplified. ☐ Business Meeting (SMT) created (COMPLETE) ☐ Quality and Safety meeting ToR to be reviewed and signed off at next meeting. ☐ Meeting structure at LMT level to feed into these two key meetings. ☐ Performance meetings are in place monthly with LMTs. These do not require a Tor & feed directly into the Business Meeting (SMT) (COMPLETE) ToRs will be updated to reflect attendees, quoracy requirements, and frequency of meetings. ToR for Locality meetings will cover all three areas to ensure consistency. All formal meetings will be minuted including who was in attendance, the key agenda items discussed, decisions made and points for future action (COMPLETE) Actions from other groups that appear to have remained open for a number of years will be reviewed, addressed and closed.	Director of Operations	Clinical Service Group Manager	Mar-21	May-21		Completed	May 2021 Update - Complete	March 2021 Update - Update will be abailable in May 2021
CAMMAN 05	Feb-21	Limited	1. We agree with the planned approach to identify CAMHS related policies in existence and to review them to ensure consistency across the localities. This work should also ensure relevance and alignment to current legislation and expected working practices. 2. Once updated, the policies should be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews.	High	CAMHS Policy Group newly established, with ToR being developed. All CAMHS policies to be identified, reviewed and standardised to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan will be devised. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews.	Director of Operations	Head of Nursing	Mar-21	01/05/2021 August 2021		In progress	May 2021 Update - CAMHS Policy Group newly established, with ToR developed. All CAMHS policies to be identified, reviewed and standardised to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan will be devised. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews. Work delayed due to key staff redeployment due to Covid & HB restructure. Confirmation on teh action taken will be confirmed in August 2021.	March 2021 Update - Update will be abailable in May 2021

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CAMMAN 06	Feb-21	Limited	1. The review of CAMHS risk register should take place to ensure all risks are scored consistently and any risks scoring below eight are, in line with the Risk Management Strategy, removed from the CSG risk register and logged separately by departments. A process should be put in place to review and monitor those risks and where necessary escalate back up to the CSG risk register. 2. The CSG should have appropriate mechanisms in place to review and monitor risks including those scoring below between 6 and 12. This should include clearly defined responsibilities within the terms of reference of the various groups. 3. The CSG should ensure risks are not only individually monitored by risk owners, but that the risk register is collectively monitored at the appropriate level, with escalation and de-escalation between groups and committees if risk scores change.	Medium	CAMHS risk register will be reviewed to ensure risks are scored consistently and any risks scoring below eight are, in line with the Risk Management Strategy, removed from the CSG risk register and logged separately by departments. A process will be put in place to review and monitor those risks and where necessary escalate back up to the CSG risk register. The CSG will have appropriate mechanisms in place to review and monitor risks including those scoring below between 6 and 12. This will include clearly defined responsibilities within the terms of reference of the various groups. The CSG will ensure risks are not only individually monitored by risk owners, but that the risk register is collectively monitored at the appropriate level, with escalation and de-escalation between groups and committees if risk scores change. Putting Things Right – themes & trends will be collated and added to bimonthly	Director of Operations	Senior Nurse Quality & Risk/Head of Nursing	Mar-21	01/05/2021 August 2021		In progress	May 2021 Update - CAMHS risk register has been reviewed to ensure risks are scored consistently and any risks scoring below eight are, in line with the Risk Management Strategy, removed from the CSG risk register and logged separately by departments. A process will be put in place to review and monitor those risks and where necessary escalate back up to the CSG risk register. The CSG will have appropriate mechanisms in place to review and monitor risks including those scoring below between 6 and 12. This will include clearly defined responsibilities within the terms of reference of the various groups. The CSG will ensure risks are not only individually monitored by risk owners, but that the risk register is collectively monitored at the appropriate level, with escalation and de-escalation between groups and committees if risk scores change. Putting Things Right – themes & trends will be collated and added to bimonthly report for CAMHS (senior nurses). Julie meeting with Governance team to progress.	March 2021 Update - Update will be abailable in May 2021
CAMMAN 07	Feb-21	Limited	1. As the revised Declaration of Interest forms are introduced by the Health Board, staff should be reminded of the requirements of the Standards of Behaviour policy and its relevance to different roles and posts within the Health Board. 2. Where individuals fail to make a return, managers should continue to prompt staff to do so.	Low	All staff (8A & above) will complete the revised Declaration of Interest forms when requested by the Health Board	Director of Operations	Clinical Service Group Manager	Annually	May-21		Completed	May 2021 Update - Complete	March 2021 Update - Update will be abailable in May 2021
CAMMAN 08	Feb-21	Limited	1. Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period. 2. Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Clinical Service Group Manager and Clinical Director in order to resolve any problems in a timely manner and ensure plans get signed off. 3. Once all job plans have been brought up to date, the Clinical Service Group should be able to assure itself that the sessions agreed on the job plan are what are actually worked by the consultants.	High	Clinical Director will ensure that all Consultant job plans are reviewed and agreed on an annual basis. A clear dispute process to be followed: Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Clinical Service Group Manager and Clinical Director in order to resolve any problems in a timely manner and ensure plans get signed off. System to provide assurance that the sessions agreed on the job plan are what are being delivered by the Consultants.	Director of Operations	Clinical Director	Mar-21	01/05/2021 August 2021		In progress	May 2021 Update - Clinical Director will ensure that all Consultant job plans are reviewed and agreed on an annual basis. A clear dispute process to be followed: Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Clinical Service Group Manager and Clinical Director in order to resolve any problems in a timely manner and ensure plans get signed off. System to provide assurance that the sessions agreed on the job plan are what are being delivered by the Consultants.	March 2021 Update - Update will be abailable in May 2021

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CAMMAN 09	Feb-21	Limited	1. Staff personal records should be stored in such a way that allows other managers to have access to them should an employee's direct line manager be absent from work for a period of time. 2. In order for absence to be properly managed, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. It should be ensured that self-certification and return to work forms are fully completed in a timely manner following the employee's return. All information contained on self-certification forms, RTW forms and ESR should correspond and the period of absence should be fully covered by self-certification forms or medical certificates. 3. Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. Where a manager exercises their discretion and chooses not to undertaken an informal or formal warning, this decision should be documented on the individuals file. 4. It should be ensured that all employees are correctly allocated on ESR to the right team within the Clinical Service Group. Incorrect allocations will have an impact on sickness, training and PDR compliance rates for teams	High	This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report. Staff personal records will be stored to allow access should a line manager be absent from work for a period of time. Incorporated into line management training package. ESR log in details to be shared as required. Comprehensive and accurate documentation in relation to each episode of sickness will be maintained. ☐ Self-certification and return to work forms are fully completed in a timely manner following the employee's return. All information contained on self-certification forms, RTW forms and ESR should correspond and the period of absence should be fully covered by self-certification forms or medical certificates. The Managing Attendance Policy will be followed where periods of absence result in a prompt being breached. Where a manager exercises their discretion and chooses not to undertaken an informal or formal warning, this decision should be documented on the individuals file. All employees will be reviewed to ensure they are correctly allocated on ESR to the right team within the Clinical Service Group.	Director of Operations	Senior Nurse	Mar-21	01/05/2021 August 2021		In progress	May 2021 Update - This action will be addressed via the Line Management responsibilities training as per finding 3 (Termination Forms). Staff personal records will be stored to allow access should a line manager be absent from work for a period of time. Incorporated into line management training package. ESR log in details to be shared as required. Comprehensive and accurate documentation in relation to each episode of sickness will be maintained. 1. Self-certification and return to work forms are fully completed in a timely manner following the employee's return. 2. All information contained on self-certification forms, RTW forms and ESR should correspond and the period of absence should be fully covered by self-certification forms or medical certificates. The Managing Attendance Policy will be followed where periods of absence result in a prompt being breached. Where a manager exercises their discretion and chooses not to undertaken an informal or formal warning, this decision should be documented on the individuals file. All employees will be reviewed to ensure they are correctly allocated on ESR to the right team within the Clinical Service Group. ESR Champion roles for each Locality.	March 2021 Update - Update will be abailable in May 2021
CAMMAN 10	Feb-21	Limited	In line with Health Board targets, all staff should participate in a PDR on an annual basis. Where departments are failing to carry out PDRs due to resource constraints, support should be provided.	High	This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report In line with Health Board targets, all staff will participate in a PDR on an annual basis. Support will be provided if a drop in compliance is due to resource constraints.	Director of Operations	Senior Nurse	Mar-21	01/05/2021 August 2021		In progress	May 2021 Update - This action will be addressed via the Line Management responsibilities training as per finding 3 (Termination Forms). In line with Health Board targets, all staff will participate in a PDR on an annual basis. Support will provided if a drop in compliance is due to resource constraints.	March 2021 Update - Update will be abailable in May 2021
CAMMAN 11	Feb-21	Limited	1. The Clinical Service Group should ensure that staff are reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that all staff are provided with the opportunity to undertake their mandatory training. 2. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for non-compliance with a view to providing	Medium	This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report. All Line Managers to ensure staff have the opportunity to undertake their mandatory training. LMT will monitor on a monthly basis to identify any problem areas, establish reasons for non-compliance and provide support or escalate to SMT where necessary.	Director of Operations	Senior Nurse	Mar-21	01/05/2021 August 2021		In progress	May 2021 Update - All Line Managers to ensure staff have the opportunity to undertake their mandatory training. This action will be addressed via the Line Management responsibilities training as per finding 3. LMT will monitor on a monthly basis to identify any problem areas, establish reasons for non-compliance and provide support or escalate where necessary	March 2021 Update - Update will be abailable in May 2021
CAMMAN 12	Feb-21	Limited	1. Management should ensure that TOIL documentation is fully completed and the hours are recorded correctly. 2. The Clinical Service Group should have a policy in place that provides guidance on the use of TOIL.	Low	This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report. Line Managers will ensure that flexi / TOIL documentation is fully completed and the hours are recorded correctly. TOIL will be used in line with HB policy.	Director of Operations	Senior Nurse	Mar-21	01/05/2021 August 2021		In progress	May 2021 Update - This action will be addressed via the Line Management responsibilities training as per finding 3 (Termination Forms). Line Managers will ensure that flexi / TOIL documentation is fully completed and the hours are recorded correctly. TOIL will be used in line with HB policy.	March 2021 Update - Update will be abailable in May 2021
CAMMAN 13	Feb-21	Limited	1. In line with the Scheme of Delegation, all requests to carry forward unused annual leave should be authorised in line with the scheme of delegation. 2. Consideration should be given to reviewing annual leave balances at intervals throughout the year to try and ensure leave is taken as the year progresses, to prevent the build of outstanding leave and the need to carry forward so	Low	This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report. All requests to carry forward unused annual leave will be authorised in line with the scheme of delegation. Line Managers will review annual leave balances quarterly during supervision to ensure leave is taken as the year progresses, to prevent the accumulation of	Director of Operations	Senior Nurse	Mar-21	01/05/2021 August 2021		In progress	May 2021 Update - An update will be available in August 2021.	March 2021 Update - Update will be abailable in May 2021
CAMMAN 14	Feb-21	Limited	1. Prior to submitting the IMTP for approval, it should be ensured that all key aspects, such as workforce planning information and finance plans are contained and that the Clinical Service Group Manager is fully sighted on them to ensure all information aligns. 2. Plans should be thoroughly reviewed and scrutinised ahead of submission to ensure no omissions.	High	Prior to submitting the IMTP for approval, all key aspects, such as workforce planning information and finance plans are contained and that the Clinical Service Group Manager is fully sighted on them to ensure all information aligns. Plans will be thoroughly reviewed and scrutinised ahead of submission to ensure no omissions and brought to the Business Meeting for discussion.	Director of Operations	Clinical Service Group Manager	Mar-21	01/05/2021 August 2021		In progress	May 2021 Update - Prior to submitting the IMTP for approval, all key aspects, such as workforce planning information and finance plans are contained and that the Clinical Service Group Manager is fully sighted on them to ensure all information aligns. Plans will be thoroughly reviewed and scrutinised ahead of submission to ensure no omissions and brought to the Business Meeting for discussion.	March 2021 Update - Update will be abailable in May 2021

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CAMMAN 15	Feb-21	Limited	The CSG Manager should work with senior colleagues within the CSG and the finance business partner to identify and develop realistic costed schemes to help achieve their CRES target. Care should be taken when producing finance reports, to ensure no errors are contained that may lead to mis-reporting.	Medium	The CSG Manager will work SMT colleagues and the finance business partner to identify and develop realistic costed schemes to help achieve their CRES target. Care will be taken when producing finance reports, to ensure no errors are contained that may lead to mis-reporting. Monthly Finance Meetings with SMT, LMTs and Finance partners are in place (COMPLETE)	Director of Operations	Clinical Service Group Manager	Mar-21	May-21		Completed	May 2021 Update - Complete	March 2021 Update - Update will be abailable in May 2021
CAMMAN 16	Feb-21	Limited	It should be ensured that the reporting and monitoring against non-financial performance indicators is undertaken at a suitable level within the CSG, with appropriate information presented to allow management to take action where necessary.	Medium	Key performance measures and indicators are standing agenda items for all LMT & SMT Business Meetings (COMPLETE) Service Clinical Performance scrutinised in monthly performance meetings A full performance dashboard will be created and updated monthly.	Director of Operations	Clinical Service Group Manager	Apr-21	May-21		Part Completed	May 2021 Update - Key performance measures and indicators are standing agenda items for all LMT & SMT Business Meetings. Service Clinical Performance scrutinised in monthly performance meetings A full performance dashboard will be created and updated monthly.	March 2021 Update - Update will be abailable in May 2021
CAMHS Compliance (February 2021)													
CAMCO 01	Feb-21	Reasonable	1) Further work needs to be carried out to ensure that budgets are correctly set up and that there is an appropriate level of scrutiny to ensure miscodings are identified. 2) Management should consider devolving the budgets out to Locality Managers/ Support Managers to ensure the right levels of scrutiny is taking place, which will also coincide with increasing the numbers of people with the authority to approve spend in Oracle.	High	New CAMHS Manager in post – separated from CYP (COMPLETE) Deputy Directorate Manager to have delegated responsibility for budget monitoring within CAMHS. New monthly Business Meeting structure with Finance colleagues presenting a budget report (COMPLETE) Monthly finance meetings with both SMT & LMTs (CTM, SBUHB & Tier 4) to ensure scrutiny and oversight at all levels (COMPLETE). CAMHS working with Finance partners to clarify staffing establishment funding for all CAMHS teams. CTM complete – work ongoing with SB Staff changes forms will be completed for all changes. CAMHS working with Finance partners to clarify staffing establishment funding for all CAMHS teams. Monthly meetings between CAMHS SMT and Swansea Bay Commissioners in place to review finances (COMPLETE) Deputy Directorate Manager to have delegated responsibility for budget authorisation within CAMHS. Locality Managers to have authorisation for local budgets – with maximum level to be agreed	Director of Operations	Clinical Service Group Manager/Directorate Deputy Manager	January 2021/March 2021	May-21		Completed	May 2021 Update - Complete	March 2021 Update - Update will be abailable in May 2021
CAMCO 02	Feb-21	Reasonable	A review of all income budgets should take place to ensure: ☐ Up to date SLAs are in place with all organisations that services are provided to. The SLAs should be approved in line with annual value limits outlined in the Health Boards Scheme of Delegation. Obsolete income targets are removed.	High	A review of all income budgets will take place to ensure: Up to date SLAs are in place with all organisations that services are provided to. The SLAs should be approved in line with annual value limits outlined in the Health Boards Scheme of Delegation. Obsolete income targets will be removed. This work will be addressed in the monthly finance meetings	Director of Operations	Clinical Service Group Manager	Apr-21	01/05/2021 August 2021		In progress	May 2021 Update - A review of all income budgets will take place to ensure: Up to date SLAs are in place with all organisations that services are provided to. The SLAs should be approved in line with annual value limits outlined in the Health Boards Scheme of Delegation. Obsolete income targets will be removed. This work will be addressed in the monthly finance meetings.	March 2021 Update - Update will be abailable in May 2021
CAMCO 03	Feb-21	Reasonable	Management must ensure that termination forms are completed and submitted in a timely manner prior the employee's termination dates to prevent over payments occurring.	Medium	Line Management flow chart/SOP & training information pack to be developed, including internal audit process. Training session to be delivered to all line managers to ensure everyone is aware of their responsibilities. Including reminding of the requirement to complete & submit termination forms in a timely manner prior the employee's termination dates to prevent over payments occurring. Responsibility with each professional lead to identify clear line management arrangements – ESR & Health Roster to reflect this.	Director of Operations	Senior Nurse/ Clinical Leads	Mar-21	01/05/2021 August 2021		In progress	May 2021 Update - An update will be available in August 2021.	March 2021 Update - Update will be abailable in May 2021
CAMCO 04	Feb-21	Reasonable	All staff should be reminded to make expense claims on a monthly basis with authorisation of claims over three months old only taking place in extenuating circumstances.	Low	All staff will be reminded to make expense claims on a monthly basis with authorisation of claims over three months old only taking place in extenuating circumstances.	Director of Operations	Clinical Service Group Manager	Jan-21	May-21		Completed	May 2021 Update - All staff will be reminded to make expense claims on a monthly basis with authorisation of claims over three months old only taking place in extenuating circumstances.	March 2021 Update - Update will be abailable in May 2021
IT Service Management (April 2021)													

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ITSM 01	Apr-21	Limited	Procedures and guidelines should be developed for the Service Desk. These should clarify how to deal with incoming calls, the information to collect, and the routing of these calls. As part of these procedures a set of predefined calls should be developed for the most common /simple calls and incidents to enable these to be resolved on first contact.	High	Service documentation has been completed and forwarded to the auditor prior to the end of February 2021. The documents detail the processes that have now been put in place to start addressing the deficiencies identified in the audit. ICT are developing a starter pack for new members of ICT which will be delivered using the Microsoft streaming platform - Stream, all current staff will be invited to access the video presentation on the use of ITSM system. The audit capabilities within Stream allows Senior managers to monitor staff compliance. Current ICT staff will be invited to participate via a link within an email with a deadline of the 31st March to complete The auditor has now been sent the documentation developed to meet the recommendations and findings for this objective. These will also be incorporated into the starter pack for distribution. 1) Helpdesk – Call Logging Process 2) Pre-defined call information document 3) Transferring a call to another team from the helpdesk. Internal & External escalation	Director of Planning & Performance	Head of Service Management	N/A			Completed		
ITSM 02	Apr-21	Limited	Procedures and guidance should be finalised and issued with training provided as appropriate. Staff should be instructed to ensure that calls and incidents are classified and prioritised correctly	High	Addressed by the response to finding 1. Guidance has been created that will mitigate the risk moving forward in ensuring ICT staff understand the difference between the both call types when raising service point calls. Documentation has been forwarded to the auditor to address the recommendations and findings made for this objective. This will be incorporated into the starter pack for distribution (COMPLETED). 1) Helpdesk Call Types - Training will be provided in house by one of the Desktop Team leaders on a MS TEAMS conference session to run through the management of calls Dates will need to be defined around the training before end of March 2021.	Director of Planning & Performance	Head of Service Management	Mar-21			Part Completed	May 2021 Update - Documents under review by the Senior management team in ICT before sign off and approval	
ITSM 03	Apr-21	Limited	A formal process to ensure call activity is maintained should be established, and calls closed appropriately.	High	Following the recommendation of the audit a document has been created to provide guidance to staff on call management. Reports are run daily through the Information Technology Service Management System. The reports cover: ☐ Calls closed in an unclassified state. ☐ Calls awaiting 3rd party ☐ Calls responded and resolved (Over 30 days) Service Management monitors breached calls and provide additional reports on the areas identified as causing concern. This documentation has been forwarded to the auditor to evidence the recommendations and findings required for this objective. This will be incorporated into the starter pack for distribution. 1) HELPDESK Managing Service Point Calls Document has been created.	Director of Planning & Performance	Head of Service Management	Feb-21			Completed		
ITSM 04	Apr-21	Limited	The process for alerts should be maintained and re-established for each team.	Medium	Alerts and Notifications have now been set and configured as per Service (Local and National). All SLA are in place and ITSM email alerts will be sent for service calls that breach SLA timescales and service calls that are due to breach SLA timescales. Service alerts and notifications on new services will be set as per business go live dates. e.g. (Digital Patient Notes) These will be produced in report format, Service Management will be notified about breached calls and report areas of	Director of Planning & Performance	Head of Service Management	Feb-21	Jul-21		In progress	May 2021 Update - The new service Digital Patient notes is being used to pilot the alerts process	

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ITSM 05	Apr-21	Limited	The formal closure process should be defined that sets out that: ☐ All calls should be closed when finished; and ☐ the extent to which user approval should be sought to close different types of calls.	Medium	Please refer to Finding 3 together with the document created for 'Managing Service Point calls' which guides and supports staff on the basis on managing calls and stipulates the actions for closing calls which will provide consistency within the department moving forward (COMPLETED). ICT staff training will be provided in house by one of the Desktop Team leaders on a MS TEAMS conference session to run through the management of calls Dates will need to be defined around the training before end of March 2021.This finding will be reinforced in ICT staff training. The auditor has been sent documentation which has been recently created to meet the recommendations and findings made for this objective. This will be incorporated into the starter pack for distribution.	Director of Planning & Performance	Head of Service Management	Mar-21			Part Completed	May 2021 - No further update provided	
ITSM 06	Apr-20	Limited	The process should be fully defined with an associated SOP and guidance.	Medium	Cwm Taf Morgannwg have set a deadline for April 30th, 2021 to formulate and sign off a Standard Operating Procedure for problem management. The documentation will cover this functionality within the ITSM system including: Problem logging ☐ Required data capture ☐ Problem management ☐ Problem transference ☐ Accessing the problem record Guidance will be created on how to identify ☐ identification and classification ☐ investigation, diagnosis and resolution ☐ creation of known errors ☐ proactive problem management Staff training on problem management will be	Director of Planning & Performance	Head of Service Management	April 2021/July 2021			In progress	May 2021 Update - No further update provided	
ITSM 07	Apr-21	Limited	Service management should consider defining a standard mechanism and process for operational knowledge management.	Medium	An initial piece of work is required to collate the various pertinent documents and standardise the format. CTM have already identified the requirement to begin the migration from isolated on-premises data repositories into a centralised, governed environment that will allow the HB to move away from traditionally costly on-premises storage solutions organisation. This programme covers three principles requirements for CTM: • Creation of a new Corporate File Plan for SharePoint Storage • • Design and deployment of CTM branded Intranet site templates • • Migration of shared folder data into SharePoint The creation of the ICT knowledge repository will be based upon the principles above and the creation of the cloud based SharePoint	Director of Planning & Performance	Head of Service Management	Jul-21	Sep-21		In progress	May 2021 Update - The move to O365 file share is underway with ICT and the Exec teams as the pilot areas	
ITSM 08	Apr-21	Limited	The basis for the compliance figures should be established, and if necessary, amended to fully reflect the situation within the Health Board. As part of the reporting process, areas for improvement should be identified and improvement plans developed.	Medium	The current ITSM solution is managed and developed by NWIS. The HB will need to work with NWIS to be able to understand the discrepancies identified in the audit. Improvements will need to be identified and escalated to the National Service Management board for discussion	Director of Planning & Performance	Head of Service Management	Sep-21			In progress	May 2021 - No further update provided	
ITSM 09	Apr-21	Limited	The Health Board should define their own impact and service levels for use within their Service Management framework.	Medium	The Health Board follow the NWIS Support Standards and all local Systems and services are governed by these service arrangements. The auditor has received the service catalogue for the ICT department which provides all Systems that are covered and documented. The service catalogue will be reviewed with regards to amending to any local system service delivery.	Director of Planning & Performance	Head of Service Management	Apr-21	Jul-21		In progress	May 2021 Update - Needs reviewing in line with ITSM10	

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ITSM 10	Apr-21	Limited	The service levels provided should be issued and agreed with each user department. As part of this process an agreement setting out the responsibilities and expectations should be defined.	Medium	As part of the IMTP ICT will need to undertake discussions with the ILG and department leads to ensure the service level definitions in the ICT service catalogue are acceptable with regards to supporting the departments	Director of Planning & Performance	Head of Service Management	May-21	Jul-21		In progress	May 2021 Update - This will be undertaken as part of the IMTP enagement	
ITSM 11	Apr-21	Limited	The operational hours of the service desk should be re-considered to ensure they fit with the wider organisational needs.	Low	Currently the health board key working hours are 8am – 6pm Monday to Friday. ICT mirrors this to provide maximum support during these hours. An on call service operates to provide support outside this period. If the health board changes its requirements around ICT support this will require a review of the departments operating hours	Director of Planning & Performance	Head of Service Management	N/A			Completed		
ITSM 12	Apr-21	Limited	Care should be taken to ensure the IT changes process is followed.	Low	The Change process will need to be monitored to ensure that the process is followed. The Change board will need to undertake audits to provide evidence of compliance	Director of Planning & Performance	Head of Service Management	Feb-21			Completed	May 2021 Update - The CAB board ensures and monitors that IT change processes are followed.	
Estates Directorate Management Arrangements (April 2021)													
EDMA 01	Apr-21	Reasonable	1. Management should ensure that the ToR for the Health Safety and Risk Group are reviewed for relevance and brought up to date to reflect all changes especially those relating to the merger with the Bridgend area. 2. The ToR should give greater clarity on the quoracy arrangements. If a percentage quoracy continues to be used, the ToR should more clearly state expected membership. 3. Management should ensure that where possible, in order to maintain continuity, groups such as the SMT continue to meet frequently as they previously did. They should take advantage of the various IT platforms and tools available such as Microsoft teams. This system has been adopted	Medium	1. It is agreed that the TOR should be amended but please note that Bridgend officers have attended the Health Safety and Risk Group. 2. Agreed, will be reflected in the amended TOR. 3. Agreed, meetings will be held at frequencies determined by the TOR, but please note the Senior team met more often during 20/21 (albeit not minuted) to enable the department to respond to the dynamic challenges of Covid 19.	Director of Finance	Head of Estates	April 2021/May 2021			In progress		
EDMA 02	Apr-21	Reasonable	A strong relationship with the Workforce & OD Business Partner team should be maintained. In the absence of CBMs, the Business Partner should have a proactive participation with the Directorate through the most relevant group or meeting. Whilst the Directorate is able to produce its own workforce data, the previously provided data packs should be used for discussion at meetings and for reconciling to Estates held data, as it is this corporately produced data that will be used in wider Health Board reporting.	Medium	PDR and training data has been provided by the training department on a monthly basis since January 2021 and has subsequently been reported at the Senior operational management team meetings, and will continue to do so. The directorate is not receiving sickness or other work force data consequently the Workforce and OD Business partner will be invited to the monthly meetings that are currently held with the Finance Business partner. If they are not available to attend the meetings the Head of Assets, Technical services and Governance will request the Workforce data pack on a monthly basis and if received will reconcile it to the directorate records.	Director of Finance/Director of People	Head of Operational Estates/Head of Assets, Technical Services and Governance	Apr-21			In progress		
EDMA 03	Apr-21	Reasonable	Management should ensure that the Asbestos Policy and Service Testing of Electrical Equipment Procedure (STEEP) are updated as soon as possible and all P&Ps which are soon due for review are updated in a timely manner.	Medium	The asbestos policy and STEEP will be updated and endorsed at the next meeting of the relevant group.	Director of Finance	Head of Assets, Technical Services and Governance	May 2021/September 2021			In progress		
EDMA 04	Apr-21	Reasonable	1. Management should ensure that relevant staff are reminded to complete a DOI or nil return on an annual basis or when changes effect earlier declarations. 2. All new staff at band 8a and above should complete a DOI as a part of Estate's induction process	Low	1. Agreed 2. Agreed	Director of Finance					Completed		

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EDMA 05	Apr-21	Reasonable	1. The Directorate should review their approach to risk management in line with any advice they have been provided by the Assistant Director of Governance and Risk. This should include the use of Datix as the organisational platform for capturing risk thus allowing the flow of risks up to the Organisational Risk Register as necessary. 2. Work should be carried out to review the content of the register to ensure it captures risks specifically relating to the Estates Directorate (not limited to, but including) operational and staff concerns. The items on the current register that are deemed as an issue and not a risk could continue to be maintained in their current format. 3. Where deemed necessary, the Directorate should request further support and training on the application of the Risk Management Strategy and use of Datix	Medium	1. This recommendation has been actioned through meetings with Assistant Director of Governance & Risk, regular communication is ongoing by emails between the Assistant Director and the Estates team to transfer high scoring risks into the Organisational Risk Register (Datix). 2. This recommendation will be picked up by the Directorate's Health, Safety and Risk group at the next meeting scheduled for May 13th. Following discussions, group members will be requested to manage general departmental risks through the same Estates Risk Register spreadsheet. 3. Meetings have been held with the Health and Safety team and Datix support meetings with officers from CTM UHB - Information Systems. Training and support has been requested from the Health and Safety team for the updates to Datix, and for the new layout and standard reports.	Director of Finance	Head of Assets, Technical Services and Governance	Sep-21			In progress		
EDMA 06	Apr-21	Reasonable	1. Management should ensure that reconciliations and checks are done periodically, especially at the start of the financial year, between their departmental records and ESR. Contact should be made with workforce colleagues to ensure the correct NHS start date is recorded for staff that have transferred into the Health Board, in order for ESR to properly calculate staff's annual leave entitlement. 2. Requests to carry forward annual leave into future years should be kept to a minimum. Where there is an operational demand and leave cannot be taken, requests and authorisation to carry forward leave should be made in a timely manner and where possible in line with the Directorate's annual leave policy. Authorisation to carry forward leave should be granted in line with the Scheme of Delegation. 3. Annual leave requests should be submitted, approved and dated in a timely manner, as stated in Estate's annual leave procedure and approved leave	Medium	1. Agreed. Checks are currently made and this will be reinforced to the management/ admin team. 2. Agreed 3. Agreed	Director of Finance/Director of People	Head of Operational Estates/Head of Assets, Technical Services and Governance	Apr-21			In progress		
EDMA 07	Apr-21	Reasonable	1. Management should ensure there is an adequate structure in place regarding the prompt monitoring of sickness prompts, the follow up of sickness interviews and maintenance of required documentation as stated in the NHS Wales Managing Attendance at Work policy. 2. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individuals file.	Medium	1)+2) An adequate supervisory structure and process is in place to ensure the recommendations are adhered to, supervisory/ management staff will instructed accordingly, a review will be carried out in September 2021.	Director of Finance/Director of People	Head of Operational Estates	Apr-21			In progress		
EDMA 08	Apr-21	Reasonable	1. In addition to being an important component of staff wellbeing, the timely completion of PDRs will be an essential part of the NHS Wales Pay progression policy, as such managers and supervisors should be reminded of the requirement to complete PDRs in a timely manner. 2. Ongoing monitoring of compliance rates should continue within the OMT meetings and reports should be requested from Workforce to support the departments own records and allow plans to be developed to return the Directorate to their previously high compliance	Medium	1. The impact of Covid undoubtedly affected compliance rates during the year. The directorate prides itself on performance which is confirmed by the 96% compliance rate in January 2020. A concerted effort has been made and the current compliance rate is circa 76%. 2. Agreed- Existing practices will continue.	Director of Finance/Director of People	Head of Operational Estates	Ongoing			Ongoing		

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EDMA 09	Apr-21	Reasonable	1. Management should liaise with the corporate Health and Safety team and establish an action plan for how fire safety training can be delivered safely to all relevant staff. 2. Regular workforce data reports should be obtained via the Workforce Business Partner and reconciled to the directorate's own records to ensure accuracy. 3. Management should continue to remind staff of the importance of undertaking their mandatory training in line with Welsh Government requirements. For new starters, completion of the mandatory WG modules should be carried out as soon as possible after	Medium	1. Online training module is now available, and staff will be requested to complete it. 2. On the basis that the information is provided by the Workforce Business Partner the Directorate records will be reconciled. 3. Compliance will be monitored on a monthly basis through the Senior team meetings to ensure staff are compliant.	Director of Finance/Director of People	Head of Operational Staff	N/A			Ongoing		
EDMA 10	Apr-21	Reasonable	Acknowledging that this has been an unprecedented year in the Health Board and IMTPs were superseded, going forward, management should ensure they follow the timeframes and content set out in the Health Board's Local Planning Framework when developing future IMTPs. Evidence should be retained of the work carried out on draft versions of the document.	High	Agreed- Timescales will be followed, and draft versions retained.	Director of Finance	Assistant Director of Capital & Estates	Apr-21			In progress		
EDMA 11	Apr-21	Reasonable	While the IMTP programme has been paused, the need to continue to plan for future workforce needs continues. Management should ensure that future planning continues to give consideration to anticipated workforce pressures.	High	Workforce planning is a continual process and discussed regularly at senior team meetings, the outcome of this will be included in the IMTP submission.	Director of Finance	Assistant Director of Capital & Estates	Apr-21			In progress		
Estates Directorate Compliance (April 2021)													
EDCO 01	Apr-21	Substantial	Staff to be reminded that all paperwork relating to purchases made via the 'Screwfix' emergency purchasing cards should be retained.	Low	It will be reinforced via the supervisors and followed up with an email to operational staff that they retain paperwork and return it to the relevant stores manager.	Director of Finance	Head of Estates	Apr-21			In progress		
Welsh Risk Pool Claim Process (April 2021)													
WRP 01	Apr-21	Reasonable	1) The Claims Team should be reminded of the requirement to submit reimbursement requests and associated paperwork to the WRP in line with the timeframes set out by the WRP. 2) For each claim, all applicable fields within Datix should be completed to allowing monitoring of compliance with timeframes.	Medium	1) Since this audit the claims team have been working closely with colleagues from WRP to ensure on-time submission of all the relevant reports including CMRs and LFERs. For March 21 all requested forms and reports as requested by the WRP have been submitted on time and spreadsheets updated accordingly. All the CMRs for the historic cases have now been submitted and the legacy LFERs continue to reduce with an aim of the LFER Task Force finishing these by end of March 2021. 2) Since the audit, the claims team have been working closely with colleagues from WRP to ensure the accuracy of the updating and reporting of claims and timescales on Datix. Each case has been reviewed individually in order to produce specific spreadsheets as requested by the WRP in preparation for their committee in March 21. CTM UHB will go live on the 1st April 21 with the new Once for Wales claims and redress module on Datix. This will enable more accurate reports to be obtained to ensure weekly review of cases between the Claims handler and	Director of Nursing	Claims Team Manager	Apr-21	Aug-21		In progress	May 2021 Update 1) Next deobtor spreadsheet for completion by July 2021. In relation to LFER's, the Task Force are aiming to complete these by end of July 2021. 2) All cases in March 21 were agreed by the WRP committee. Implementation of Once for Wales PTR datix modules has been delayed across Wales. New proposed date is 1st July 21. Once implemented this will enable more accurate reports to be obtained to ensure weekly review of cases between the Claims handler and the Claims and Redress manager.	
WRP 02	Apr-21	Reasonable	Care should be taken to ensure that information stated on documentation or email is proof-read and accurate before submission to Welsh Risk Pool and saving to Datix	Low	Since the audit, the claims team have been working closely with colleagues from WRP to ensure the accuracy of the updating and reporting of claims and timescales on Datix. Each case has been reviewed individually in order to produce specific spreadsheets as requested by the WRP in preparation for their committee in March 21.	Director of Corporate Governance/ Board Secretary	Claims Team Manager	Apr-21			Completed	May 2021 Update - This has now been completed	
Financial Systems (April 2021)													

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FS 01	Apr-21	Reasonable	1. The current fund holder role should be reviewed and if necessary, an additional fund holder added to take responsibility for expenditure on patients. 2. Fund holders should be made aware of the expectations being placed upon them and their responsibilities in line with the Charitable Funds FCP. 3. Plans should be put in place for the prompt expenditure of donations on patients and staff, in line with the likely spirit in which they were originally donated.	High	The Covid-19 fund that was set up when the initial amount was received was set up for the purposes of patient benefit, staff & equipment. This was included on the signed form for the purpose of the fund by the fund holder. We will ensure that it is known that this fund is available for the agreed purposes. It is the responsibility of the fund holder to manage the expenditure of the fund. The monthly reports provide an analysis of committed expenditure of the fund. There are further aspects of Covid-19 charitable fund donations that are being worked through with the relevant officers, these will be confirmed with identified fund holders and committed expenditure in the new financial year in line with expected use of the funds. Additional Covid allocations have been received from WG during the year to fund Covid related expenditure. This has meant that WG funding has been used in the first instance rather than utilising the Charitable Fund. This would allow for its use in coming months when WG funding may not be available. We will identify future commitments for the fund in the coming	Director of Finance	Fund holder / DDoF / Head of Corporate – Finance	May-21			In progress		
FS 02	Apr-21	Reasonable	Specific instructions relating to donations should be clearly communicated to the fund holder to ensure donations are spent in accordance with the donors wishes and expectations.	High	Evidence gained by IA shows that specific use is identified and included on the forms provided to and signed by the fund holder. However, we will ensure that this is continued to be communicated within the monthly budget reports provided.	Director of Finance	Senior Finance Oficer - Charitable Funds	Immediate			In progress		
FS 03	Apr-21	Reasonable	1. As part of the ongoing review of the Charitable Funds FCP the inconsistencies between the FCP and Scheme of Delegation should be resolved, and updates made where processes and appendices have been amended. 2. Consideration should be given to introducing tolerance levels, below which finance can approve variations in payment values, as opposed to requiring fund holder authorisation. 3. Relevant staff should be made aware of the revised FCP and old copies of	Medium	Agreed, FCP needs to be reviewed in line with the Scheme of Delegation and updated.	Director of Finance	Head of Corporate Finance	Jun-21			In progress		
FS 04	Apr-21	Reasonable	The work of the project team to identify and implement alternative process for the timely removal from the financial system of terminated users or users that have changed their role should recommence as soon as possible and changes made to the FCP if necessary. In the meantime, consideration should be given to restarting the periodic issuing of Oracle hierarchy reports to managers asking them to confirm that the details are still correct.	Medium	Agreed with recommendation and in line with the FCP, we have actioned the end date of inactive users and a new monthly monitoring process has been put in place which is due to go live this month.	Director of Finance	Systems Accountant	Mar-21			In progress		

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FS 05	Apr-21	Medium	If there is a move towards less frequent physical verification work by the capital finance team, consideration should be given to other controls: • Reviewing the frequency of requesting directorates (now Clinical Service Groups) to review their asset reports. At the current time reports are issued quarterly with a response required once a year. A move to detailed reports issued every six months and ensuring a greater response rate should be considered. • Liaising with the Clinical Engineering department to cross match assets they have verified as part of their planned preventative maintenance (PPM) cycles of work, allowing the capital finance team to focus their verification efforts on those assets that may not form part of a PPM cycle.	Medium	As mentioned in the finding changes are being made to the current FCP regarding the information sent to directorates and the 18-month physical verification cycle. • Asset reports will be sent to directorates biannually rather than quarterly. It will remain that once a year Clinical Service Group Managers are required to return a signed and dated copy of the report to the Capital Accountant. A greater response rate to this will be targeted through regular follow up. • The change to physical verification is moving to a sample physical verification exercise of each directorate on a 3-year rolling period. The FCP will state that this exercise will include an element of physical verification by the Senior Finance Officer but also using data available from Clinical Engineering records of equipment service and maintenance. In addition to this the FCP will state that this exercise will be formally recorded in the asset register which was not the case previously. Note the action and deadline set for this is considered to be through updating the FCP for the above. Evidence of the changes in action would not be seen in full until March 2022	Director of Finance	Capital Finance Manager	Apr-21			In progress		
FS 06	Apr-21	Reasonable	Management may want to consider creating a procedure, as it will help strengthen efficiencies, deliver best practice and more importantly it will provide added support should the department have new staff working in that area.	Low	Agreed. A manual for the fixed asset register will be created.	Director of Finance	Finance Manager	Sep-21			In progress		
PCH Redevelopment Governance Audit (April 2021)													
PCH GOV 01	Apr-21	Reasonable	Reporting to ECMG should provide RAG ratings for this and the prior period against key criteria such as time, cost, quality and risk (D).	Low	Agreed. Future reporting will utilise existing Capital Review Meeting notes with the addition of RAG for sectional completions as detailed by PM progress report.	Director of Finance	Deputy Senior Responsible Officer	Mar-21			Completed	May 2021 Update - ECMG report furnished with the update most recently delivered to CRM and RAG rating from PM report included.	
PCH GOV 02	Apr-21	Reasonable	Key roles and responsibilities should be defined at the Project Execution Plan as the main point of reference (D).	Low	Agreed. Whilst individuals are performing the expected roles, the corresponding documentation will be updated.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		In progress	May 2021 Update - Review of PEP required to define amendments of roles and responsibilities. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.	
PCH GOV 03	Apr-21	Reasonable	Appropriate arrangements will be made to ensure that vacancies identified within the resource schedule are filled as a matter of priority (O).	High	Agreed. All of the appointments for additional resources are progressing and the Senior Responsible Officer has confirmed that all are permanent positions (Noting that the appointments are for a 5.5 year construction programme and employment rights become permanent due to this duration). Responsibility for the appointments rests with departmental heads to progress these positions with assistance from the Major Projects Unit.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		In progress	May 2021 Update - One Commissioning Officer in post. 2 Estates posts addressed; Offer made and being processed for Informatics Officer and additional hours granted to part time Officer. 2 Estates post being addressed; applications received with no suitable candidates, being re-advertised. Discussion held with IT about committing resource to project of Contracted member of staff. Discussion held with IPC regarding need to advertise for post. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.	
PCH GOV 04	Apr-21	Reasonable	Internal change control arrangements (PIF) should be introduced to demonstrate compliance with Standing Financial Instructions (O).	Medium	Actioned since audit fieldwork.	Director of Finance		N/A			Completed		

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PCH GOV 05	Apr-21	Reasonable	The Deputy Senior Responsible Officer will continue to monitor Project Board attendance (O)	Medium	Agreed. The attendance at Project Board will continue to be monitored. Attendance at the last Project Board (January 2021) was quorate with senior representation from the ILG and planning department. The Health Board recognise the pressures that the Covid pandemic has placed on all individuals to date and emerging structural re-organisation on a locality basis. At the last meeting it was identified that certain strategic decisions were not within the gift of the Project Board and required escalation to Chief Executive and other key individuals. This has been promptly recognised and actioned with an initial meeting being arranged to discuss over-arching Health Board considerations that may have an impact on the project. To this extent attendance has improved (noting that Phase 2 is now 'real' and not something that has had a number of false dawns) and equally recognises its limitations on over-arching matters and escalates	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		In progress	May 2021 Update - Need for attendance stressed to attendees and confirmation of attendance sought. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.	
PCH GOV 06	Apr-21	Reasonable	Timing of Project Board meetings will be reviewed in order to ensure there is adequate time for financial papers to be disseminated (O).	Low	Agreed. Depending on when the Project Board falls, it can result in a shortened period for the issue of papers following the Financial Review Group and WG dashboard return. The schedule of Project Board meetings for 2021/22 will be reviewed so that impacted meetings are re-arranged.	Director of Finance	Programme Director						
PCH GOV 07	Apr-21	Reasonable	The Service Project Team membership and quorum should be reviewed (D).	Medium	Agreed. The membership and quorum will be reviewed. In terms of membership, there was no formal ILG site structure previously which to explains the wide reaching membership that has been required. The quorum will likely involve the Core Planning Team members of the group and will be extended to include clinical representation	Director of Finance	Programme Director	Mar-21			Completed	May 2021 Update - The review of the Service Project Team TOR has been undertaken and membership revised in line with Audit recommendations	
PCH GOV 08	Apr-21	Reasonable	An action log should be introduced for the progress meetings with details of the proposed action, the lead and expected timeline to resolve (D).	Low	Agreed	Director of Finance	Programme Director	Mar-21			Completed	May 2021 Update - Action Logs are now produced for every Service Project Team meeting and PCH G&FF Project Board and have been in use for a couple of months now	
PCH Redevelopment Financial Management (April 2021)													
PCH FM 01	Apr-21	Reasonable	The funding position will be recorded at the risk register and monitored (O).	Medium	Actioned since audit fieldwork.	Director of Finance	N/A	N/A			Completed		
PCH FM 02	Apr-21	Reasonable	The presentation of funding throughout the cost report should be consistent to allow simple interpretation by lay members of the Project Board (O).	Low	Agreed. The cost adviser will be instructed to review the report ahead of the next iteration.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		In progress	May 2021 Update - Audit recommendations shared with Cost Advisor to address in next round of reporting. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.	
PCH FM 03	Apr-21	Reasonable	The narrative at the cost report supporting the VAT reclaim will be reviewed to provide greater clarity for the reader (O).	Medium	Agreed. It should be noted that other cost reporting reflected the VAT position correctly, including reporting to Welsh Government. The cost adviser will be instructed to review the report ahead of the next iteration.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		In progress	May 2021 Update - Audit recommendations shared with Cost Advisor to address in next round of reporting. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.	
PCH FM 04	Apr-21	Reasonable	The cost adviser report should outline whether both the approvals and/or costs have been uplifted for anticipated changes, in the derivation of the gain share (O).	Medium	Agreed. The cost adviser will be instructed to review the report ahead of the next iteration.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		In progress	May 2021 Update - Audit recommendations shared with Cost Advisor to address in next round of reporting. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.	
PCH FM 05	Apr-21	Reasonable	Terminology used at cost adviser reports will be consistent, to ensure reports are easy to follow (D).	Low	Agreed. The cost adviser will be instructed to review the report ahead of the next iteration.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		In progress	May 2021 Update - Audit recommendations shared with Cost Advisor to address in next round of reporting. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.	
PCH FM 06	Apr-21	Reasonable	Supporting charts and tables to the Cost Adviser report will be reviewed for accuracy and updated (O).	Medium	Agreed. This information is not routinely referenced and is considered superfluous. It will therefore be removed from future reports.	Director of Finance	Deputy Senior Responsible Officer	Mar-21	Aug-21		In progress	March 2021 Update - Audit recommendations shared with Cost Advisor to address in next round of reporting. Agreement obtained from NWSSP Audit (E.Jones) that Implementation Date becomes end of July due to new RO in post.	
PCH Redevelopment Technical Compliance (April 2021)													
PCH TC 01	Apr-21	Reasonable	Appropriate approval will be obtained for the interim award for Asbestos consultancy.	Medium	Recommendation 1 agreed.	Director of Finance	Deputy Senior Responsible Officer	Apr-21			Completed	May 2021 Update - Approval obtained. Appointment extended until 31/07/21	
PCH TC 02	Apr-21	Reasonable	The full tender exercise for Asbestos Consultancy will be progressed as a matter of priority.	Medium	Recommendation 2 agreed.	Director of Finance	Deputy Senior Responsible Officer	Jul-21	Aug-21		In progress	May 2021 Update - Tender documents being prepared for appointment by end of July 21.	
PCH TC 03	Apr-21	Reasonable	The Project Bank Account will be established to meet Cabinet Office minimum requirements.	Medium	Agreed	Director of Finance	Deputy Senior Responsible Officer	Jun-21			Completed	May 2021 Update - PBA in place and to be utilised for next payment round	

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PCH TC 04	Apr-21	Reasonable	The UHB should request that NWSSP have similar payment processing arrangements in place for this project as observed for other major projects.	Medium	Agreed	Director of Finance	Deputy Senior Responsible Officer	Apr-21			Completed	May 2021 Update - Single point of contact identified within NWSSP for payment processing.	