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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 Public Health	Assistant Director of ICT	Apr-19	March 2020 December 2020 July 2021 Now December 2021		In progress	September 2021 - A number of documents are complete, overarching to pull them together will be done once a full list is complete.	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. 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. July 2021 Update - Work has recommenced since return. Solarwinds document ready for review, Pathology at PCH has also been started. In addition a service catalogue template has been developed using SharePoint online which will provide the Health Board one place where ICT systems and software details can be found. This will also assist in providing information required by NHS Wales Cyber Security Unit (CRU) as part of the NIS Regulations.
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 Public Health	Assistant Director of ICT	Apr-19	January 2020 December 2020 December 2021		In progress	September 2021 - As per previous updates, any issues identified during the creation of the documents are rectified or a plan put in place to do so.	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. 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 2021 Update - Work has recommenced since return. Solarwinds document ready for review, Pathology at PCH has also been started. In addition a service catalogue template has been developed using SharePoint online which will provide the Health Board one place where ICT systems and software details can be found. This will also assist in providing information required by NHS Wales Cyber Security Unit (CRU) as part of the NIS Regulations.

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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 Public Health	Assistant Director of ICT	Apr-19	April 2020 December 2021		In progress	September 2021 - No further update	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. May 2021 - no progress has been carried out on this recommendation. July 2021 Update - no update. RTO will be established with the departments and can then be tested against once documents are complete
Mandatory Training (March 2019)													
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 Now December 2021		In progress	September 2021 - No significant update other to note that work is on track to meet the commitment of providing new starters with ESR E learning training commencing October 2021. Compliance rates are increasing ablbeit marginally and further work is required to ensure those lower scoring areas such as Fire, health & safety and mvoing nad handling are appropriatly resourced and facialitedvirtually where possible to allow as many staff as possible access to the learning opportuntiyy. Resource constraints (as cited by Hd of H&S) are impacting the availabiilty of training and thus the ability for staff to complete these core areas of training. Bank Manager will be required to update on her areas of interest seperatly. Update from Staff Bank Manager September 2021- Staff Bank are activly engaged in compliance, there is currently ongoing work to validate the bank registrar and bank workers with zero compliance are being targeted. Those who have not actively worked inline with their Terms of Engagement are being de-registered, those who are are being contacted with ensure they have an active nadex account (IT are deactivating accounts that have not been accessed in over a year) and a live @wales email address. This work follows the bank RN pilot where funding was secured to pay for training. Discussions on an all Wales Basis to target Bank worker training have resumed. There are however limited staffing rescourses within the bank team to manage and monitor M&S bank worker compliance. No decision has been made as toany penalties for bank workers who remain non compliance or payment to attend training - this will result in a significant increase in the staff bank training budget.	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. 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. July 2021 - A steering group has now formed and meeting monthly to address the strateegic issues and challenges of compliance. Hierachies were cited as a key issue and a meeting wwith Dir for People and Heads of Workforce ILG is due to take place to begin to address this issue and improve the controls. Alied to this is training requirements for roles, L&D are drafting an action plan to carry out a grass roots review of roles working with HR and LM's to determine staff correct treaining requirements. L&D are currentyl going through a significant change activity where roles and staff are displaced and we are activly recruiting to meet our compliance outputs. A Festival of Compliance has been trialled in WFOD to look are how we can engage more staff in compliance across CTM more broadly. The aim is to roll out the festival to each ILG. L&D are working with all Wales ESR Training forums to examine more effective ways to engage staff in compliance training, the forum is due to report later in the year. There is work onoing to reduce Inter Authority Training and already this has reduced by 50% with the aim to reduce this further to 30% by the end of July. L&D are short;y to begin work with the ESR team to broaden the HR dashboard and use BI to provide more insightful and usable L&D trainign data. L&D are also drafting a process to
Patient Experience (April 2019) Reasonable Assurance													

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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 Now December 2021		In progress	September 2021 Update - CIVICA PM appointed and produced timeline for roll out within CTM. 'Have your Say' generic people's feedback being placed as a link on the CTMUHB intranet page. Plan for Draft People's Engagement document by December 2021.	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. 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 2021 Update - The Patient Experience Plan will be updated in accordance with the Health Board Strategy/Ambition once produced. This will include a joint People's Experience and engagemment 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. A project manager has been appointed for the implementation of CIVICA and they commence in post end July 2021.
Mobile Phones (May 2019) Reasonable Assurance													
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 Public Health	Assistant Director of ICT	Jun-19	July 2019 April 2021 August 2021 Now November 2021		In progress	September 2021 - Survey completed awaiting submissions to the tender, hoping to award in Oct 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. May 2021 - The tender document has been released and is aiming for a go live date of 1st Aug 2021. July 2021 Update - Tender document still out to potential bidders
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 Now December 2021		In progress	September 2021 Update. Nothing further to add - target date remains December 2021.	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. 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. July 2021 Update - Process underway to update and amalgamate all policies from two distinctive ones to a whole
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	01/02/2021 Now November 2021 Now December 2021		In progress	September 2021 Update. Nothing further to add - target date now December 2021.	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	01/01/2021 Now November 2021 Now December 2021		In progress	September 2021 Update. Nothing further to add - target date now December 2021.	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. May 2021 - nothing further to report this month. July 2021 Update. Additional information received from Information colleagues to be escalated the ILGs immediately.
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 Now October 2021 Now December 2021		In progress	September 2021 Update. Nothing further to add - target date now December 2021. Informal discussion with SGMs suggests strongly that Medical Secretaries are provided with support with training.	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. May 2021 Update - Nothing further to report this month. July 2021 Update. No change reported.
Consultant Job Planning (October 19) - Limited Assurance													

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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		Part Completed	September 2021 - No further 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 with the ILGs has
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 Now October 2021 Now December 2021		In progress	September 2021 Update - • Development of a policy document was required to standardise the approach across the UHB for SPA and DCC split, to ensure fairness and equity for all Medics that take part in the job planning process. • There has been a document produced regarding the process for deciding SPA and DCC allocation. This was shared with the LNC in February 2021 and a number of amendments were suggested. • These amendments were made and the document was submitted to the LNC in August 2021 for review, there were additional comments on the paper that the staff representatives would like changed for them to agree with its roll out across the UHB. The British Medical Association (BMA) representatives will formally set out their concerns before the next LNC in December 2021, to allow the guidance to be agreed in partnership at that meeting.	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

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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	September 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 August 2021 and a number of amendments were suggested by staff representatives. These will be formally recorded and shared by the BMA, then worked into the document where appropriate and will be shared with the LNC at the next meeting in December 2021 to allow for agreement on this guidance in partnership. • An SOP has been developed and shared for job planning, which clearly sets out the responsibilities and process that allows for effective job planning.	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. May 2021 Update - No further update to provide. July 2021 update – Job planning SOP now in place. Awaiting
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 Now March 2022		Part Completed	September 2021 Update • A standardised rate card was produced in collaboration between Medical Workforce, Finance, the AMD for Medical Workforce and the Medical Director. • Following publication of the aforementioned ADH rate card, it was determined that further work was required on it to review the proposed rates, this was following extensive feedback from Medical colleagues and the LNC. • A financial control procedure was also produced and approved. Within this is confirmation of a standard rate card development for payment of ADHs. • A paper was submitted to management board for approval of the approach to gather the information for the rate card, rather than create one without solid data to support it. The Medic bank was then launched in Bridgend ILG without a rate card, but the software solution Patchwork in place to manage the ADH booking and approvals. • What this provides the Health Board with is the ability to 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. • The medical bank software solution has now launched successfully in the Bridgend ILG and has received positive feedback from the end users. It will be launched in the RTE and M&C ILGs over the remainder of the financial year, providing the required data for the rate card development.	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.
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 Now March 2022		Part Completed	3. September 2021 Update - Supplier still awaiting approval for remote access (to update and set system up to Version 2 of software and database) from ICT. Access issues for the tracking system on Citrix at POW still being resolved with ICT. Quote received to apply fixed reader points to fully cover RGH site as next phase and submitted to Capital for funding, awaiting decision. (DW WG 20/09/2021).	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 Now September 2021 Now December 2021		In progress	Sept 21 update: Due to inability to get interested parties to agree on the final policy, alongside the cancellation of the last 2 meetings for not being qourate, the policy has not progressed further. The policy is awaiting agreement in partnership to progreess to polciy group.	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. 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. July 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has been completed. It needs a final review with the group
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 Now September 2021 Now December 2021		In progress	Sept 2021 update: Due to inability to get interested parties to agree on the final policy, alongside the cancelleation of the last 2 meetings for not being qourate, the policy has not progressed further. The policy is awaiting agreement in partnership to progreess to polciy group.	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. 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 2021 Update - Policy development group has been difficult to complete due to the pandemic and poor attendance at meetings to make them quorate. The policy is still under review in conjunction with the union representation, but has

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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 Now September 2021 Now December 2021		In progress	Sept 2021 update: Due to inability to get interested parties to agree on the final policy, alongside the cancelleation of the last 2 meetings for not being qourate, the policy has not progressed further. The policy is awaiting agreement in partnership to progreess to polciy group.	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. APRIL 2021: See above for policy amendments. Remaining recommendations delayed due to the pandemic but will be taken forward in the same
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 Now September 2021 Now December 2021		In progress	Sept 2021 update: Due to inability to get interested parties to agree on the final policy, alongside the cancelleation of the last 2 meetings for not being qourate, the policy has not progressed further. The policy is awaiting agreement in partnership to progreess to polciy group.	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. APRIL 2021: The Rostering Policy has been updated and is currently in the system for approval. A new Rostering Group has been
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 Public Health	Assistant Director of ICT	Jun-19	July 2020 December 2020 May 2021 July 2021 Now September 2021 Now November 2021		In progress	September 2021 - meetings have been organised to commence the policy and procedure, which will be competed by the end of October 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. May 2021 - there has been a delay in completing the procedure due to work pressures, date has been extended to July 2021. July 2021 Update - A policy and procedure will be presented to the RAGCSB August meeting.

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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 Public Health	Assistant Director of ICT	Jun-19	September 2020 November 2020 May 2021 August 2021 Now April 2022		In progress	September 2021 - work is continuing on removing out of date operating systems within the server estate between members of the server team and system managers. The work is hampered by third party system software vendors providing updated software that will operate on modern 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. 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. July 2021 Update - Work is continuing on eradication out of date operating system software. There
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 Public Health	Assistant Director of ICT	Jul-19	June 2020 December 2020 March 2021 July 2021 Now August 2021 Now February 2022		In progress	September 2021 - work is continuing on the installation of the Skybox application. Work has been delayed due to the Firewall replacement programme on the PCH and RGH Firewalls which is due to be completed by the end of October 2021.	**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)													

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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 Now December 2021		Part Completed	September 2021 Update. Target date remains December 2021. Work remains ongoing here.	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. 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. July 2021 Update - For RTE ILG (ENT) more work needed here - though likley to be small numbers. Remains red. For Bridgend ILG (Ophthalmology), all staff aware that this should be completed. No response from MC ILG. For MC (OMFS), colleagues are aware that this should happen and are in the process of undertaking an inventory
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 Now December 2021		In progress	September 2021 Update. Head of Audiology has now met with stock leads across Audiology, to emphasise background and context. There is now a draft stock protocol available. Further, there are plans to develop local minimum stock levels and standing orders for hearing aids and batteries. The Head of Audiology has been assured regarding stock security on all audiology sites. There have been delays in resolving this situation - they relate to long term sick and the ongoing structural issues in the department. However, work is progressing albeit slowly in the context of HR OCP pending as well.	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. 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. July 2021 - No further update provided
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	September 2021 - No further update	This work is currently on hold due to the current Covid-19 epidemic and a completion time is not currently predictable. July 2021 -This work is currently on hold due to the current Covid-19 epidemic and a completion time is not currently predictable.
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	01/06/2021 Now 31/08/21 01/06/2021 Now 31/08/21 New Policy Approved September 2021 Interactive webpages will be completed by 31/12/2021		Part Completed	UPDATE SEPTEMBER 2021: The Health Board's new Health and Safety Policy was ratified by the Quality and Safety Committee in August 2021. Work is still underway with the Health Board's Intranet Manager to transform this Policy in to a set of Webpages to allow all staff ease in identifying and understanding their responsbilities under the new Policy. The interactive webside will be demonstrated at the next Health, Safety and Fire Committee.	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. July 2021 - The newly formed intranet pages will be live by 31/08/2021
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	01/07/2021 Trial Audit on Social Distancing completed August 2021. New completion date for audit package to be suitable foir H&S Audits 31/01/2022		Part Completed	SEPTEMBER 2021: The above audit findings were presented as a draft to the last Health, Safety and Fire Committee in September 2021. There are still some issues with the audit package producing an exeutive summary of the audit undertaken. The Health, Safety and FIre Team are in further dicussions with the Clinical Audit Team and AMaT to resolve this. Whilst awaiting this system fix an audit programme is being set up and will be rolled out once the system fixes have been completed.	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. July 2021 - Audit Package currently undergoing further testing due so some reporting issues on the AMaT system.
Directorate Review Acute Medicine & A&E (July 2020)													
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 reviewing and updating the policy.	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	01/04/2021 Now April 2022		In progress	September 2021 Update - This remains a key risk and represents a significant amount of work in an area where capacity is stretched. No further action to report, but it remains an issue about which the Service Group is aware	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. 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. July 2021 update. For RTE and MC ILG, no change – remains a key risk area. Will be addressed when capacity allows.

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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		Completed	September 2021 Update - PDR compliance – continues to be monitored via the monthly ILG performance review	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. 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. July 2021. For RTE this area continues to be monitored closely and progress reported to the ILG Directors. In MC ILG, ongoing improvement in PDR compliance with challenge to achieve 5% improvement month on month.
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 Now December 2021		Completed	September 2021 Update. RTW interviews - continues to be monitored via the monthly ILG performance review	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. 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. July 2021 Update. For RTE, there are still issues with the ESR and Allocate systems as they do not talk to each other so the information is never correct. We are regularly reviewing the position and reporting progress to the ILG. In MC ILG, ongoing improvement in PDR compliance with challenge to achieve 5% improvement month on month.
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	September 2021 Update. No change to report, the target date remains April 2022	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. 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. July 2021 Update - no change for RTE and MC ILGs at present however this

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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 personal possessions.	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 Now March 2022		Completed	September 2021 Update - Staff have been reminded about patients property	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. 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. July 2021 Update. For RTE this remains an issue. For MC ILG it is complete.
MDR 01													
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	September 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 is due to these areas using separate products to Health Roster that they are unwilling to give up, until the functionality in their own systems is recreated in Health Roster. • Although Health Roster is rolled out in all ILGs now, the data suggests that full uptake and utilisation of the systems capabilities is still relatively low. • For ED POW and ACT to transition to Health Roster, the additional functionality they require is contained within the 2 extra modules to be from Allocate. The 2 modules are Medic On Duty (MOD) and Activity Manager (AM). AM is yet to be purchased. • The additional functionality of the products were recently showcased to ED in POW, to an audience containing the clinical and administration staff. Feedback was not supportive of adopting the allocate packages as a rostering system, wishing to remain with their current product. • Conversion of ACT & ED will not be revisited until the pandemic is over, due to the current main focus within both the Departments and eRostering being maintenance of current service.	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. July 2021 Update - After meeting with ED representation and showing them a demo for the system with full functionality, the ED leads have taken the decision that Health Roster does not work for them and they do not want to use it. This puts us in a situation that is difficult to bypass. The areas do not want to use the system and say it doesnt work for them, but the audit report says that they absolutley should be using the systsem. A decision needs to be made as to whether we make the area use a system that they feel doesnt deliver what they want, purely because the audit report recommends it.

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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	September 2021 Update - • A rostering policy is in draft form that was developed in collaboration between the Assistant Medical Director and Medical Workforce. This will be developed further in partnership through the LNC. • There are end user accessible guides on how to use Health Roster already held within the system and now on an intranet eRostering site, alongside video guides for the most common queries. • Separate guides for non eRostering areas are no longer required as most areas (apart from ACT and ED) are now on Health Roster.	January 2021 Update - Intital scoping and collection of documnetation has been completed. This work will commence again after the pandemic. July 2021 update - the policy is in active devlopment and a policy group has been set up with stakeholders involved.
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 resource.	Director for People	Head of Workforce Productivity & E-Systems	Sep-20	01/12/2021 Now April 2022		In progress	September 2021 Update • All areas within the UHB, except ED POW & ACT, are now active on Health Roster due to the refreshed implementation plan undertaken by the medical eSystems team. • The final phase will be completed when ED POW and ACT are fully using Health Roster. • Sick leave recorded on Health Roster automatically feeds into ESR.	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. APRIL 2021: Work delayed during the pandemic, revised implementation dates provided. July 2021 update - a training initiative was undertaken with all Medic areas using health roster in the Health Board and everyone was given update training on the system and sickness was included in this. All the training was recorded and certificates of completion issued to all areas.
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	01/12/2021 Now April 2022		In progress	September 2021 Update - • For effective Rotas and Rosters to be built, establishments need to be developed. Once this work is done they can actually be monitored for effectiveness, as a set agreed standard is present to be monitored against. • Systems such as Health Roster can monitor EWTD and set limits on amount of hours worked. This is then additionally monitored locally by the Roster managers for each area, as they have oversight and intimate knowledge of the day to day running of their rosters. If there is a requirement to turn this setting off, it can only be removed centrally by the eRostering lead. • KPIs will be introduced for Medical rostering, which will be reported on at the ILG efficiency meetings. These KPIs will be developed alongside the rostering policy and held within the policy. • As the development and recording of establishment work is still in its infancy, this work cannot be completed until this data is held.	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. APRIL 2021: Work delayed during the pandemic, revised implementation dates provided. July 2021 update - a training initiative was undertaken with all Medic areas using health roster in the Health Board and everyone was given update training on the system and rota management was included in this. All the training was recorded and certificates of completion issued to all areas.
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	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	September 2021 Update • A policy has recently been finalised covering study leave entitlements across CTM. This clarifies how much is available and how to apply for it. • This was taken to the LNC for agreement in partnership in August. The LNC staff representatives raised some areas of the policy they would like changed and a separate meeting has now been setup to work the comments into the policy, to allow for the policy to be agreed	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. APRIL 2021: Work delayed during the pandemic, revised implementation dates provided. July 2021 update - The policy has been to LNC. Additional queries where raised that are being worked on by Nerys Conway. This will be taken to the next LNC for view by the committee with a view for sign off.

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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	01/12/2021 Now April 2022		In progress	September 2021 Update • This required the roll out and implementation of MOD and AM. This work will not be complete until at least April 2022, so the alignment work will be tied to that. • These applications automate the upload of the job plan. This will ensure exact reflection of the agreed job plan. • Local management will play a vital role in this, ensuring that job plans reflect what is shown on the Health Roster as the activity. Additionally for best results, the job plan should meet the identified need AM will provide to the clinical areas to build job plans around.	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. APRIL 2021: Work delayed during the pandemic, revised implementation dates provided. July 2021 update - Medic on Duty and Activity manager have not been purchased as yet. Talks are still underway with IT who finance the prducts to allow for the purchase.
Head & Neck Management Arrangements (August 2020)													
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 taken.	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 Now December 2021		Part Completed	September 2021. Work remains ongoing - date is still December 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. 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. July 2021 Update - In RTE and MC ILGs, this action is complete. In BILG, training is underway for action 1, for action 2 it is in place for clerical and medical staff and for the other two work is complete.
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 Now December 2021		Part Completed	September 2021. Work remains ongoing - date is still December 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. 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. July 2021 Update - For RTE ILG and BILG, this is an aim but not achieved across both areas given the implications of covid. There is a plan with WOD colleagues and intent for this to be improved. This is monitored in ILG Performance Review meetings monthly. In both areas the information is readily available if needed. No response from MC. For MC ILG (OMFS) this is complete.

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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 Now December 2021		Part Completed	September 2021. Work remains ongoing - date is still December 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. 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. July 2021 Update - In RTE ILG (for ENT), all staff are aware that this is mandatory and so the action is complete. In BILG (for Ophthalmology), ESR is not used and so training is underway, so not yet complete. For MC ILG, this is complete and happening across all areas of the Clinical Service Group.
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 Now October 2021		Part Completed	September 2021. Work remains ongoing - date is still October 2021.	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 by the SGM and the Clinical Director. 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. July 2021 Update - In RTE ILG, the aim is to complete plans annually and there has been an improvement with a plan in place. For action 2 this does take place. In BILG, job planning is underway and should be completed by September 2021, so this is almost complete. In MC ILG, this was complete pre-COVID-19. Unfortunately as a consequence of the response, job plans are still fluid and in a state of flux. However, Job plans for all specialties of the Clinical Service Group are being planned for September 2021.
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	01/06/2021 Now 31/10/2021		In progress	September 2021 Update - The Medical Workforce Scrutiny Goup is scheduled to take place on 28th September 2021. ToR has been agreed 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. 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. July 2021 Update - The Medical Workforce Scrutiny Group (MWSG) has not been implemented yet, this is due to the changes at a Senior level (MD). A meeting between the MD, AMD and Workforce colleagues is scheduled in early September and the first (MWSG) will be set up following the meeting.
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	September 2021 Update - Bridgend ILG – presentation on the agenda of the Audit & Risk Committee on the 4th October to capture progress, delivered by the ILG Nurse Director. Rhondda Taf Ely ILG - All Clinical Service Groups (CSGs) report having reviewed their entire risk registers. However, there is still room for improvement to ensure the standard fully aligns with the Risk Management Strategy. Meetings are taking place, being led by the ILG Operations Director, over the next week to provide targeted support to CSGs where required and ensure consistency of approach and calibration across the ILG. It is anticipated that RTE will have a fully reviewed risk register by mid-October at the latest. Merthyr & Cynon ILG – All Clinical Service Groups (CSGs) continue to review their entire risk registers. A focussed risk session is scheduled for the 6th October led by the ILG Head of Quality & Safety with the support of the Assistant Director of Governance and Risk. This session and further targeted support will assist CSGs where required and ensure consistency of approach and calibration across the ILG. It is anticipated that M&C will have a fully reviewed risk register by the end of October 2021.	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. 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 July 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	01/07/2021 Now October 2021 Now December 2021		In progress	September 2021 Update - The Training Needs Analysis is complete, however, the Assistant Director of Governance & Risk is working with peers across NHS Wales to develop Level 1 - 3 Risk Training packagaes available on the ESR E-Learning platform. Level 1 is currently with ELearning Teams to finalise and Level 2 development has been commenced. An extension to the implementation date is requested to allow for the launch to coincide with the training packages being made available on E-Learning on an All Wales Basis. The Health Board is working with All Wales colleagues to ensure a consistent approach to risk is adopted and transferable across Wales.	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. 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 July 2021 - Training Needs Analysis completed and will be shared across the Health Board one the training packages that align to the TNA have been developed. Level 1 Training Package- draft being shared with Elearning colleagues w/c 26th July 2021 to start development of esr module. Level 2 - Training package development to commence August 2021.
CAMHS Management Arrangements (February 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 Now December 2021		In progress	September 2021. Work on the policy reviews continues, the target date remains December 2021.	March 2021 Update - Update will be abailable in May 2021. 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. July 2021 Update. CAMHS Policy Group newly established, with ToR developed. All CAMHS policies identified, to be reviewed and standardised to new format to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan devised to ensure rolling programme. 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 the action taken will be confirmed in August 2021

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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 Now September 2021		Completed	September 2021 - CAMHS is currently achieving 69% compliance with PDRs, with the Lead Nurse coordinating the improvement work around this target and significant work has been undertaken	March 2021 Update - Update will be abailable in May 2021. 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. July 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. PDR compliance has increased in CAMHS and is currently at 72.6% Support will provided if a drop in compliance is due to
CAMHS Compliance (February 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 Now September 2021 Now December 2021		In progress	September 2021 Update - Line Management training currently being delivered across CAMHS to ensure all staff who line manage others are fully aware of their responsibilities. CAMHS due to receive feedback from the recent re-audit undertaken by NSWWP in month	March 2021 Update - Update will be abailable in May 2021. 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. July 2021 Update -This should be complete - a final check will be undertaken. 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.
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 Now September 2021 Now December 2021		In progress	September 2021 Update - Line Management training currently being delivered across CAMHS to ensure all staff who line manage others are fully aware of their responsibilities. CAMHS due to receive feedback from the recent re-audit undertaken by NSWWP in month	March 2021 Update - Update will be abailable in May 2021. May 2021 Update - An update will be available in August 2021. July 2021 Update - This action should now be complete - final check to be undedrtaken this month. Training pack completed & training to be rolled out to all managers. ESR being updated to reflect line management arrangements.
IT Service Management (April 2021)													
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 Public Health	Head of Service Management	Mar-21	Sep-21		Part Completed	September 2021 - No further update	May 2021 Update - Documents under review by the Senior management team in ICT before sign off and approval. July 2021 Update - The staff training element of this recommendation has not yet been completed. Training has not yet taken place

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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 Public Health	Head of Service Management	Mar-21	Oct-21		Part Completed	September 2021 - No further update	May 2021 - No further update provided. July 2021 Update - Documentation has been distributed to the service desk. Desktop team leaders have taken responsibility of training new members of ICT on the use of the ITSM system.
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 Public Health	Head of Service Management	Jul-21	Sep-21		In progress	September 2021 - No further update	May 2021 Update - The move to O365 file share is underway with ICT and the Exec teams as the pilot areas. July 2021 Update - EUC have been designing training content and material and the idea was to bolt knowledge management to the new ICT site.
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 Public Health	Head of Service Management	Sep-21			In progress	September 2021 - No further update	May 2021 - No further update provided. July 2021 Update - No further update
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 Public Health	Head of Service Management	Apr-21	01/07/2021 Now November 2021		In progress	September 2021 - No further update	May 2021 Update - Needs reviewing in line with ITSM10. July 2021 Update - Service Catalogue is being looked at by Paul Thomas who has only recently starting this process, an import from the existing excel spreadsheet has been conducted. This is work in progress.
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 Public Health	Head of Service Management	May-21	01/07/2021 Now October 2021		In progress	September 2021 - No further update	May 2021 Update - This will be undertaken as part of the IMTP enagement. July 2021 Update - This remains ongoing
Estates Directorate Management Arrangements (April 2021)													

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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 for People	Head of Operational Estates/Head of Assets, Technical Services and Governance	Apr-21			In progress	September 2021 - No further update	July 2021 - No further update provided
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	September 2021 for STEEP element. Now January 2022		Part Completed	September 2021 Update - a revised completion date has been provided for the STEEP element of this recommendation	July 2021 Update - The Asbestos Policy has been reviewed, updated approved and published to SharePoint, so this item is complete. The Asbestos Management Plan is reviewed annually with the next review due on the 31st January 2022. STEEP is referring to the In Service Testing of Electrical Equipment procedure, which is being actioned by the Electrical Safety Group, led by Jason Williams. This is currently being reviewed and in the process of being completed, and will require approval through the Electrical safety group, for noting at the HS&R committee, and final approval at the Capital and Estates Governance committee.
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	01/08/2021 Now September 2021		Completed	September 2021 Update - LFER deadlines now being met, or agreement with WRP reached on deferrals. Once for Wales implementation delayed but CTM working with Programme Board to implement which will support improved reporting and learning.	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. July 2021 Update - The claims team continue to work closely with WRP in order to submit for reimbursments on time. The new Once for Wales RL Datix system has been implemented in CTM for Claims, Redress and Complaints. Considerable work has been undertaken to submit LFERs for the 31st July deadline, however, engagement from the operational teams has not been consistent across the Health Board. The taskforce which was in place to follow up on learning and evidence of learning will be stepping down after 31st July. A new process is being proposed going forward linking the claims team directly with the CSGs. In addition a Health Board Committee will be established in order to monitor these more effectively.
Financial Systems (April 2021)													
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	01/08/2021 Now November 2021		In progress	September 2021 Update - New Model Standing Financial Instructions are to be adopted by the board in October. Following this will require review of the full suite of FCPs, including Charitable Funds FCP. This has started and will be completed in the next couple of months.	July 2021 Update - Charitable Funds have recently been moved onto the Oracle system which allows for greater consistency of governance and controls, these are currently being bedded in and reviewed. The FCP needs to be updated to reflect these changes.
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	September 2021 - No further update	July 2021 Update - Action on target to be completed by September 2021
Digital Response to Covid (June 2021)													

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DRC 02	Jun-21	Reasonable	A proactive process of contacting users to identify their digital needs should be established within the Health Board that feeds into the assessment structure such as the PPB.	Medum	The second phase of the infrastructure review will appraise the gaps that exist between needs and capability in the digital area and the options for bridging this gap in the short and medium term, recognising the myriad of other factors that will need to be considered (e.g. cyber resilience, people's willingness to use their own device, fit within the infrastructure architecture)	Director of Public Health	Chief Information Officer	Jul-21	Autumn 2021		In progress	Sept 2021 Update - Second phase is underway - 5 deep dives have been agreed which incoproate the recommendation. Anticipate these will report in Autumn now. DDC are being kept informed of developments.The roll out of the WNCR across YCR has been on time and rather successful. Consequently YCC rimplementation remains on track for start of October	July 2021 Update - Second phase is underway - 5 deep dives have been agreed which incoproate the recommendation. Anticipate these will report in Autumn now. DDC are being kept informed of developments. In addition the UHB has agreed to fund the roll out and implementation of the Nursing Care Record. This is a huge development which will provide learning around what is required in different ward environments. The roll out across YCR will commence in August 2021
DRC 03	Jun-21	Reasonable	Work to ensure benefits are achieved should be completed. This should identify what has worked well, what has not worked and should be reconsidered and what needs additional input in to sustain the move towards digital health provision. Factors which have impacted on benefit delivery should be identified to ensure that lessons are learned for the future. As part of this work the impact on clinical outcomes and health inequality should be assessed, both in terms of disease type and population / demographic group. An assessment of the infrastructure required to support the ongoing provision of digital services should be undertaken to ensure that services are sustainable for the future.	Medium	The UHB is approaching this in two phases. The first is to review the wider impacts of covid on the health and wellbeing of our population, to understand: - who got covid - who died during the covid period - who died of covid during the covid period (COMPLETED) The second will then be to ascertain whether there were differentials in access to services over the covid period, and whether or not the organisation's digital response inadvertently had an impact by exacerbating or closing these differentials. The second stage of the infrastructure review has been established to make recommendations of the sustainable infrastructure requirements.	Director of Public Health	Chief Information Officer	Jul-21	Autumn 2021		Completed	Sept 2021 Update - Completed - results have been discussed at Digital Delivery Board and are due for further discussion at Digital and Data Committee in October	July 2021 Update - As above this has progressed, and will be completed as analytical resources and competing priorities permit
Clinical Audit (August 2021)													
CA 01	Aug-21	Reasonable	1. Management should discuss with the Health Board's Governance Team the process to follow to ensure that risks logged in Datix, relating to clinical audits, can be allocated to clinicians to manage. 2. Management need to ensure that all clinical audit related risks are recorded consistently on the risk register, including audits that are delayed or where there has been issues with collecting the data. A wider review of risks should be undertaken to ensure that other risks, such as the reliance on the AMaT system and the current level of training uptake on the system, have been considered for inclusion on the register. 3. The Clinical Audit and Effectiveness risk register should be a standing agenda item on the Clinical Audit & Effectiveness Group and reviewed at each meeting.	High	1. Meetings schedule to review the risk log arrangements and agree ILG governance arrangements for logging risks linked to clinical audit outcomes. 2. Management review of Clinical Audit Risk Log management and development of standard operating procedure for this process. 3. The revised Clinical Audit and Effectiveness risk register has been added as a standard agenda item for the inaugural Clinical Audit & Effectiveness Group meeting in June 2021 and then as a standing agenda item.	Medical Director	Head of Clinical Audit & Quality Informatics	31 August 2021 for Actions 1 and 2 30 June 2021 for Action 3	Now November 2021		Part Completed	September 2021 Update - 1. The Head and Deputy heads of Clinical Audit and Quality Informatics meet weekly to review the Clinical Audit and Effectiveness risk log (Complete) 2. Draft SOP developed. Meeting scehduled with the Assistant Director of Governance & Risk on the 22/09/2021 to finalise the risk log SOP. 3. Risk Register has been added as a standard agenda Item for the quarterly Clinical Audit & Effectiveness Group meeting. First meeting November 2021 Following finalisation of the SOP and approval at the Clinical Audit & Effectiveness Group in November 2021 this risk will be catgorised as GREEN and complete.	
CA 02	Aug-21	Reasonable	Management should ensure that departments undertaking clinical audits are provided with training on the AMaT system. In addition, the clinical audit department could target staff / departments to be trained on the AMaT system and general clinical audit principles whereby the quality reviews highlight potential problems with how their audits are being undertaken.	Medium	A plan has been formalised to address the training backlog for 2021-22, caused by the pandemic, with the Deputy Assistant Medical Director for Clinical Audit that will include: • A regular training session following each monthly / bi-monthly specialty clinical audit meeting. • Formal classroom based departmental training courses booked on a monthly basis. • 1:1 Adhoc training for individual provided by their clinical audit facilitator in person or over Teams	Medical Director	Head of Clinical Audit & Quality Informatics	Jul-21			Completed	September 2021 Update - 1. A standing agenda item has been included for all Clinical Audit meetings and training provided where required (Complete) 2. Department training sessions have been established for 2021-22 where required and staff are available and a mechanism to book planned session put in place (Complete) 3. All clinical audit staff are trained and provide adhoc training to clincians when required. This has been in place since April 2020 (Complete) Training statistics are being maintained of all adhoc and formal training provided for inclusion in reports to the QSC	
CA 03	Aug-21	Reasonable	Management should ensure that the Clinical Audit & Effectiveness Policy & Strategy is approved by the correct committee as detailed within the document. Going forward, it should be reviewed on a regular basis to ensure it remains current.	Medium	After consideration it was deemed inappropriate for review by the Clinical Policy Group and instead the Policy & Strategy document was approved at the Audit and Risk Committee on the 18/05/2021, Equality Impact Assessment approved on the 20/05/2021 and has been submitted for final approval at the July 2021 Quality and Safety Committee	Medical Director	Head of Clinical Audit & Quality Informatics	Jul-21			Completed	September 2021 Update - Completed	

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CA 04	Aug-21	Reasonable	Due to the Covid-19 pandemic and the pausing of committees and groups, clinical audit plans were not able to be approved as outlined in the Clinical Audit & Effectiveness Policy & Strategy. Going forward: 1. The Health Board's Clinical Audit Programme and Annual Clinical Audit Forward Plan should be appropriately approved. 2. The ILG Governance Groups, in compliance with the Clinical Audit & Effectiveness Policy & Strategy should approve their ILG clinical audit programmes. 3. The speciality groups should approve the forward work plans for each of their specialities.	Medium	1. The Clinical Audit Programme and Annual Clinical Audit Forward Plan has been scheduled for approval in the July 2021 Quality & Safety Committee and dates set for quarterly updates through to March 2022. Due to purdah and the transfer of responsibilities for the NHS Wales National Clinical Audit & Outcome Review Plan (NCA&ORP) from Welsh Government to Digital Health and Care Wales (formerly known as NWIS) there is currently no date set for release of the NCA&ORP for 2021-22. Therefore, the CTMUHB Clinical Audit Plan will be rolled over from the 2020-21 programme of national audits and reviewed once the NCA&ORP is released later this year. 2. After the Clinical Audit & Effectiveness Policy & Strategy has been approved by the Quality and Safety Committee, in July 2021. The 2021-22 ILG plans will be signed off for their tier 1-4 clinical audits in accordance with the approach defined in the policy and strategy. 3. The specialty group 2021-22 forward plans are on the agendas for the June – August clinical audit meetings for discussion and sign off across all specialities. In accordance with the pre-pandemic process, that was suspended during the pandemic due to restrictions placed by the Health Board on the organisation of clinical meetings.	Medical Director	Head of Clinical Audit & Quality Informatics	31 July 2021 for action 1. 30 September 2021 for action 2. 31 August 2021 for action 3.			Part Completed	September 2021 Update - 1. Clinical Audit Forward Plan submitted to the July Quality and Safety Committee (QSC) as planned. (Complete) 2. The ILG Clinical Forward Plans aere on track to be signed off by the end of September 2021 (in progress) 3. The HB Specialty Clincial Audit plans have been discussed, signed off and uploaded to the AMaT Clincial Audit system following the August round of audit meetings. (Complete)	
CA 05	Aug-21	Reasonable	As the Health Board moves out of the pandemic, clarity should be sought around the role and remit of the Audit & Risk Committee and the Quality & Safety Committee to ensure there is no overlap or duplication of reporting. The Clinical Audit Department should seek advice from the governance team and consider the frequency of providing performance reports on the progress against the Health Board Clinical Audit Programme to the relevant committee. In line the Clinical Audit & Effectiveness Policy & Strategy, the Clinical Audit & Effectiveness Group, ILG Governance Groups and the department / speciality / ward clinical audit meetings should review the progress of the clinical audit	Medium	The CTMUHB Clinical Audit Forward Plan 2021-22 will go to the July Quality & Safety Committee, subsequent update reports will then go to the QSC on a quarterly basis. Submission timetable agree with corporate team. A review of the Terms of Reference for all groups will be undertaken to ensure incorporation of the requirement to regularly review progress against the Health Board, ILG and Specialty audit plans.	Medical Director	Head of Clinical Audit & Quality Informatics	31 July 2021 and 30 September 2021	Now November 2021		In progress	September 2021 Update - Clinical Audit Forward Plan submitted to the Quality and Safety Committee (QSC) as planned. (Complete) Clinical Audit update report delayed due to rescheduling of QSC and then request to to take update papers to Managment Board before QSC. Plan for paper to go to October MB and November QSC Committee. (In Progress)	
CA 06	Aug-21	Reasonable	Management should ensure that the Quality & Safety Committee receive, in line with agreed timescales, a performance and monitoring report which considers the findings of national and local clinical audits, including outcomes and actions to address risks identified. A decision should be made as to whether the findings of local audits should be presented at the Quality & Safety Committee or if there is a more appropriate committee or group to receive these reports. The policy should be updated to reflect any changes. In addition, the Clinical Audit & Effectiveness Group should receive summaries of national clinical audit reports and completed local clinical audit reports with recommendations and action plans.	Medium	As part of the review of the Risk Log arrangements in consultation with the Deputy Assistant Medical Director for Clinical Audit and ILGs and agree the approach to considers the findings of national clinical audits, including outcomes and actions to address risks identified. We have already reviewed the policy and saw the mistake in reporting requirements and have notified for changes to made to the policy. A review of the Terms of Reference for Clinical Audit & Effectiveness Group will be undertaken to ensure incorporation of the requirement to receive summaries of national clinical audit reports and completed local clinical audit reports with recommendations and action plans.	Medical Director	Head of Clinical Audit & Quality Informatics	31 August 2021/31 July 2021/30 September 2021			In progress	September 2021 Update - Linked to CA 01: Arrangments on track for completion by the end of September 2021	
Facilities Directorate Review (Workforce Arrangements) Follow Up (August 2021)													
FDR 01	Aug-21	Reasonable	Both sites 1. The annual leave policy at both ILGs should be reviewed to ensure they capture all relevant aspects of administering annual leave, such as the process for managing emergency leave requests. 2. The policies should reflect the correct organisation name and the name of the ILG that they relate to	Medium	RGH / RTE and PCH / M&C The annual leave Policy and operating principles at both ILGs will be reviewed and updated to reflect the new ILG structure.	Executive Director of Operations	Facilities Regional Managers	Sep-21			In progress	September 2021 - No further update	

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FDR 02	Aug-21	Reasonable	Both sites 1. At both ILGs, consideration should be given to providing training to the porter service staff on the use of the ESR mobile application in order for annual leave requests to be made and approved directly in ESR. 2. Where annual leave is purchased or carried forward, correct forms should be completed in line with the Health Board Annual Leave policy and authorisation in line with the scheme of delegation should be obtained. PCH / M&C 1. Whilst paper records continue to be used: • All records in relation to annual leave requests should be fully completed, authorised and retained, with approved leave recorded on ESR. • A reconciliation between the ESR system and the paper record should be carried out at the start of each leave year to ensure the correct allocations. Periodic checks should take place throughout the year to confirm accuracy of records and ensure staff are taking leave evenly throughout the year. 2. Consideration should be given to adopting the audit checks in place in RGH to assist in identifying non-compliance with the annual leave policy. Corporate The Health Board's Annual Leave Policy should be reviewed to ensure the authorisation information on the forms contained within it, align to the current version of the scheme of delegation.	Medium	RGH / RTE and PCH M&C 1. We will work with Porter Services staff to support access to ESR Accounts. The Health Board are aware of the issues for Facility staff accessing ESR for learning and development and this is being supported with training and learning, development. The paper system for requesting annual leave and approving and recording will be better supported now that staff are in place at Supervisory level to continue and manage – also will be supported by weekly regular audits for compliance monitoring. 2. The purchase of, or the carryover of leave will be supported using the Health Board Policy and relevant changes will be made to the scheme of delegation to reflect the management structures. 3. Regular Audit checks in place in RGH to assist in identifying non-compliance with the annual leave policy. Corporate We will discuss and arrange with Workforce and OD for the Health Board's Annual Leave Policy to be reviewed to ensure the authorisation information on the forms contained within it, align to the current version of the scheme of delegation.	Executive Director of Operations	Facilities Regional Managers	Sep-21			In progress	September 2021 - No further update	
FDR 03	Aug-21	Reasonable	The TOIL procedure and forms should be reviewed to ensure they meet the ILGs' needs, align to any wider Health Board policy or procedure and are updated to reflect the correct organisation name and the name of the ILG that they relate to.	Low	RGH / RTE and PCH M&C The TOIL procedure will be amended to reflect correct ILG structure.	Executive Director of Operations	Facilities Regional Managers	Sep-21			In progress	September 2021 - No further update	
FDR 04	Aug-21	Reasonable	Whilst both sites are now using sickness absence summary sheets that will aid the identification of staff who hit a prompt, the process for subsequent management of staff should be reviewed to ensure compliance with the All Wales Managing Attendance Policy. Where prompts are hit, records of the informal or formal meetings should be held on file. Where management discretion is applied to not undertake an informal or formal meeting, a record should be maintained on file explaining the reason for the decision.	Medium	RGH / RTE and PCH M&C 1. The process for the management of staff will be reviewed to ensure compliance with the All Wales Managing Attendance Policy. 2. Where prompts are hit, records of the informal or formal meetings will be held on file. Where management discretion is applied to not undertake an informal or formal meeting, a record will be maintained on file explaining the reason for the decision. 3. Supervisory training will further support sickness absence application. To further support compliance Team Leaders will support monthly audits for	Executive Director of Operations	Facilities Regional Managers	Sep-21			In progress	September 2021 - No further update	
FDR 05	Aug-21	Reasonable	An action plan should be developed by both sites that outlines the steps they are going to take to ensure all staff have received a PDR.	Medium	RGH / RTE and PCH / M&C An action plan and process will be developed that outlines the steps required and action to be taken to ensure all staff have received a PDR. Where required the management and supervisory team will be supported with PDR training.	Executive Director of Operations	Facilities Regional Managers	Sep-21			In progress	September 2021 - No further update	
FDR 06	Aug-21	Reasonable	RGH / RTE An action plan should be developed that outlines the steps that need to be taken to ensure all staff complete their mandatory training, with particular reference to those modules where overall compliance rates are low. PCH / M&C The action plan being put in place to address outstanding training should focus in the first instance on those modules where the overall compliance rate is low.	Medium	RGH / RTE and PCH / M&C 1. An action plan and process will be developed that outlines the steps required and action to be taken to ensure all staff undertake mandatory training learning sessions. 2. A rolling programme of mandatory training will be put in place to address the decline in compliance due to the availability of training which had been reduced due to the pandemic operational impact. Particular focus will be given to those modules where overall compliance rates are low.	Executive Director of Operations	Facilities Regional Managers	Sep-21			In progress	September 2021 - No further update	

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FDR 07	Aug-21	Reasonable	**Original Recommendation.** A set of policies and procedures should be developed for use across all sites that allows for the consistent and efficient running of porter services.	High	**Original Management Response** As per the porter redesign and current staff/supervisor/dispatchers Organisational Change process mentioned at previous Finding 6. Facilities supported by WF & OD business partners is currently in a period of status quo and grievance with staff and trade unions on a number of rota compliance and terms and condition issues. Grievance policy negotiations are ongoing with staff and staff side trade union colleagues. The new rota and the principles for rota management are key to ensuring compliance and to be agreed with staff and trade union colleagues and directed across the Porter Services teams at all sites. These Principles will support Porter Services re-design, reflecting appropriate manning levels, rota, service requirements and Supervisor/Dispatcher Organisational Change process.	Executive Director of Operations	Facilities Managers	Jan-19			Completed	**Current Position.** The Facilities Directorate Manager has developed a set of common principles for use across all sites. These covered the management of rotas, the allocation of overtime, annual leave and sickness absence. The introduction of the new operating model in April 2020 including the move to an ILG structure has allowed greater autonomy to be applied at the ILG level. We understand that the Facilities Manager in the M&C ILG has refined some sections of the common principles to ensure they fully align to the new roster templates that were introduced in March 2021. We consider this action **Implemented**	
FDR 08	Aug-21	Reasonable	RGH / RTE Consideration should be given to introducing the signing in / out sheets that are used in PCH as these are deemed more fit for purpose than the current signing in / out book and will assist in more accurate completion of pay returns	Low	RGH / RTE The signing in sheets have been received from PCH Site and will be introduced to RGH Site to support better protocol for signing in and out.	Executive Director of Operations	Facilities Regional Manager	Sep-21			In progress	September 2021 - No further update	
FDR 09	Aug-21	Reasonable	Both sites Work should continue in relation to the procurement of a more up to date portering management system that would allow the service to be delivered in a more efficient and effective manner.	Low	RGH / RTE and PCH / M&C 1. Work will continue to progress forward in view of managing rota alignment that will support service demands and pressures. This will be always flexible and open to change in view of changing service needs within the Hospitals. 2. A bid for funding for a new Porter Services IT management system solution (Symbiotic) has been submitted in the Facilities IMTP 2021-2022.	Executive Director of Operations	Facilities Regional Managers	Sep-21			In progress	September 2021 - No further update	
FDR 10	Aug-21	Reasonable	At both sites Where overtime is allocated on rosters, the Facilities Managers should approve these in advance of the rosters being published. Accuracy checks should be undertaken on pay returns prior to being submitted to payroll for processing.	High	RGH / RTE and PCH / M&C 1. Where overtime is allocated on rosters, the Facilities Managers will ensure that any overtime is approved in advance of the rosters being published. 2. Accuracy checks will be undertaken on pay returns prior to being submitted to payroll for processing. 3. Supervisors and staff will also be briefed on this requirement.	Executive Director of Operations	Facilities Regional Managers	Sep-21			In progress	September 2021 - No further update	
Mass Vaccination Programme (August 2021)													
MVP 01	Aug-21	Substantial	Consideration should be given in any future projects to ensuring that there is not over-reliance on a small number of individuals to be managing the programme on a day-to-day basis.	Low	The COVID vaccination programme has been established as part of the emergency response to COVID and learning from this will feed into the wider COVID learning. The continued requirements for COVID vaccination, mean that the project needs to be converted to 'business as usual'. A business case is being developed to create a core team for 2022/23	Director of Public Health	Deputy Director of Strategy & Transformation	Dec-21			In progress	September 2021 Update - On track to be approved by December 2021 and in place by 1 April 2022	
Sunnyside Health & Wellbeing Centre (August 2021)													
SUN 01	Aug-21	Reasonable	Management should confirm revised governance arrangements via a Project Execution Plan including: • effective cost management; • contractual relationships, values and payment arrangements; • committee reporting of project risks; • scheduled outputs from sub-groups for scrutiny; and • stakeholder engagement.	Medium	The Health Board will work with the external project manager to develop a Project Execution Plan to be signed off at the Project Board, this will provide a formalised single record of all of the above criteria which have been approved separately by Project Board.	Director of Finance	Head of Capital	Sep-21	Now January 2022		In progress	September 2021 Update - the PEP is being drafted however there have been delays in the same due to the administration of the contractor. It was anticipated the the completion contract would have been issued by this time however due to internal process at Linc Cymru this has been delayed to the end of September, as a result the PEP will not be completed until the new contractor is know and this is not likely to be until December 2021 at the earliest.	
SUN 02	Aug-21	Reasonable	Management should ensure that: • sufficient information is provided to the Project Board to enable appropriate scrutiny/ challenge; and • there is appropriate membership / representation at the Project Board to ensure effective scrutiny of project costs at the Project Board. (D)	Medium	The updated financial reporting spreadsheet will be amended to the standard project Highlight Report which enables the Board to have more detail on the financial position. This will be supported in completion by regular meetings of the finance and commercial group. It will be proposed to the Senior Responsible Officer that the Capital Finance Manager will be invited to attend Project Board.	Director of Finance	Head of Capital	Sep-21			Completed	September 2021 Update - This will be used in the September Project Board meeting after being approved in the August Project Board meeting	

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SUN 03	Aug-21	Reasonable	Management should ensure appropriate reporting, forecasting and management of project costs and delivery in accordance with its contractual rights and obligations, including overall project reporting of: • Full Business Case approved budget; • contacted sums; • expenditure to date; • forecast out-turn; and • associated variance commentary.	Medium	The updated financial reporting spreadsheet will be amended to the standard project Highlight report which enables the Board to have more detail on the financial position. This will be supported in completion by regular meetings of the finance and commercial group. It will be proposed to the Senior Responsible Officer that the Capital Finance Manager will be invited to attend Project Board.	Director of Finance	Head of Capital	Sep-21			Completed	September 2021 Update - This will be used in the September Project Board meeting after being approved in the August Project Board meeting	
SUN 04	Aug-21	Reasonable	Management should ensure that individual cost provisions within the works information are reported to understand charges and adjustments to provisional sums.	Medium	The updated reporting template includes a section detailing provisional sums and contingencies and tracks through the release of provisional sums into actual costs, as well as all contingency items, these will be reported monthly to Project Board as part of the financial template. However there will need to be a further tender and revised provisional sums with the letting of a contract for completion therefore an extended target date is provided to ensure the most up to date information is captured	Director of Finance	Senior Project Manager	Mar-22			In progress	September 2021 Update - Remains in progress to be agreed with the new contractor when appointed	
SUN 05	Aug-21	Reasonable	Management should ensure provision of project manager and cost adviser reports, in support of the Welsh Government Dashboard return.	Medium	These will be included as required as soon as the project recommences, and a new contractor is appointed. This is likely to take at least a further 3-4 months hence the longer target date.	Director of Finance	Senior Project Manager	Jan-22			In progress	September 2021 Update - Remains in progress to be agreed with the new contractor when appointed	
SUN 06	Aug-21	Reasonable	Management should confirm agreed and costed equipping schedules (net of transfers) for inclusion within cost reporting.	Low	Room data sheets and equipment schedules have been drawn up and are in the process of being analysed for transfer and new purchase.	Director of Finance	Senior Project Manager	Nov-21			In progress	September 2021 Update - Equipment schedules are vritually complete and expected to deliver in line with progress	
SUN 07	Aug-21	Reasonable	Management should obtain documentation to which the client is entitled under the contract, including collateral warranties, and a copy of the construction performance bond, and confirm assurances provided at the latter.	Medium	These are available and will be supplied by the developer.	Director of Finance	Senior Project Manager	Sep-21	Now November 2021		In progress	September 2021 Update - There have been delays in obtaining all of this due to the priority being the completion ontract works these are in hand to be provided by the time of the next meeting.	
SUN 08	Aug-21	Reasonable	Payments for both the Health Board's and the developer's adviser activities should be monitored against contracted activity schedules.	Low	Schedules are in place and will continue to be monitored at every payment application date.	Director of Finance	Senior Project Manager	Sep-21			Completed	September 2021 Update - Internal processes in place to check schedules against the application for payment and formal sign off processes in place	
SUN 09	Aug-21	Reasonable	Performance of relevant parties should be monitored appropriately	Low	As above although there will be a delay with the appointment of a new contractor.	Director of Finance	Senior Project Manager	Sep-21	Now January 2022 for Contractor only		In progress	September 2021 Update - Complete for advisors but will not be complete for contractor until a new contractor is appinted	
SUN 10	Aug-21	Reasonable	Management should be provided with proposed contact variations and monitoring to facilitate timely Health Board scrutiny, in accordance with entitlements under the contract.	Medium	This will be provided when the project restarts and all design works are completed.	Director of Finance	Senior Project Manager	No Date Identified	Mar-22		In progress	September 2021 Update - To be completed and agreed with new contractor on appointment	
SUN 11	Aug-21	Reasonable	The Health Board require the developer to remind the contractor of its contractual obligations to formally notify of any delays (and their associated time/cost impact within the contractual time frames).	Medium	With the original contractor there was confidence that much of the time could be recovered and therefore no formal application had been made. Clearly with the current contractor going into administration there will need to be a new contractor appointment. The Health Board will ensure that the need for a contractual. notification of future delays is communicated to the new contractor.	Director of Finance	Senior Project Manager	Mar-22			In progress	September 2021 Update - To be completed and agreed with new contractor on appointment	
SUN 12	Aug-21	Reasonable	A costed risk register should be regularly maintained and reported to facilitate monitoring of the build.	Medium	A fully costed capital risk register is in existence and will continue to be kept up to date as risks are realised or not throughout the project, however this will be revisited with decision on process for and appointment of a new contractor.	Director of Finance	Head of Capital	Nov-21			In progress	September 2021 Update - In progress and development - risk of some slippage due to delays in the tender for the completion contract but all steps are being taken to ensure this is completed by November	
SUN 13	Aug-21	Reasonable	Management should actively monitor and report the value of residual construction cost risks v remaining contingency.	Medium	This is picked up in the appendix to the standard Highlight Report discussed in action 2.	Director of Finance	Head of Capital	Sep-21	Now March 2022		In progress	September 2021 Update - One off exercise done to date but this will not be actively monitored until construction works recommence	
SUN 14	Aug-21	Reasonable	Risks reported at the Welsh Government Dashboard should be reflective of current project reporting.	Medium	The project Dashboard will be updated in line with the Project Board reporting – target date in line with reporting dates for the Welsh Government Project Progress (Dashboard) Returns.	Director of Finance	Senior Project Manager	Oct-21			In progress	September 2021 Update - Due to be incorporated into the next report in October	
SUN 15	Aug-21	Reasonable	The Health Board should obtain engrossed and signed copies of all relevant developer adviser contracts in accordance with entitlements to inform of potential liabilities and costs, and report relevant implications to appropriate groups/committees.	Medium	This cannot be fully achieved without the appointment of a new contractor. The Health Board will ensure that all contracts have been received and filed centrally. The new contractor contract will be provided by the developer on signature .	Director of Finance	Project Leader	Sep-21	Now January 2022		In progress	September 2021 Update - Contracts for all save for the new contractor are complete - for the new contractor this will not be delivered until 2022	
SUN 16	Aug-21	Reasonable	The Health Board should obtain and retain all historic documentation within a central repository in the event of any future challenge or contractual disputes.	Medium	All electronic documentation is filed in a central shared file. All papers will be moved to a single central location accessible by all Health Board project officers.	Director of Finance	Senior Project Manager	Sep-21	Now October 2021		In progress	September 2021 Update - Sickness and annual leave have delayed this but central file has been set up and all steps now are being taken to ensure all relelvant documentation is filed wihtin this area	
SUN 17	Aug-21	Reasonable	Management should instigate a process for formal review and sign-off of any further design changes with relevant parties.	Low	The Health Board already has in places processes for sign off of design by users and this process will be used in this scheme moving forward (also to be detailed in the Project Execution Plan).	Director of Finance	Senior Project Manager	Nov-21			In progress	September 2021 Update - Ongoing	

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SUN 18	Aug-21	Reasonable	Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	Medium	The Primary Care lead will continue to work with NWSSP Specialist Estates Services to ensure that the lease is signed off as soon as possible.	Director of Finance	Primary Care Estates and Development Manager	Jan-22			In progress	September 2021 Update - Ongoing with GPs partners however new contract and revised cost is required now to finalise this	
SUN 19	Aug-21	Reasonable	Management should confirm an agreed service model with measurable outcomes for front line and support services.	Medium	The Bridgend Integrated Locality Group (ILG) will link with the Primary Care team over the service model and support functions. This will be developed during the construction period for the site and given that the completion is likely to slip to late 2/23 the target is to complete in order that any financial consequences are picked up in Integrated Medium Term Plan (IMTP) planning cycles.	Director of Finance	Bridgend ILG Community Lead	Mar-22			In progress	September 2021 Update - Ongoing	
SUN 20	Aug-21	Reasonable	Objectives at the business case should be measurable.	Medium	The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	Director of Finance	Head of Capital	Jan-22			In progress	September 2021 Update - Ongoing	
SUN 21	Aug-21	Reasonable	Management should review and confirm project objectives based on only measurable outcomes within a Benefits Realisation Plan.	Medium	Please see response above .	Director of Finance	Head of Capital	Jan-22			In progress	September 2021 Update - Ongoing	