Audit & Risk Assurance Committee
TABLE OF ACTIONS
Arising from Meeting held on 19th October 2021

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(21)105	**10/06/2021**	**Local Deployment of the Welsh Immunisation System (WIS) (Reasonable Assurance)**	To share with ARAC, once published, the DHCW All Wales review into WIS.	AT	~~August~~ December 2021	*DHCW have still to finalise their review and lessons learned report; Health Boards are anticipating a draft in September 2021 for comment.* Update for December 2021 ARAC meeting: DHCW have not yet published the report. The specific Audit Recommendation within the WIS report has been closed, as it external to the Health Board.
AC(21)117	**22/06/2021**	**Annual Review of the Committee's Self-Assessment of Effectiveness – Analysis of Findings**	To schedule a review of progress in implementing changes/improvements in 6 months' time.	CM	December 2021	Forward planned for 14th December 2021 meeting.
AC(21)118	**22/06/2021**	**Report on the Adequacy of Arrangements for Declaring, Registering and Handling Interests, Gifts, Hospitality,**	To explore other digital solutions for obtaining and collating this information;	HT	~~August~~ ~~October~~ December 2021	*Update for August 2021 ARAC meeting:* *The Digital team is exploring the use of Office 365 as a suitable solution. Specifically using MS forms and power automation. The*

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		Honoraria and Sponsorship				*discovery phase will be completed within 4 weeks, with a proposal following this phase of work.* *<u>Update for October 2021 ARAC meeting:</u>* *The discovery work has been completed and a SharePoint Developer with skills in Power Automate has been assigned the work package. A proposed solution will be scoped and a beta version will be available by the end of November 2021, for testing.* <u>Update for December 2021 ARAC meeting:</u> The Digital team is still working on the solution, and anticipates that the beta version will be available by mid December 2021.
AC(21)155	**24/08/2021**	**Radiology Directorate Internal Audit Update**	If not possible earlier, to provide an update to the June 2022 ARAC meeting.	AC	~~June~~ April 2022	Forward planned for ~~June~~ April 2022 meeting. See AC(21)174, below

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AC(21)156	**24/08/2021**	**Field Hospital Decommissioning (Advisory Review)**	To provide details of the management lead and timescale for the 'Lessons Learned' exercise.	AC	~~October~~ December 2021	*Update for October 2021 ARAC meeting:* *The Deputy Director of Operations was party to an initial planning meeting, on 6th October 2021, where the approach to a follow-up workshop involving a broader representation of colleagues involved in the Field Hospital campaign was determined. The workshop is expected to take place in October 2021; the output will be a short report on lessons learned.* *A recap will follow after the Selwyn Samuel Centre is fully decommissioned in 2022.* Update for December 2021 ARAC meeting: The lessons learned workshop was held on 8th November 2021. A written report will follow and will be revisited following final decommission of the

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						remaining two FH sites (expected Q1 2022/23).
AC(21)174	**19/10/2021**	**Table of Actions**	To schedule an update on Radiology for April 2022 in the first instance.	CM	December 2021	Forward planned for April 2022 meeting.
AC(21)176	**19/10/2021**	**Review of Capital Governance Arrangements**	To add the requested information regarding whether schemes came in on time and on budget, and whether PPEs were completed to the table of capital projects;	PW	December 2021	Attached at Appendix 1. In response to the query regarding the Designed for Life framework – the Head of Internal Audit advises that the Designed for Life: Building for Wales framework are generally let on a 3yr (+1+1 extension options - providing a break rather than committing to a 2 year extension), which has generally meant that three generations of the framework let since 2006 have been approx. 5 years each (with a small period of lapse during 2017). SES have extended the current framework which was awarded in 2018, and are looking to go out next year for the fourth generation of the framework.

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			To share a copy of the Internal Audit report from the Grange Hospital capital scheme review;	SC	December 2021	The Audit & Assurance Specialist Services team is currently working with the Health Board providing advice on capital projects and governance. Key findings and lessons learned will be provided through this process. These findings are not contained in a single report as many reports were issued over a period of time.
			To prepare a formal management response and present this to the next meeting.	LD	December 2021	Forward planned for 14th December 2021 meeting.
AC(21)183	**19/10/2021**	**Quality Governance Arrangements**	To take steps to address the inconsistency between the strategic intent/ambition and operational delivery by examining Directorate governance processes;	AC	December 2021	The following actions have been taken to address inconsistencies and to strengthen governance processes: • Re-issued to teams an expected standard agenda of themes to be covered via business processes. • The first in a series of a programme of events, supported by HDdUHB Organisational Development was held on 30th

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						November 2021. Initial conversations have been had at the Operational Team away day to begin to look at developing a governance structure and organisational structure that will be able to meet the HB's objectives as we emerge from the pandemic. • The Senior Operations Business meeting being has been strengthened. The inaugural meeting is being held in January 2022.
			To review/revise the management response to include interim milestones, and present this to the next meeting.	AC	December 2021	The management response is being reviewed at a meeting scheduled for 9th December 2021.
AC(21)185	**19/10/2021**	**RCP Medical Records Keeping Standards Internal Audit Update**	To explore potential learning from other organisations who use written records;	PK	April 2022	To be incorporated in update scheduled for April 2022.
			To provide further information regarding milestones/timescales for	JE	December 2021	• A set of generic principles for record keeping will be

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			the introduction of a unified Medical Records Keeping policy;			shared with the Clinical Record Keeping Policy Steering Group by 30th November 2021. • Steering Group members will be given until 31st December 2021 to comment on the draft principles. • The Clinical Record Keeping Policy is in draft, utilising the new Policy template, the first draft will be completed by 31st January 2022. • The first draft will be shared with Steering Group members and other interested parties and a meeting convened to discuss in February 2022. Proposed amendments will be incorporated into an updated draft, prior to 28th February 2022. • Development of supporting documentation including EQIA and SBAR will commence

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						during February 2022. • The Policy will be circulated for global consultation in early March 2022, for a minimum of 2 weeks. • Comments received will be incorporated into a final version, for Owning Committee approval by the Effective Clinical Practice Advisory Panel at the April 2022 meeting (date TBC) and approval at the following meeting of the Clinical Written Control Documentation Sub-Group.
			To provide a further update to the April 2022 meeting.	PK	April 2022	Forward planned for April 2022 meeting.
AC(21)187	**19/10/2021**	**Discharge Processes Review**	To prepare a formal management response and present this to the next meeting.	AC/JP	December 2021	Attached at Appendix 2.
AC(21)188	**19/10/2021**	**Women & Child Health Directorate Governance Review (Reasonable Assurance)**	To explore further the apparent lack of consistency across Directorate Governance reports.	JJ	December 2021	The audit reports have been reviewed and it is considered that the recommendation priority ratings had been consistently applied, with a distinction intended

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						between the findings in the individual reports.
AC(21)189	**19/10/2021**	**Medical Staff Recruitment (Reasonable Assurance)**	To investigate and advise whether this audit is being replicated in any other Health Boards;	SC	December 2021	The specific scope of work is not currently being undertaken at other Health Boards. The scope of work at HDdUHB was designed to cover specific risks identified as part of the local planning process.
			To review/revise the management response and present this to the next meeting.	AC/LG	December 2021	Both the Director of Operations and Director of Workforce & Organisational Development have reviewed the management response, update to which is attached at Appendix 3.
AC(21)192	**19/10/2021**	**PPH Directorate Governance Review (Reasonable Assurance)**	To explore in more detail concerns regarding the rating awarded to Matter Arising 4 at the Sustainable Resources Committee.	HT	December 2021	Completed. Item addressed through SRC, as agreed with the Chair of SRC, who raised the issue in ARAC.
AC(21)193	**19/10/2021**	**Mental Health & Learning Disabilities Directorate Governance Review (Reasonable Assurance)**	To establish whether the statement in paragraph 2.17, that the Directorate has overspent, requires correcting.	JJ	December 2021	A minor amendment to wording has been made to clarify it was specific areas of overspend that should have been referred to.

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AC(21)202	**19/10/2021**	**Counter Fraud Update**	To review whether any Counter Fraud activities require re-classification into the Strategic Governance category.	BR	December 2021	Will be referenced within Counter Fraud Update report to 14th December 2021 meeting.

Scheme	Site	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	PPE	On Time	On budget	Comment
		£m	£m	£m	£m	£m	£m	£m				
Front of House	BGH	3.449	2.594	2.374	2.167	1.022			PPE on the new build 2015/16 PPE on remainder of scheme Jan 2022	Yes	Yes	On time and budget based on the extended programme which included main theatres refurbishments and evacuation lift.
Pathology Labs	PPH/WGH	3.425	0.529						No	Yes	Yes	
Cardigan ICC	Cardigan	0.695	1.415	0.337	0.591	9.569	9.059		Nov-21	Yes	Yes	
Women & Children's Phase 1	GGH	3.858							Yes	Yes	No	
Mynydd Mawr	PPH	4.386	0.080						No	Yes	Yes	
MRI GGH	GGH	1.572							No	Yes	Yes	
Unscheduled care	PPH		1.113	0.315					No	Yes	Yes	
Ward Refurbishment	GGH		0.554						No	Yes	Yes	
X-ray room	PPH			0.935					No	Yes	Yes	
Pharmacy Robots	Multiple			1.756					No	Yes	Yes	
Bronglais Fire Escape Elevator	BGH				2.684	0.044			Jan-22	Yes	Yes	
Anti Ligature works	Multiple				1.283				No	Yes	Yes	
Aberaeron ICC	AICC				0.778	1.493			Mar-22	Yes	Yes	
Ward 9 & 10 refurb	WGH					1.330	1.891		Sep-21	Yes	No	
Fishguard	Fishguard					0.627			No	Yes	Yes	
MRI BGH	BGH						4.430		May-22	Yes	Yes	
Cross Hands ICC	Cross Hands						0.907		Business Case development stage PPE will be undertaken 12 months following scheme completion	N/A	N/A	
Imaging equipment	Multiple						1.333		No	Yes	Yes	
MRI WGH	WGH							0.814	Jul-22	Yes	No	Cost of scheme exceeded WG allocation but was delivered within the revised agreed budget set by UHB
WGH Fire Precaution work	WGH							0.462	PPE will be undertaken 12 months following scheme completion	N/A	N/A	
Women & Children's Phase 2	GGH	2.277	0.048	0.628		4.078	11.052	6.848	Lessons Learnt undertaken PPE will be undertaken 12 months following scheme completion	No	No	
TOTAL		**19.662**	**6.333**	**6.345**	**7.503**	**18.163**	**28.672**	**8.124**				

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4	Whilst WG's COVID-19 Hospital Discharge Service Requirements (Wales) (referred to hereon as 'WG Requirements') are deemed temporary until the end of the COVID19 emergency period, the Health Board's Discharge and Transfer of Care Policy does not reflect the current requirements and continues to be live on the Health Board's Clinical Written Control Documentation intranet page	Review and update the Discharge and Transfer of Care – Adults Policy, Policy number 370 to reflect the Discharge Service Requirements process, as this still remain current. Task and Finish group to be established as part of the UEC programme under policy goal 6, to set consistent principles and standards, with staff reps from across HB community and acute and work through the recommendations together – appreciating that localities may have differing processes this group could share best practice and consideration given as to whether these practices can be taken forward across HB. This approach may also aid identifying training required.	Assistant Director of Nursing for Quality, Assurance and Professional Regulation Policy Group Lead	March 2022	
4	The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	It is accepted that an integrated (joint) approach to delivering effective and efficient Discharge 2 Recover and Assess models is essential. It will be difficult however to establish consistency given the three LAs may have differing approaches to delivery. We should however as 'systems' ensure that we strive to achieve the 'standards' outlined in the Discharge Requirements. Providing we are able to demonstrate delivery of those standards how the services are constructed should not matter. A baseline assessment has been undertaken previously in relation to these standards and each County System has a plan in place to deliver	SRO UEC Programme		

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		these (the Carms plan is mentioned in the report). A community dashboard is being developed by Performance team which will allow us to report 'how much and how well' against these standards which will give us the opportunity to review at three County level. NB such a dashboard is not consistent across the whole of Wales. Our work will contribute to 'pathfinding' at All Wales level. As part of the UEC programme Policy Goals (PG) 5 and 6 will provide oversight of this. PG 5 & 6 UEC workstream meetings will be scheduled to progress this work and ensure alignment with the national PG5 & 6 workstream.	County Directors Policy Goal Implementation Leads	April 2022 January 2022	
4/ 3.13	Regular training on discharge planning is not provided to key staff which may contribute to the lack of a 'whole system' approach due to poor understanding of their roles, responsibilities and interdependencies within the wider discharge process. A common theme arising from our enquires was that the discharge planning process often starts too late and only once the patient is medically	It is recognised that training is required on regular basis however, discharge planning is a core part of the role of the ward MDT and supported by nursing documentation. Pre pandemic the DU and our improvement team provided support in this area. Following a recent staff survey one of the key recommendations is to develop better, very practical and locally delivered discharge planning	SRO UEC Programme County Directors / Acute General Managers /	 April 2022	

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	optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate care packages are put in place.	training. A plan is in development to do this, working in partnership with the Improvement Team, and to focus this on home first principles, understanding the D2RA principles and purpose, build better relationships across the MDT and communication through the SharePoint system. This training will need to be incorporated in agency and temporary staff induction to ensure consistency of the discharge process being applied. SharePoint does give us the opportunity to identify the time between someone being admitted and added to the system, this gives us a baseline and therefore monitor the impact. For patients discharged in October (319 patients) who were added to SharePoint the average number of days between admission and being added to the system: Bronglais – average 9.1 days Glangwili – average 16.8 days Prince Philip – average 14.0 days Withybush – average 10.9 days Important to note that there is still work to be done on data quality. This will be part of project work associated with Policy Goals 5 and 6 of the UEC programme. Success of any training however is dependent on 'ownership' of discharge planning processes by	Improvement Team Policy Goal Implementation Leads	April 2022	

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		acute and community staff. A regional task and finish group is being established to discuss how the conversation about future plans can commence on admission and information can be provided to facilitate a conversation.			
4	The centralised patient discharge monitoring tool used to monitor complex patients' status and to inform discharge planning, has not been adopted by Bronglais General Hospital.	All three county acute sites now utilise the new Complex Discharge tool although there is more to be done on improving the data quality of recording. A report has been developed to provide performance information that can be shared weekly with WG colleagues via the Delivery Unit monitoring tool and also provide quarterly updates to WG via the Regional Partnership Board on discharge to assess pathways. We have greater granularity and detail in our reporting than the previous DTOC reporting gave. The Board IPAR has regular monthly commentary on non-mental health discharge delays and incorporates performance trend graphs from the Complex Discharge tool.			Complete
4 / 3.25	Suspension of formal DTOC reporting to Welsh Government has resulted in the Health Board no longer monitoring delays internally and not being apprised of performance related issues Whilst IPARs continue to be regularly presented to the relevant statutory committee (The Strategic Development & Operational Delivery Committee as of 1st August 2021) and to the Board, they no longer include non-mental health DTOC due to reporting being suspended by WG.				Complete
4	Lessons learned reviews are not undertaken to identify and address failure points, or areas of good practice.	Where sub optimal discharges occur these are reported via our Datix system and investigated accordingly. Any lessons learned are then brought to our joint QA Senior management team for discussion.	County Directors / Secondary Care Director alongside Policy Implementation Lead	April 2022	

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		However a regional solution to share learning should be developed alongside the county approach.			

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4 / 3.8	The Expected Date of Discharge (EDD) should be used to inform the discharge planning process. However, the purpose and value are misunderstood, resulting in inconsistent use and non-compliance with WG requirements. WG's SAFER Patient Flow Guidance issued in February 2018 states that all patients should have an EDD based on the clinical and functional criteria for discharge and should be set with the assumption of ideal recovery and no avoidable delays. This is reinforced within the WG COVID-19 Discharge Flow Chart (Appendix B) which requires an EDD and clear Clinical Plan within 24 hours of the patient being admitted in hospital.	The report does not clearly articulate that a critical component of realistic EDD is dependent on clinicians determining on day one of admission the clinical goals the patient needs to achieve during acute admission. Similarly the MDT needs to also determine the functional deficit on admission and the minimum the patient needs to achieve in terms of functional gain during admission. Collectively this is known as establishing Clinical Criteria for Discharge (CCD). Without CCD it is impossible to determine EDD and appropriate discharge pathway. It is not uncommon for this to be set to a default e.g. 2-4 weeks after date of admission rather than based on MDT discussion. EDD is usually recorded on SharePoint but not the CCD – both of which are set out clearly as important early steps in the discharge planning process. It must be recognised that workforce compromise in acute hospitals across nursing, senior clinicians and therapy is contributing to us not being able to deliver this effectively. Community has invested in DLNs, Senior Flow Managers and additional therapists who are based in the hospital to try and encourage this practice.	County Directors / Secondary Dare Director alongside Policy Goal Implementation leads	April 2022	

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4 / 3.12	Only one acute site is compliant with the requirement for two daily board rounds (as per WG Requirements). WG Requirements stipulate the responsibilities and required actions from each of the identified roles within the D2RA process, including Health Boards, Local Authorities and Adult Social Care services, Local Health and Social Care Partners, Voluntary Sector and Care Providers. Our review highlighted that although representatives from the aforementioned services are involved in various stages of the patient discharge process, there is a lack of a whole system approach to discharge planning.	Counties have reviewed and strengthened their whole system flow process. Whole system 'Board Rounds' are also undertaken daily as part of the daily touchpoint meetings across acute, community and primary care. A programmatic and phased approach we are taking is to ensure that Board Rounds are operating effectively on all wards once a day. As outlined above our review has demonstrated that Board Rounds were not being conducted appropriately (as per SAFER guidance). As such we have introduced the targeted / focused approach outlined in point above.	County Directors / Secondary Dare Director alongside Policy Goal Implementation leads	April 2022	
3.13	A common theme arising from our enquiries was that the discharge planning process often starts too late and only once the patient is medically optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate care packages are put in place.	Actions outlined in 4 / 3.8 and 4 / 3.12 apply	County Directors / Secondary Dare Director alongside Policy Goal Implementation leads	April 2022	

Management Action Plan

Matter Arising 1: Recruitment Delays (Operation)	**Impact**	
Of the 10 sampled consultants and junior doctors, delays were identified for six individuals that resulted in several internal KPIs, where the recruiting manager was responsible, being breached including notice date to authorisation date and the time taken to approve the vacancy request.	Potential risk of: • delays in recruiting medical staff resulting in high locum costs and a negative impact on patient care.	
Recommendations	**Priority**	
The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	**HIGH**	
Agreed Management Action	**Target Date**	**Responsible Officer**
Continue to deliver formal training at the New Consultant Development Programme and any other relevant leadership/management development programmes for those responsible for staff in the Medical & Dental staff group to ensure recruiting managers are aware of their responsibilities and key performance indicators.	31st March 2022	Sally Owen (Head of Recruitment & Workforce Equality, Diversity and Inclusion)
In addition to formal delivery of training, continue to promote access to virtual training which is already available on the intranet in '10 top tips' which covers preparing to recruit.	31st March 2022	Sally Owen (Head of Recruitment & Workforce Equality, Diversity and Inclusion)
Develop further training including virtual Trac training which will reinforce the need to place vacancies on Trac at the earliest opportunity.	31st March 2022	Sally Owen

		(Head of Recruitment & Workforce Equality, Diversity and Inclusion)
Share Medical Recruitment KPI performance with other officers in the W&OD Directorate e.g. OD Relationship Managers, Medical Workforce Team, Workforce Efficiency team, Workforce Planning Team etc to encourage them to support the importance of timely recruitment when they liaise with managers	31st March 2022	Sally Owen (Head of Recruitment & Workforce Equality, Diversity and Inclusion)
Explore the option of electronic leaver forms to trigger prompt actions to recruit in a more timely manner.	31st March 2022	Sally Owen (Head of Recruitment & Workforce Equality, Diversity and Inclusion)
Medical Recruitment Team to routinely share monthly KPI performance on Medical Recruitment with the Director of Operations highlighting areas of improvement or deterioration and service areas where performance requires improvement.	31st December 2021	Sally Owen (Head of Recruitment & Workforce Equality, Diversity and Inclusion)
Director of Operations to routinely address monthly KPI performance on Medical Recruitment at the Operational Leads Delivery meeting highlighting areas of improvement or deterioration and service areas where performance requires improvement.	31st December 2021	Andrew Carruthers, Director of Operations

Matter Arising 2: Delays in the Recruitment Process (Design)	**Impact**	
We identified a number of other delays in the recruitment process including occupational health clearance, candidate queries over salaries, extended notice periods and immigration status checks undertaken by the Home Office.	Potential risk of: • delays in recruiting medical staff resulting in high locum costs and a negative impact on patient care.	
Recommendations	**Priority**	
Management should undertake a targeted review of consistent bottleneck areas within the recruitment process and develop actions in order to promptly address medical staff vacancies.	**MEDIUM**	
Agreed Management Action	**Target Date**	**Responsible Officer**
Medical Recruitment Team to review consistent 'bottleneck' areas and develop an action plan to address them. Example areas will include a) starting salary process b) occupational health process c) notice periods d) immigration process. This list is not exhaustive as the review may identify other bottleneck areas which need to be addressed.	31st January 2022	Sally Owen (Head of Recruitment & Workforce Equality, Diversity and Inclusion)

Matter Arising 3: Onboarding Process (Design)	**Impact**	
The pastoral element of the onboarding process is undertaken between the recruiting manager and the Medical Recruitment Teams. The Health Board has arrangements in place such as a 'buddy scheme' for overseas new starters and providing support with accommodation. However, we were informed by the Head of Recruitment & Workforce Equality, Diversity and Inclusion that the uptake of these schemes were low.	Potential risk of: • lack of onboarding procedures which may detrimentally affect new recruits and the Health Board's reputation and future ability to recruit.	
Recommendations	**Priority**	
Management should undertake a review of the onboarding process and engage with key stakeholders to establish whether enhancements can be made to the current system.	**LOW**	
Agreed Management Action	**Target Date**	**Responsible Officer**
As part of the recruitment pathway strategic objective the recruitment team are reviewing information shared with key stakeholders in a bid to improve the recruitment journey including onboarding/pastoral care. The medical recruitment team are also supporting the Medical Directorate in a piece of work to further explore candidate connections pre Day 1 and on/around Day 1 for the M&D staff group. The findings of this audit and the outcomes of the discovery stages of the above workstreams will be consolidated to develop an action plan which focusses on improvement to the onboarding process.	31st May 2022	Sally Owen (Head of Recruitment & Workforce Equality, Diversity and Inclusion)