Audit & Assurance Committee Meeting

07 July 2020, 09:00 to 12:30
Via Skype

Agenda

1. Welcome & Introductions

John Union

1.1. Apologies for Absence

John Union

1.2. Declarations of Interest

John Union

1.3. Quorum

John Union

1.4. Minutes of the Committee meeting held on 28th May and 29th June 2020

Decision

John Union

- 1.4 Final Public Audit Mins - May 2020 SR.NF.pdf (6 pages)
- 1.4 Public Audit Mins - June 2020 Final.pdf (4 pages)

1.5. Action log following meeting held on 28th May and 29th June 2020

John Union

- 1.5 Final Action Log Public May 2020 SR.NF.pdf (2 pages)

1.6. Any Other Urgent Business:

To agree any additional items of urgent business that may need to be considered during the meeting.

John Union

2. Items for Review & Assurance

2.1. Internal Audit Progress and Tracking Reports

(Also to provide sample of validation from Clinical Boards to test for accuracy in a future Internal Audit and Review)

Ian Virgill

- 7.1 CV AC A&A Progress Report cover July 20.pdf (3 pages)
- 7.1 CV AC A&A Progress Report July 20.pdf (15 pages)

2.1.1. Audit Wales Office Update

Audit Wales

- PA288 - Update on the AGW's programme of NHS Performance Audit work.pdf (7 pages)

3. Items for Approval / Ratification

3.1. Declarations of Interests, Gifts & Hospitality Tracking Report

Nicola Foreman

- 8.1 Declarations of Interest and Gifts and Hospitality Tracking Report - July 2020.pdf (3 pages)

3.2. Internal Audit Tracking Report

Nicola Foreman

	8.2 Internal Audit Tracker Covering Report.pdf	(2 pages)
	8.2 Internal Audit Summary Tables - Appendix 1.pdf	(3 pages)
	8.2 Internal Audit Tracker - July 2020 for Audit Committee.pdf	(23 pages)

3.3. Audit Wales Tracking Report

Nicola Foreman

	8.3 External Audit Recommendation Tracking report covering report.pdf	(2 pages)
	8.3 External Audit Summary Table - Appendix 1.pdf	(1 pages)
	8.3 WAO July 2020- Audit Committee Report.pdf	(7 pages)

4. Items for Information & Noting

4.1. No items

5. Any Other Business

John Union

6. Review of the Meeting

Discussion

John Union

7. Date & Time of Next Meeting

Tuesday 8th September 2020

Information

9.00am -12:30pm

John Union

Via Skype /Woodlands House

UNCONFIRMED MINUTES OF THE PUBLIC AUDIT AND ASSURANCE COMMITTEE HELD ON THURSDAY, 28 MAY 2020 NANT FAWR 1, WOODLAND HOUSE

Chair		
John Union	JU	Independent Member – Finance
Present:		
Eileen Brandreth (via Skype)	EB	Independent Member – ICT
Dawn Ward (via Skype)	DW	Independent Member – Trade Union
In Attendance:		
Nicola Foreman (via Skype)	NF	Director of Corporate Governance
Chris Lewis (via Skype)	CL	Deputy Finance Director
Helen Lawrence (via Skype)	HL	Head of Financial Accounting and Services
Ian Virgil	IV	Head of Internal Audit
Rhodri Davies (via Skype)	RD	Wales Audit Office
Secretariat		
Sian Rowlands	SR	Head of Corporate Governance
Apologies:		
Bob Chadwick	BC	Executive Director of Finance
Mark Jones	MJ	Wales Audit Office
Mike Usher	MU	Sector Lead – Health & Central Government
Anne Began	AB	Wales Audit Office

AAC 20/05/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting.	**ACTION**
AAC 20/05/002	**Apologies for Absence** Apologies for absence were noted.	
AAC 20/05/003	**Declarations of Interest** There were no declarations of interest.	
AAC 20/05/004	**Minutes of the Committee Meeting held on 21 April 2020** The Committee reviewed the minutes of the meetings held on 21 April 2020. **Resolved that:** (a) the minutes of the meeting held on 21 April 2020 be approved as a true and accurate record.	
AAC 20/05/005	**Action Log following the Committee Meeting held on 21 April 2020**	

	The Committee reviewed the Action Log and noted the following updates: **AC: 20/03/008 and AAC: 20/04/005** – It was confirmed that Consultant job planning had moved forward and had been considered in detail a few meetings prior. The Head of Internal Audit would be providing an update at the February meeting. **AC 19/12/012** – The WAO Effectiveness of Clinical Audit Report would be kept as outstanding as its status had been affected by COVID-19. The Director of Corporate Governance would speak with WAO about plans to progress post COVID-19. **AAC 20/04/008** – It was confirmed that the aim would be to bring a report detailing Declarations of Interest in relation to Ysbyty Calon Y Drraig to the July meeting but it might be September. The Committee was advised that a record was being kept of Declarations of Interest relating to Ysbyty Calon Y Drraig. **AAC 20/04/009** – Likewise the Regulatory Compliance Tracking Report would resume July / September subject to being able to return to normal business. **AAC 20/04/013** – The Head of Internal Audit confirmed that he would provide a verbal update regarding the Annual Internal Audit Plan to the Committee today. **AAC 20/04/015** – The Committee would await confirmation from MU and the WAO team regarding the All Wales learning from the pandemic. **Resolved that:** (a) the Committee noted the Action Log and the verbal updates provided.	**NF**
AAC 20/05/006 Tolley.Laura 07/06/2020 11:04:49	**Internal Audit Progress and Tracking Reports** The Head of Internal Audit advised the Committee that the usual progress report was presented and that the Internal Audit plan tied in with the Annual Report to be discussed in the later Workshop. The Head of Internal Audit talked the Committee through the report, highlighting that it provided detail of progress with the delivery plan since the last meeting. Section 2 of the report showed eight audits had been completed since the last meeting and all received positive assurance reports. The Committee was advised that two audits were submitted to the Committee today in draft format as finalisation of the reports had not been possible due to COVID-19.	

	The Committee agreed to receive the reports in draft as it would not be reasonable for departments to have to agree actions at this time. The Head of Internal Audit would revisit with managers and bring a confirmed action plan to a future meeting for completeness. The Independent Member – ICT commented that the approach of giving sight of the draft report and bearing with managers was appropriate and that she supported it. The Independent Member – Trade Union agreed that it was a sensible and sensitive approach. The CC concluded that it was good to see that the last update for the year was positive and one of reasonable assurance and recognised the hard work of Internal Audit and of managers in responding. The Head of Internal Audit explained that section 3 of the report fed into the annual opinion provided. Internal Audit were able to produce 39 completed reports which gave enough coverage across the domains to provide an annual audit opinion. Appendix C and D provided the Committee with information on key performance indicators; all were green save for those relating to the time taken for managers to respond to reports. The Committee was advised that this has been impacted by COVID-19 but progress was being made in this area. The Committee was advised that in terms of the 2020-21 plan, there had been a discussion with the Executive Director of Finance and Director of Corporate Governance regarding looking at the general governance arrangements and financial governance around COVID-19. As there was also a detailed KPMG audit currently being conducted around this, a brief would be pulled together to avoid duplication of work. The Director of Corporate Governance added that it was important to get the scope of the Internal Audit governance review right and that it would be sensible to wait for the outcome of the KPMG report which had looked at the whole governance structure to avoid duplication. In addition, WAO also were intending to review governance. The CC asked whether there was a date agreed for the KPMG report and it was confirmed that there was not currently but that an outcome meeting was being arranged and that a date would no doubt be provided then which could be fed back to the CC. The Deputy Finance Director added that the KPMG audit had been commissioned by Welsh Government and was due to include in around a fortnight. The audit was concentrating on financial due diligence, governance and contracting with a focus around the Dragon's Heart Hospital. The Independent Member – ICT asked whether we had received Terms of Reference for the KPMG audit.	**IV** **NF**

	The Deputy Finance Director responded that the Terms of Reference had been requested but not released to us. The CC confirmed that he had received a presentation regarding the audit that he would share. The Independent Member – Trade Union commented that she was pleased to hear that we would be looking back at this period and auditing it. The CC queried the normal number of internal audits in a given year. The Head of Internal Audit responded that between 40-50 for the plan but the intention was to reduce the number and increase the scope to provide more detail. Audits not done this year would feed into next year's plan but this would be considered on a risk basis as to whether these audits were still appropriate. **Resolved that:** (a) the Committee considered the Internal Audit Progress Report and the findings and conclusions from the finalised and draft individual audit reports.	**CC**
AAC 20/05/007	**Report of the Losses and Special Payments Panel** The Deputy Finance Director advised the Committee that the Losses and Special Payments Panel met twice a year and brought its recommendations to the Committee for approval as per the Scheme of Delegation. The Panel met on 13 May 2020 and considered the period for the second part of the year. The Assessment section of the report made a number of recommendations. The Committee was advised that losses were included in the financial accounts for final sign off. The Deputy Finance Director advised the Committee that there was a big number for Clinical Negligence which related not to cost but the size of the loss. The large figure for ex-gratia payments was highlighted and the £250k relating to stock right off across areas, the Committee was advised that this figure was £461k the preceding year so was not out of synch with past years. The CC raised a query about the wheelchair losses after the flood. The Deputy Finance Director advised that as the connected losses were so large, this was not within the delegated authority of the Health Board to approve and therefore it had gone to Welsh Government who had approved the losses so this would come to a future Committee for noting as it related to the new financial year. The Independent Member – Trade Union was happy to approve the write offs but asked whether going forward, in the spirit of protecting public	

	money, there was anything more that could be done regarding stock control. The Deputy Finance Director responded that as Chair of the losses and special payments panel, it was within his remit to make further enquiries regarding items as necessary. In keeping with this, he had made a special request for detail regarding stock write offs but there was nothing that stood out as a serious breach of control. The aim going forward was to obtain better trend analysis. The Independent Member – ICT commented that it was unclear how much of the debt write off had been referred to a collection agency and what percentage of this became a write off. The Deputy Finance Director agreed to provide this information before the next Audit Committee meeting. Putting the figure into context, he advised that the amount was extremely small in comparison to the income received. The Independent Member – ICT commented that there was no knowing whether we were better or worse in comparison with others so information regarding this would be helpful. The Deputy Finance Director explained that the details of clinical negligence go through another Committee of the Board. **Resolved that:** (a) the Committee approved the write offs outlined in the Assessment Section of the report.	**CL**
AAC 20/05/008	**Internal Audit Reports** The Committee received the Internal Audit reports provided. The Independent Member – Trade Union commented that tremendous progress had been made around reassessment but that it was a little alarming to observe a slight downward trend of audits happening in some of the clinical areas and it was important to consider how to better motivate and engage staff and reinforce the importance of audit. The CC added that we should as a Committee be congratulating areas on positive assurance findings. The Head of Internal Audit confirmed that the team meets with Health Board staff and pushes the importance of audit in these meetings. The CC added that we also now had the Internal Audit Tracker in place which was good progress and he was reassured by the reports done and actions being taken. The Head of Internal Audit confirmed that he would be reviewing the reports and would pull into an overall report for Committee.	**CC** **IV**

	Resolved that: (a) the Committee noted the Internal Audit reports.	
AAC 20/05/009	**Good Governance During COVID-19** The Director of Corporate Governance confirmed that the report was for information only as it had already received Board approval but as the Committee had not formally seen the arrangements it was being brought for noting. The report described the framework put in place initially (the structure resembled Gold Command), and where the Health Board were with Committees that had been cancelled. The Committee was advised that the Health Board were now starting to revert to business as usual and the Chair had asked Committees to look at their terms of references so that we do not fully revert to as we were before. The document would also be attached as part of the Chair's report to the Board to be ratified. The Independent Member – Trade Union queried the timescales for reverting back to business as usual. The Director of Corporate Governance explained that the structure was constantly under review. The Operational meeting was still convening daily, and taking lessons from what worked well, this was likely to continue. There was talk to now stand down the Strategic Group and revert to the normal Management Executive meeting. The UHB had kept to the Scheme of Delegation and SFIs so reverting back would not be an issue. **Resolved that:** (a) the Committee noted the report setting out the Governance Structure and arrangements during COVID-19 (b) the Committee noted arrangements to the Board and Committees set out at paragraph 2.7 and appendix 2 (c) the Committee noted the changes to Standing Orders set out in Appendix 3 of the report.	
AAC 20/05/010	**Review of the Meeting** The CC facilitated a review of the meeting. Members confirmed that given the current circumstances, all aspects of the meeting worked well and ran smoothly.	
AAC 20/05/011	**Date and Time of Next Meeting** **Special Audit Committee** Monday, 29 June 2020 10:00 am Executive Meeting Room, 2nd floor, Woodland House	

Unconfirmed Minutes of the Public Audit and Assurance Committee
Held on Monday 29th June 2020 10:00am – 11:00am
Executive Meeting Room / Via Skype

Chair		
John Union	JU	Independent Member – Finance
Present:		
Eileen Brandreth (via Skype)	EB	Independent Member – ICT
Dawn Ward (via Skype)	DW	Independent Member – Trade Union
In Attendance:		
Bob Chadwick	BC	Executive Director of Finance
Nicola Foreman	NF	Director of Corporate Governance
Mark Jones	MJ	Audit Wales
Chris Lewis	CL	Deputy Finance Director
Helen Lawrence (via Skype)	HL	Head of Financial Accounting and Services
Ian Virgil (via Skype)	IV	Head of Internal Audit
Rhodri Davies (via Skype)	RD	Audit Wales
Secretariat		
Laura Tolley	LT	Corporate Governance Officer
Apologies:		

AAC 20/06/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting.	**ACTION**
AAC 20/06/002	**Apologies for Absence** Apologies for absence were noted.	
AAC 20/06/003	**Declarations of Interest** There were no declarations of interest.	
AAC 20/06/004	**A Report on the Annual Accounts of the UHB 2019-20** The Deputy Director of Finance (DFD) introduced the report and confirmed the Annual Accounts also formed part of the Accountability Report. The DFD reminded the Committee that the report had previously been reviewed and scrutinised at the meeting held on 28th May 2020. Adjustments to the report were outlined on page 2, however these did not change the impact of the report on the financial position of the UHB.	

AAC 20/06/005	**Audit Wales ISA 260 Report** Audit Wales (AW) introduced the report and confirmed that the accounts were materially true, fair and prepared with the exception of stock, this was due to AW being unable to attend the stock take for 2019-20 due to COVID-19, therefore, this would not report negatively for the Health Board. AW advised the Committee of two emphasis of matter which were explained as: • Valuation of Land – The Health Board carried out 7 valuations during 2019-20, 4 of which were conducted during COVID-19. AW confirmed it was an emphasis of matter due to the unreliability around valuations due to market uncertainty. • Pension Regulations – This affected all Health bodies with the exception of HEIW. AW confirmed the narrative around this had been agreed with Audit Wales and Welsh Government. AW advised the Committee that the Auditor General intended to certify on the 2nd July 2020 and Welsh Government were expected to lay the accounts on the 3rd July 2020 which would include a press release. AW expressed thanks to the UHB Finance team, Corporate Governance team and all staff involved with the audit, advised it had been a difficult year to deal with the reports virtually but all stakeholders worked very well together to achieve this.	
AAC 20/06/006	**The Head of Internal Audit Annual Report for 2019-20** The Head of Internal Audit (HIA) introduced the report and confirmed that the Audit Annual Report for 2019-20 had been reviewed and scrutinised during the meeting held on 28th May 2020 and no changes had been made. The DCG confirmed that the Audit Annual Report for 2019-20 had also been presented to Management Executive and was also reflected through the Annual Governance Statement.	
AAC 20/06/007	**The Counter Fraud Annual Report for 2019-20** The Counter Fraud Manager (CFM) introduced the report and confirmed the following: • The appointment of a Band 4 team member to assist with awareness training going forward;	

	• 59 new investigations and 11 cases brought forward from 2018-19; • Collaborative working was being undertaken with HR colleagues to address identified policy weaknesses; • Self-assessment had been completed, signed off by the Executive Director of Finance (EDF) and submitted within the set deadline to the NHS Counter Fraud Authority on 31st March 2020; • All areas are rated green against areas set by NHS Counter Fraud Authority, this was positive, however it was important to note a challenging year ahead; • Total cost of running a Counter Fraud department for the UHB totalled £91,000.00, however, the UHB had recovered £27,000.00 in costs. The CC commented it was very positive to see all areas reporting green and thanked the Counter Fraud department for all work undertaken and achieved during 2019-20 and noted the difficulty heading into 2020-21.	
AAC 20/06/008	**To receive and consider the following for 2019-20:** **a. The Letter of Representation included within the ISA 260 report** AW introduced the report and confirmed this was a standard letter used, however there was a specific section within the letter which highlights corrections, this letter would require Board, CEO and Chair approval. The Independent Member – Trade Union (IM-TU) queried if there would be consequences over the estimated stock levels and valuations. In response, the DFD confirmed from a UHB perspective he was confident these were correct, therefore there was no cause for concern. The Independent Member – ICT (IM-ICT) asked in relation to the treatment of pool budget, the UHB had corrected 2019-20 accounts, but had not corrected previous year's accounts. In response, the DFD advised confirmation from Welsh Government had been received which explained that previous changes did not need to be made. **b. The response to the audit enquiries to those charged with governance and management** The DFD confirmed this was endorsed at the meeting on the 28th May 2020, in addition to being endorsed by the Chair, CEO and DCG. **c. The Annual Accountability Report including the Financial Statements** The DCG confirmed that the Annual Accountability Report had been reviewed and scrutinised at the meeting held on 28th May 2020. Audit	

	Wales and Welsh Government comments had been included in the final document. Part 1, related to the performance report was to be developed and presented at the Annual General Meeting on 27th August 2020.	
AAC 20/06/009	**Resolved that:** The Audit and Assurance Committee:- (a) noted the reported financial performance contained within the Annual Accounts and that the UHB has breached its statutory financial duties in respect of revenue expenditure. (b) noted the changes made to the Draft Annual Accounts; (c) reviewed the ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation, the response to the audit enquiries to those charged with governance and management and the Annual Accountability Report which includes the Annual Accounts and financial statements; (d) recommended to the Board that it agrees and endorses the ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation and the response to the audit enquiries to those charged with governance and management; (e) recommended to the Board approval of the Annual Accountability Report for 2018-19 including the Annual Accounts and financial statements.	
AAC 20/06/010	**Items to bring to the attention of the Board / Committees** The Committee agreed the following items would be taken to the Board: (a) Audit Wales ISA 260 Report; (b) The Head of Internal Audit Annual Report for 2019-20; (c) The Letter of Representation included within the ISA 260 report; (d) The response to the audit enquiries to those charged with governance and management; (e) The Annual Accountability Report including the Financial Statements;	**NF**
AAC 20/06/011	**Review of the Meeting** The CC thanked all involved in developing the reports and documents presented at the meeting. The IM-TU thanked the CC and Committee members for informed and transparent reporting.	
AAC 20/06/012	**Date and Time of Next Meeting** Tuesday 7th July 2020 9.00am – 12:00pm Via Skype	

Action Log
Following Audit & Assurance Committee Meeting
29th June 2020

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
AAC 20/05/006	KPMG Presentation	To share KPMG presentation with Committee members	John Union	June 2020	Complete
Actions in Progress					
AAC 20/03/008 **AAC 20/04/005**	Consultant Job Planning Follow-up: Limited Assurance Report	For an update to be presented to the Committee in February 2021. It was agreed an Internal Audit Report would be carried out at an appropriate time agreed with Stuart Walker	Ian Virgil	9.02.21 TBC	Update to be provided at February 2021 meeting. To be confirmed
AAC 19/12/012 **AAC 20/05/005**	Effectiveness of Clinical Audit Report	To consider arrangements to deliver effective programme of Clinical Audit To clarify plans to progress post COVID-19 with WAO	S Walker Nicola Foreman		This is currently being considered as part of the Self-Assessment of Current Quality Governance arrangements - May 2020
AAC 19/12/015	Internal Audit Tracking Report	The acting Head of Internal Audit to provide sample of validation from Clinical Boards to test for accuracy in a future Internal Audit and Review	I Virgil	7.07.20	To be brought to the July 2020 meeting
AAC 20/04/008	Declarations of Interest	A report detailing Declarations of Interest in relation to Ysbyty Calon Y Drraig be brought to a future meeting	Nicola Foreman	08.09.20	To be provided at the September Audit Committee Meeting

AAC 20/04/009	Regulatory Compliance Tracking Report	A report detailing all visits and sign off for Ysbyty Calon Y Ddraig be brought to a future meeting	Nicola Foreman	08.09.20	To be provided at the September Audit Committee Meeting
AAC 20/04/010	Internal Audit Tracking Report	Work be carried out with the Director of Digital & Health Intelligence to improve transparency and detailed responses	Aaron Fowler	08.09.20	Meeting with the Director of Digital Health Intelligence and Head of Risk Management to take place prior to September Audit Committee Meeting
AAC 20/04/015	Annual Audit Plan – Impact of COVID-19	Work undertaken on an All Wales Level relating to learning from the pandemic be shared with the UHB	Mike Usher	To be confirmed	To be confirmed
AAC 20/05/006	Internal Audit Progress	Draft Internal Audit reports presented at the May meeting to be followed up with managers and confirmed action plans to be brought to a future meeting	Ian Virgil	TBC	TBC
AAC 20/05/006	KPMG Audit	To inform Committee Chair of date agreed for receipt of KPMG report	Nicola Foreman	June 2020	It is unclear yet as to whether the Health Board will receive a report although the Audit has been completed and recommendations made they are WG recommendations.
AAC 20/05/007	Losses and Special Payments	To provide Committee members with information on how much debt write off had been referred to a collection agency and what percentage of this became a write off	Chris Lewis	June 2020	
AAC 20/05/008	Internal Audit Reports	To congratulate areas on positive assurance findings. To provide an overall report for Committee	John Union Ian Virgil	September 2020 July meeting	
Actions referred to other Committees / Board					

REPORT TITLE:	Internal Audit Progress Report								
MEETING:	Audit & Assurance Committee						**MEETING DATE:**	07.07.20	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**	**x**	**For Information**		
LEAD EXECUTIVE:	Director of Governance								
REPORT AUTHOR (TITLE):	Head of Internal Audit								

PURPOSE OF REPORT:

SITUATION:

The Internal Audit progress report provides specific information for the Audit & Assurance Committee covering the following key areas:

- Detail around proposed amendments to the content and timing of the previously agreed 2020/21 Internal Audit Plan
- Specific detail relating to progress against the audit plan.

REPORT:

BACKGROUND:

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

The work undertaken by Internal Audit is in accordance with its plan of work, which is prepared following a detailed planning process and subject to Audit Committee approval. The plan sets out the programme of work for the year ahead as well as describing how we deliver that work in accordance with professional standards and the process established with the UHB and is prepared following consultation with the Executive Directors.

The progress report provides the Audit and Assurance Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan and proposed amendments to the plan.

ASSESSMENT:
The progress report provides the Committee with a level of assurance around the management of a series of risks covered within the specific audit assignments delivered as part of the Internal Audit Plan. The report also provides information regarding the areas requiring improvement and assigned assurance ratings.

RECOMMENDATION:

The Audit & Assurance Committee is asked to:

Consider the Internal Audit Progress Report.

Approve the proposed amendments to the Internal Audit Plan for 2020/21.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	Prevention		Long term	x	Integration	x	Collaboration	x	Involvement		
EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable										

Kind and caring / Caredig a gofalgar | Respectful / Dangos parch | Trust and integrity / Ymddiriedaeth ac uniondeb | Personal responsibility / Cyfrifoldeb personol

Tolley, Laura 07/06/2020 11:04:49

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee July 2020

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

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

Disclaimer notice - Please note:

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

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

1. INTRODUCTION

1.1. This progress report provides the Audit & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2020/21 Internal Audit plan.

1.2. The report includes information regarding proposed changes to the content and timing of the 2020/21 Plan along with details of the early progress made towards delivery.

1.3. The initial plan for 2020/21 was agreed by the Audit & Assurance Committee in April 2020 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. PROPOSED ADJUSTMENTS TO THE INTERNAL AUDIT PLAN

2.1. Full details of the proposed adjustments to the Internal Audit Plan are provided within the updated Plan at Appendix 1.

The key additions, removals and timing adjustments are summarised below:

2.2. **<u>Audits to be added to the 20/21 plan</u>**

- **Governance Arrangements during COVID-19 Pandemic.**

The All-Wales Finance Directors Group requested that the Audit & Assurance service undertake a review of governance arrangements during COVID-19 at all NHS Wales bodies.

The review will assess the adequacy and effectiveness of internal controls in operation during the Covid-19 outbreak, with particular regard to the principles set out by the Welsh Government regarding maintaining financial governance.

This will be an advisory review so the assignment will not be allocated an assurance rating, but advice and recommendations will be provided to facilitate change and improvement.

• Completion of the COVID-19 Governance review may identify areas where changes have been made to key Health Board processes, procedures or controls. If further specific assurance is required around the appropriateness and effectiveness of these changes then additional audits may be undertaken on these areas.

2.3. Audits to be removed from the 20/21 plan

- **Public Health Audit 1**

Removed to allow allocated days to be utilised for the COVID-19 Governance review.

- **IT Strategy**

The Director of Digital has requested that the review is deferred to the 21/22 plan. The COVID situation has impacted the timing of IT work so the Strategy delivery / roadmap needs to be reassessed.

- **Implementation of New IT Systems**

The Director of Digital has requested that the review is deferred to the 21/22 plan. COVID has affected IT system implementations and the audit would need input from departments.

2.4. Proposed adjustments to timing of Audits

The originally agreed 20/21 Internal Audit plan included proposed timescales for undertaking the identified audits. As a result of the ongoing COVID-19 situation we have reviewed the planned timescales and made adjustments to ensure that we don't undertake work within key clinical areas until later in the year.

Full details of the adjusted planned timings are included within Appendix 1. The table below highlights those audits that we are now proposing to commence first, with an aim to complete them within Quarter 2.

Audit	Outline Scope
IM&T Control & Risk Assessment	Review and assess the control environment for the management of IM&T within the organisation.
Health and Care Standards	Review utilisation of standards within the Health Board and process for assessing performance against them.
Engagement Around Service Planning	Review processes for consulting with key stakeholders around service change.
Regional Partnership Board	Review UHBs arrangements for engaging with RPBs. Focus on governance arrangements around funding flows.
Annual Quality Statement	Check if the AQS is developed in accordance with WG guidance and check the accuracy, completeness and consistency of information.
Concerns / Serious Incidents	Review processes and controls in place for managing concerns. Focus on closure of Serious Incidents and lessons learnt.

Integrated Health Pathways	Review of processes for the development, implementation and utilisation of pathways tool. Establish if benefits are being realised.
Sustainability Reporting	To establish if the Health Board has robust systems in place to record and report minimum sustainability reporting requirements as required by the WG.
Fire Safety	Assess compliance with statutory regulations in relation to fire precautions.
Asbestos Management	Assess of the controls and practices in place to ensure compliance with key asbestos regulatory requirements.
Capital Systems Management	A review of the systems, policies and procedures in place to manage those projects not specifically identified within the audit plan.

2.5. The information above summarises the proposed adjustments to the Internal Audit plan that have been identified to date. It is however likely that further adjustments may be required going forward, to reflect the Health Board's changing risks and assurance requirements as the COVID-19 situation develops.

Any such required adjustments will be discussed with the Director of Governance and relevant lead Executive as they arise and will be communicated to future meetings of the Audit and Assurance Committee for formal approval.

3. DELIVERY OF THE 20/21 INTERNAL AUDIT PLAN

3.1. Following the delay in commencing delivery of the Internal Audit Plan, due to the COVID-19 situation, there are no audits that have been completed in time for presentation to the July Audit Committee meeting.

3.2. We have now however commenced work on a small number of audits and details of these are included within Appendix B. The outcome of these audits, along with the others planned to be completed within Quarter 2 will be reported to the September and November meetings of the Audit and Assurance Committee.

UPDATED 20/21 INTERNAL AUDIT PLAN

Audit	Exec Director Lead	Original Quarter Per Plan	Revised Quarter	Notes	
(1) Corporate governance, risk and regulatory compliance					
IM&T Control & Risk Assessment	Transformation & Informatics	1	2	Delayed due to COVID-19.	
Risk Management	Corporate Governance	4	4		
Health and Care Standards	Nursing	4	2	Brought forward as review will now cover the delayed 18/19 assessment process.	
Claims Reimbursement	Nursing	3	3		
Whistleblowing Policy	Corporate Governance	3	3		
Governance during COVID-19	Corporate Governance	/	2	Review added to plan following request from Directors of Finance.	
(2) Strategic planning performance management and reporting					
Engagement Around Service Change	Strategic Planning	2	2		
Regional Partnership Boards	Strategic Planning	3	2	Brought forward as no work required in clinical areas.	
Commissioning	Strategic Planning	3	3		

Audit	Exec Director Lead	Original Quarter Per Plan	Revised Quarter	Notes	
Strategic Performance Reporting	Transformation, & Informatics	3	3		
Data Quality Performance Reporting	Transformation, & Informatics	4	4		
Public Health Audit 1	Public Health	2	/	Removed. Days used for COVID-19 Governance review.	
Public Health Audit 2	Public Health	3	3		
(3) Financial Governance and management					
UHB Core Financial Systems	Finance	3	3		
Charitable Funds	Finance	2	3	Delayed due to COVID-19	
Directorate Level Financial Control	Finance	2	3	Delayed due to COVID-19	
(4) Clinical governance quality and safety					
Annual Quality Statement	Nursing	1	2	Delayed due to COVID-19	
Nursing Staffing Levels Act	Medical	1	3	Delayed due to COVID-19. Work will be required within clinical areas.	
Concerns / Serious Incidents	Nursing	2	2		
Clinical Board's QS&E Governance	Nursing	3	3		

Audit	Exec Director Lead	Original Quarter Per Plan	Revised Quarter	Notes	
Integrated Health Pathways	Transformation & Informatics	2	2		
(5) Information Governance and Security					
IT Service Management (ITIL)	Transformation & Informatics	1	3	Delayed due to COVID-19	
IT Strategy	Transformation & Informatics	2	/	Dir of Digital has requested deferral to 21/22. COVID has delayed Strategy delivery / roadmap needs to be reassessed.	
Infrastructure / Network Management	Transformation & Informatics	3	3		
Implementation of New IT Systems	Transformation & Informatics	2	/	Dir of Digital has requested deferral to 21/22. COVID has affected implementations and work would need input from departments.	
Departmental IT System	COO	3	4	Delayed due to COVID-19. Work will be required within a clinical area.	
Tentacle IT System Follow-up	Transformation & Informatics	3	4	Delayed due to COVID-19	
Cyber Security / GDPR Follow-up	Transformation & Informatics	4	4		
(6) Operational Service and Functional Management					
Specialist CB - Stock Management in ALAS	*COO*	2	3	Delayed due to COVID. Scheduled for Q3 as relatively less work in clinical area.	
Surgery - Sickness Absence Management	COO	2	4	Delayed due to COVID-19. Work will be required within key clinical areas.	

Audit	Exec Director Lead	Original Quarter Per Plan	Revised Quarter	Notes	
Medicine CB - Bank & Agency Nurses Scrutiny Process	COO	3	4	Delayed due to COVID-19. Work will be required within key clinical areas.	
MH CB - Monitoring of Outpatient Clinic Cancellations	COO	3	3	Keep scheduled for Q3 as relatively less work in clinical area.	
PCIC CB - GP Access	COO	3	3	Keep scheduled for Q3 as relatively less work in clinical area.	
CD&T - US Governance	COO	4	3	Brought forward to Q3 as relatively less work in clinical area.	
C&W CB - Rostering I Community Children's Nursing	COO	4	4		
(7) Workforce Management					
Recruitment and Retention of Staff	Workforce	2	3	Delayed due to COVID-19	
Management of staff Sickness Absence	Workforce	3	3		
Consultant Job Planning Follow-up	Medical	4	4		
(8) Capital and Estates					
Sustainability Reporting	Finance	1	2	Delayed due to COVID-19. Annual reporting deadline has changed.	
Fire Safety	Finance	2	2		
Asbestos Management	Finance	2	2		
Major Capital Scheme - UHW II	Planning	1-4	1-4		

Audit	Exec Director Lead	Original Quarter Per Plan	Revised Quarter	Notes	
Major Capital Scheme - UHW New Academic Avenue	Planning	3	3		
Shaping Future Wellbeing in the Community Scheme	Planning	4	4		
Capital Systems Management	Planning	2	2		
Development of Integrated Audit Plans	Planning	1-4	1-4		

CARDIFF AND VALE UHB INTERNAL AUDIT ASSIGNMENT STATUS SCHEDULE

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Regional Partnership Board	07	Strategic Planning	Q2	Work in Progress		Sept
Annual Quality Statement	16	Nursing	Q2	Work in Progress		Sept
Sustainability Reporting	38	Finance	Q2	Work in Progress		Sept
Governance During COVID-19	46	Corporate Governance / Finance	Q2	Work in Progress		Sept
IM&T Control & Risk Assessment	01	Transformation & Informatics	Q2	Planning		Sept
Health and Care Standards	03	Nursing	Q2	Planning		Sept
Engagement Around Service Planning	06	Strategic Planning	Q2	Planning		Sept
Fire Safety	39	Finance	Q2	Planning		Sept
Asbestos Management	40	Finance	Q2	Planning		Sept
Claims Reimbursement	02	Nursing	Q3			Nov
Whistleblowing Policy	05	Corporate Governance	Q3			Nov
Charitable Funds	14	Finance	Q3			Nov

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Concerns / Serious Incidents	18	Nursing	Q2	Planning		Nov
Integrated Health Pathways	20	Transformation & Informatics	Q2	Planning		Nov
Specialist CB – Stock Management in ALAS	28	COO	Q3			Nov
MH CB – Monitoring of Outpatient Clinic Cancellations	31	COO	Q3			Nov
CD&T CB – US Governance	33	COO	Q3			Nov
Capital Systems Management	*44*	*Strategic Planning*	*Q2*	*Planning*		*Nov*
Commissioning	08	Strategic Planning	Q3			Feb
Strategic Performance Reporting	09	Transformation & Informatics	Q3			Feb
Public Health	12	Public Health	Q3			Feb
UHB Core Financial Systems	13	Finance	Q3			Feb
Directorate Level Financial Control	15	Finance	Q3			Feb
ITIL Service Management	21	Transformation & Informatics	Q3			Feb
Nurse Staffing Levels Act	17	Nursing	Q3			Feb
Clinical Board QS&E Governance	19	Nursing	Q3			Feb

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Infrastructure / Network Management	23	Transformation & Informatics	Q3			Feb
Medicine CB – Bank & Agency Nurses Scrutiny Process	30	COO	Q3			Feb
PCIC CB – GP Access	32	COO	Q3			Feb
Recruitment & Retention of Staff	35	Workforce	Q3			Feb
Management of Staff Sickness Absence	36	Workforce	Q3			Feb
Major Capital Scheme – UHW New Academic Avenue	42	Strategic Planning	Q3			Feb
Risk Management	02	Corporate Governance	Q4			April
Data Quality Performance Reporting	10	Transformation & Informatics	Q4			April
Departmental IT System	25	Transformation & Informatics	Q4			April
Tentacle IT System Follow-up	26	Transformation & Informatics	Q4			April
Cyber Security System Follow-up	27	Transformation & Informatics	Q4			April
Surgery Sickness Absence Management	29	COO	Q4			April
C&W CB – Rostering in Community Children's Nursing	34	COO	Q4			April

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Consultant Job Planning Follow-up	37	COO	Q4			April
Major Capital Scheme – UHW II	41	Strategic Planning	Q1-4			April
Shaping Future Wellbeing in the Community Scheme	43	Strategic Planning	Q4			April
Development of Integrated Audit Plans	45	Strategic Planning	Q1-4			April
Reviews deferred / removed from plan						
Public Health Audit 1	11	Public Health		Removed to allow allocated days to be utilised for the COVID-19 Governance review – TBA by July AC		
IT Strategy	22	Transformation & Informatics		Director of Digital requested deferral to the 21/22 plan. The COVID situation has impacted the timing of IT work so the strategy delivery / roadmap needs to be reassessed – TBA by July AC		
Implementation of New IT Systems	24	Transformation & Informatics		Director of Digital has requested deferral to the 21/22 plan. COVID has affected IT system implementations and the audit would need input from departments. – TBA by July AC		

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To: Chief Executives, NHS bodies
Cc: Chairs
Audit Committee Chairs
Board Secretaries

Reference: PA288/DT/hcj
Date issued: 11 June 2020

Dear all

Update on the AGW's programme of NHS Performance Audit work

I trust this letter finds you all well as the service continues to navigate its way through the next phases of the COVID-19 outbreak. It truly has been an unprecedented challenge for the NHS and its partners, and I'd just like to echo the sentiments expressed by the Auditor General in his letter of 30 April to public sector Chief Executives (attached again here in case you missed first time around), thanking public servants for the phenomenal work they are doing for the people of Wales. More specifically, myself and colleagues at Audit Wales are really grateful to NHS bodies for the way they've maintained engagement with us throughout the crisis. It has helped us stay connected to developments and also to appreciate the tremendous amount of work that has been undertaken in such a short space of time to respond to the challenges presented by COVID-19.

In his letter, the Auditor General provided some information on how we were adapting our work in response to COVID-19 and I'd like to use this opportunity to provide a further specific update on our programme of NHS performance audit work. As you know we took the early decision to suspend on-site performance audit work at all NHS bodies and to progress our work remotely as far as we can. That continues to be the situation and as part of our own business continuity planning, we've been looking afresh at our current programme of work to assess how it gets taken forward in the context of COVID-19. The Annex attached to this letter provides an update on our current plans for each of the main strands of work in our programme.

In addition to re-shaping the existing elements of our work programme as set out in the Annex, we are keen to ensure that we focus our attention on issues that are specific to the current situation. We're currently reviewing the information in the Welsh Government's supplementary budget and accompanying explanatory memorandum as we consider those areas that merit some specific work. At a more local level, our 2020 structured assessment work will allow us to understand how NHS bodies are maintaining their corporate and financial governance arrangements in the context of COVID-19, as well as the progress being made on recovery planning. Further information on our 2020 structured assessment work is provided in the attached project specification, which has recently been shared with Board Secretaries.

As referenced in the Auditor General's letter, we have also started work on a "COVID-19 learning project" that will seek to identify and share examples of new ways of working that have been introduced as a result of the pandemic, and wider learning points that can help with the plans to continue to control the virus and rebuild a stronger and better NHS. We are aware that there is already quite a lot of activity in this area within the NHS, so we are working closely with the NHS Confederation and Welsh Government to ensure that what we do in this space complements and adds value to existing activities.

The information I've set out in this letter represents the current position and our latest thinking but we'll continue to adopt an agile approach and where necessary adjust the content and focus of our work to ensure we are deploying our resources to areas where outputs from ourselves will add most value in the current environment. We'll continue to keep you informed of any further developments to our programme through our local engagement channels and communications such as this.

Whilst this update primarily concerns our performance audit work, I thought it would also be useful to provide a brief update on our accounts work. Our teams have continued to liaise with Directors of Finance and the wider Finance teams as we are drawing our work to a close. The Auditor General is planning to sign off the opinions on the financial statements of NHS bodies on the 2nd July 2020.

I trust this update is helpful and my thanks once again for your positive on-going engagement with our audit teams, and for all the hard work that is being done by yourselves and your organisations in response to the current situation. If you had any queries about the any aspect of this update, then please don't hesitate to contact me.

Your sincerely

David Thomas
Audit Director

ANNEX: NHS PERFORMANCE AUDIT WORK PROGRAMME UPDATE

A: Work included in local audit plans

Review	Update
Structured Assessment 2020	Our annual structured assessments are one of main ways in which the AGW discharges his statutory requirement to examine the arrangements NHS bodies have in place to secure efficiency, effectiveness and economy in the use of their resources. In the context of COVID-19, we have designed an approach which allows us to undertake structured assessment work remotely and with minimal impact on NHS bodies in terms of time and resource to support the work. Our lines of enquiry will be based on the same broad areas as previous years' work but our audit questions in this year's work will have a COVID-19 context, taking note of Welsh Government guidance and frameworks issued in response to the pandemic, and including a focus on recovery planning. We are aware that the internal audit service has been asked to undertake some early work on aspects of governance related to COVID-19. We've had a constructive dialogue with internal audit colleagues and we are devising approaches at each NHS body to ensure our respective programmes of work are co-ordinated and mutually informed.

Review	Update
Reviews of quality governance arrangements at NHS bodies	Following the Joint Review of quality governance arrangements at Cwm Taf Morgannwg UHB, we had been developing a programme of work to examine these arrangements at all relevant NHS bodies. The cessation of on-site fieldwork as a result of COVID-19 has meant that we've had to put this work on hold. In the interim will use this year's structured assessment to get an overview of quality governance arrangements at NHS bodies and how they have been maintained during the pandemic. Subject to how the COVID-19 situation pans out, we hope to be in a situation where we can resume some form of on-site work later in the year. However, if that is not possible, we will look to design an alternative approach to capturing information we require, collaborating with Healthcare Inspectorate Wales, and other stakeholders as necessary in the design of that work.
Follow up work on orthopaedic services (and the national AGW follow up study on elective NHS waiting times)	At the point the pandemic hit we were preparing local and national reports to summarise the progress made in response to the recommendations we made in 2015. However, in the context of the Minister's decision to suspend routine elective NHS work to create capacity to deal with the expected surge in COVID-19, it seemed inappropriate to issue these reports in the format which they had been drafted. We are therefore looking to reshape these outputs so that they inform the recovery planning discussions that are starting to take place locally and nationally, and to help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges.

Review	Update
Governance review of Welsh Health Specialised Services Committee	We had made good progress with this review up to March of this year, but we do still need to gather in views on the current arrangements for specialised services commissioning from leaders in NHS bodies. We hope to be able to do this remotely over the coming month, potentially through the use of survey software, although we will take soundings from some key contacts in the service to test our thinking and inform our approach before we progress this. Subject to being able to collect this additional information, we would envisage having a draft output to share for comment by the end of the summer.
Whole system review of unscheduled care	We have split this work into two phases. The first phase has involved collection of data across the unscheduled care pathway with the aim of creating an interactive database that can shared with external stakeholders and used to inform the focus of audit work in the second phase. Our ability to undertake more focused audit work in the second phase will largely be shaped by the restrictions associated with COVID-19 and stakeholders' ability to engage with the audit work. In the short term, i.e. through to the end of July, we will focus on preparing the database and discussing the most productive ways of sharing this information with external stakeholders. We have continued to take this work forward in close collaboration with Healthcare Inspectorate Wales

Review	Update
Locally specific performance audit reviews	In several NHS bodies, our work programme had included reviews that were specific to local circumstances in those organisations. These reviews were at various stages of completion at the point the COVID-19 restrictions were introduced. Where we can, we have continued to progress these pieces of work remotely and our performance audit leads at each site will continue to liaise with Board Secretaries to keep them up to speed with individual reviews and check on the NHS body's ability to support the remainder of the work required, including the ability to provide comments on the factual accuracy of products at the draft report stage.

B: Other AGW NHS Performance Audit Work

Review	Update
Counter Fraud Services	The AGW has undertaken a public sector wide review of counter fraud services and is due to publish his findings on 14 July. That national report will be supported by summaries of our local findings at individual NHS bodies. We'll shortly be issuing those local reports for final factual accuracy checks ahead of them being ready to be shared with Audit Committees at their autumn meetings alongside the national output
Clinical Coding	We are currently preparing a short publication that aims to share some key messages from our recent local follow up work on clinical coding. We plan on publishing this work towards the end of July and think it will be a timely aid to discussion on the importance of clinical coding in ensuring good information flows to support decision making in response to COVID-19.
Welsh Community Care Information System (WCCIS)	We will shortly be commencing the clearance process through the WCCIS Leadership Board and the Welsh Government and, where relevant, with individual NHS bodies. This will be with a view to report publication in early autumn.
Follow up: Local public health team collaborative working	Comments on the factual accuracy of our draft report have been received and reviewed. A finalised output is in preparation with a view to publication later this summer.
Other cross sector work	Scoping work is currently underway on several pieces of work which are not NHS-specific but which are likely to involve some evidence gathering from NHS bodies. These topics include digital resilience in the public sector, collaborative working across emergency services and work on the General Equality Duty.

Report Title:	**Declarations of Interest, Gifts, Hospitality & Sponsorship**								
Meeting:	**Audit & Assurance Committee**						**Meeting Date:**	**7th July 2020**	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		**X**
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

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

The Corporate Governance team have cleared the backlog of outstanding declarations, therefore, this report provides a fully up to date position.

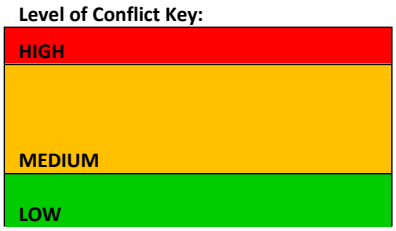
Due to the ongoing COVID-19 situation, all planned Standards of Behaviour communication has been paused and will commence again in the coming months. Initial communications will tie in with the Health Board's Health Charity to remind all staff members of the need to declare gifts following the increase in donations over previous months. Thereafter communications will focus on key events and dates throughout the year to include Christmas and sporting events (as and when they resume).

In the event of any further spike in COVID-19 related activity an additional reminder will be circulated in anticipation of a further increase in informal donations, as has been experienced over the previous 4 months.

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

The following number of Declarations were received and included on the register during the 2019/2020 financial year:

- 1,302 Declarations of Interests, Gifts, Hospitality & Sponsorship Forms
- 59% of staff banded 8a and above had returned their declaration forms.
- The Declarations of Interests G, H&S forms received were RAG rated by the Corporate Governance Team to ensure appropriate action and monitoring. The RAG rating system is as follows:



High Conflict which needs managing

Potential Conflict - Line Manager should be made aware and expectation that declaration is updated should conflict arise

No cause for concern

- 79.5% of Declarations received were rated **Green**.
- 20% of Declarations received were rated **Orange**.
- 0.5% of Declarations were rated **Red.**

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Since the 1st April 2020 the following additional Declarations have been received:

- Three Declarations of Interest with 'No Interest' declared; and
- Two Declarations of Gifts which present no cause for concern.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

The management of the Standards of Behaviour Policy by the Corporate Governance Team should provide the Audit and Assurance Committee with assurance that adequate systems are in place for the ongoing monitoring of conflicts of interest and the declaration of gifts and hospitality.

Further assurance should be taken from the Corporate Governance Team's ongoing work with the Health Board's Countefraud Department for the investigation of specific cases and also following recent developments that will allow Declarations to be lodged and recorded through the ESR record keeping system which will allow a more efficient and all encompassing approach to be taken to the recording of declarations.

Recommendation:

The Audit & Assurance Committee is asked to:

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

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	X	Long term	X	Integration		Collaboration		Involvement	X

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Internal Audit Recommendation Tracker Report**						
Meeting:	Audit Committee				**Meeting Date:**	7th July 2020	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	**Director of Corporate Governance**						

Background and current situation:

The purpose of the report is to provide Members of the Audit Committee with assurance on the implementation of recommendations which have been made by Internal Audit by means of an internal audit recommendation tracking report.

The internal audit tracking report was first presented to the Audit Committee in September 2019 and approved by the Committee as an appropriate way forward to track the implementation of recommendations made by internal audit.

The tracker goes back 3 financial years and shows progress made against recommendations from 17/18 and18/19. It also show recommendations which have been made during 19/20.

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

As can be seen from the attached summary tables the overall number of outstanding recommendations has increased from 212 individual recommendations to 226 for the period March 2020 to June 2020. This is due to new internal audit recommendations been added for 2019/20 reports and also tracking of recommendations not taking place over the COVID 19 period. However, it can also be demonstrated that some actions were completed during this period.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

A review of all outstanding recommendations has been undertaken since the last meeting of the Audit Committee where the internal audit tracker was presented (March 2020). Each Executive Lead has been sent the recommendations made by Internal Audit which fall into their remits of work. In addition to this the audits undertaken during the financial period 2019/20 have also been added to the tracker and progress reported.

The table below show the number of internal audits which have been undertaken over the last three years and for the financial year 2019/20 and their overall assurance rating.

	Substantial Assurance	Reasonable Assurance	Limited Assurance	Rating N/A	Total
Internal Audits 17/18	7	25	5	-	37
Internal Audits 18/19	10	26	7	-	43
Internal Audits 19/20	10	25	2	2	39

Attached at Appendix 1 are summary tables which provide an update on the March 2020 position.

ASSURANCE is provided by the fact that a tracker is in place. This assurance will continue to improve over time with the implementation of quarterly follow ups with the Executive Leads.

Recommendation:

The Audit Committee Members are asked to:

(a) Note the tracking report which is now in place for tracking audit recommendations made by Internal Audit.
(b) Note that progress will be seen over coming months in the number of recommendations which are completed/closed.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	~~Yes / No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2017/18 (July 2020 Update)

	Update July 2020				Update July 2020				Update July 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Complete												
Overdue under 3 months												
Overdue over 6 months under 12 months												
Overdue more than 12 months	8	3	5		25	15	6	4	25	5	3	4
Superseded												
Total	**8**	**3**	**5**		**25**	**15**	**6**	**4**	**12**	**5**	**3**	**4**

Total number of recommendations outstanding as on 27th June 2020 for financial year 2017/18 is **45** compared to the position in March 20 which was a total number of outstanding recommendations of **54**

INTERNAL AUDIT REPORT RECOMMENDATION FOR 2018/19

	Update March 2020				Update March 2020				Update March 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached												
Complete												
Overdue under 3 months												
Overdue by over 3 months under 6 months												
Overdue over 6 months under 12 months	10	2	2	6	24	6	8	10	7	4	1	2
Overdue more than 12 months	10	1	6	3	36	25	7	4	17	9	3	5
Superseded												
Total	**20**	**3**	**8**	**9**	**60**	**31**	**15**	**14**	**24**	**13**	**4**	**7**

Total number of recommendations outstanding as on 27th June 2020 for financial year 2018/19 is **104** compared to the position in March 20 which was a total number of outstanding recommendations of **133**

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2019/20

	Update March 2020				Update March 2020				Update March 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached												
Complete												
Overdue under 3 months												
Overdue by over 3 months	5	3		2	29	14		15	8	4		4
Overdue over 6 months	9	3	2	4	18	10	3	5	5	3	1	1
Overdue more than 12 months	1		1		1	1			1	1		
Superseded												
Total	**15**	**6**	**3**	**6**	**48**	**25**	**3**	**20**	**14**	**8**	**1**	**5**

Total number of recommendations outstanding as on 27th June 2020 for financial year 2019/20 is **77** compared to the position in March 20 which was a total number of outstanding recommendations of **25.**

	D	F	G	K	L	N	O	Q	V	W	Z
1	**Financial Year Fieldwork Undertaken**	**Audit Title**	**Executive Lead for Report**	**Rec. Rating**	**Recommendation Narrative**	**Management Response**	**Executive Lead for Recommendation**	**Agreed Implementation Date**	**Please confirm if completed (c), partially completed (pc), no action taken (na)**	**Executive Update**	**Status of Report Overall**
2	2017-18	Progress against findings from the Human Tissue Authority (HTA) Inspection of UHW	Chief Operating Officer	L	Management must ensure that the terms of reference of the HTA Licence Compliance Group are formally agreed and that the Group effectively operates as planned.	The Human Tissue Authority compliance group is currently running in parallel to HTA Gold command. The terms of reference for the HTA compliance group have been positively reviewed by the HTA and added to the agenda of the next HTA compliance group (22nd May 2018) for ratification and acceptance ready for eamless transition between the two governance groups.	Chief Operating Officer	22.05.2018	COMPLETED	The HTA compliance group has a terms of reference and has been effectively operating on monthly basis	Audit open over 12 months
4	2017-18	WLI Payments Follow-Up	Chief Operating Officer	M	The UHB has produced a WLI Payments Policy /Procedure and this has been disseminated to Directorates, but has yet to be finalised and approved by the organisation. Additionally, there are no local Directorate procedures in place for the management of WLI payments as they will work to the UHB Payments Policy/Procedure (Finding 1 – Partially Actioned).	Not Provided	Chief Operating Officer	01.06.2018	Partially completed	Formal pricing structure has been implemented for both long term and short term stays and implemented	Audit open over 12 months
5	2017-18	WLI Payments Follow-Up	Chief Operating Officer	M	Testing identified that whilst Cardiac Surgery make the appropriate checks and accurately record and approve submitted claims, they do not retain copies of the fully authorised WLI Claim Forms as they are sent directly to Payroll. Therefore, at the present time a full audit trail does not currently exist and it is ecommended that upon authorisation by the Clinical Board Director of Operations a copy should be taken and provided to Cardiac Surgery management for retention (Finding 10 – Partially Actioned).	Not Provided	Chief Operating Officer		Partially completed	SOP's drafted and hard copies available in the residences office.	Audit open over 12 months
6	2017-18	Residences	Director of Planning	L	The UHB should document future plans for the provision and utilisation of residences.	The UHB is currently embarking on a significant master planning exercise for the UHB site and an estate rationalisation programme across the UHB. The provision of accommodation will be considered as part of this exercise. This process will likely take in excess of 12 to 18 months. Progress will be reported as part of the verall master planning exercise.	Director of Finance		No action taken	All rental arrears are addressed with tennats and payments are agreed.	Audit open over 12 months
7	2017-18	Residences	Director of Planning	L	The UHB should refer to the PFI contract/SLA to consider whether expectant vacant rooms must be communicated by Charter Housing to the Health Board within a certain timescale if void rents are to become chargeable.	Currently being reviewed by PFI Manager.	Director of Finance	01.04.2018	No action taken		Audit open over 12 months
8	2017-18	Surgery Clinical Board - Anaesthetist Rota Management	Chief Operating Officer	H	Standard Operating Procedure notes covering the administration of the CLW rota system should be developed and made available to all relevant staff.	It is accepted by the Directorate that there is no written SOP for staff, although all three rota masters currently in post have been formally and comprehensively trained by the CLWRota team to carry out processes within the system. The CLWRota team provide remote and on-site support as requested/required. The rota masters are overseen by the Clinical Director and Deputy Clinical Directors who are also rota masters. There is a workflow chart for writing a weekly rota currently in	Chief Operating Officer		Partially complete	Finance and CI were fully onboard and agreed KPI pack for trial. Report to Exec to follow with this data pack in Q4 2019.	Audit open over 12 months
9	2017-18	Pilot Model Ward Review	Director of Planning	L	For future projects the plans for financial costing should be more detailed within the project outline.	As this was a clear pilot and proof of concept. Costings were genuinely not known. We had agreed "success" criteria, which, we met for patients eating and drinking more. (Being hydrated and had improved nutritional status) This was always the main aim. The third one was improvement in patient flow. This could not be quantified over a period of 6 weeks (which was discussed). Only after the pilot, could we see what happened during this period and start to look at costs for further development and detailed costing for the elements the teams felt worthwhile keeping as part of the model. We changed and tweaked aspects of the model each week to ensure we made efficient use of resource whilst maximising patient experience and matched our success criteria. Only after a review following completion could we accurately sit down and look at lessons learnt and see what	Director of Planning		Partially completed	Audit undertaken in 2018/19.	Audit open over 12 months
10	2017-18	Pilot Model Ward Review	Director of Planning	L	For future projects a defined terms of reference that identifies membership, frequency of meetings, roles and responsibilities will be incorporated from the outset.	Agreed for applicable future projects.	Director of Finance		Partially completed	Audit undertaken in 2018/19.	Audit open over 12 months
11	2017-18	Wellbeing of Future Generation	Director of Public Health	M	The Health Board/ Management should produce an Action Plan to provide a cohesive approach on how it plans to embed the obligations of the Act within the Health Board. The Action Plan should detail/include columns for: ▪ The Key priorities required to embed the WFGA obligations within the Health Board; ▪ The Actions required to achieve the key priority; ▪ The responsibility for each of the actions; ▪ The target date for implementation; and ▪ The status of implementing the action. The WFG Steering Group would be the appropriate forum for monitoring any progress against the Action Plan.	The Steering Group agreed the need to develop an Action Plan at its meeting on 12 March 2018. A task and finish group is being established to develop a first draft to discuss with the wider group at the next meeting of the Steering Group on 4 June 2018.	Director of Public Health	04.06.2018	Completed	Action plan reviewed and updated quarterly at every WFG Steering Group, with new annual plan agreed for each financial year. Steering Group meetings currently on hold due to Covid-19	Audit open over 12 months
12	2017-18	Wellbeing of Future Generation	Director of Public Health	M	The Terms of Reference for the WFG Steering Group should be formalised and appropriately approved.	Draft Terms of Reference were discussed at the meeting of the Steering Groupon 12 March 2018 and amendments agreed. Final draft ToR to be submitted to HSMB for sign-off.	Director of Public Health	01.05.2018	Completed	Terms of Reference exist for the WFG Steering Group which are reviewd annually by the Group	Audit open over 12 months
13	2017-18	Wellbeing of Future Generation	Director of Public Health	M	The Health Board should formalise and approve the role and responsibility of the 'WFG Champion'.	A draft WFG Champion role was discussed at the Steering Group on 12 March. Final role description to be agreed between the Chair of the Steering Group, Vice Chair, Chair and Board's Director of Governance.	Director of Public Health	01.04.2018	Completed	The WFG Champion role has been agreed and is reviewed annually	Audit open over 12 months
14	2017-18	Wellbeing of Future Generation	Director of Public Health	M	The Health Board must ensure that its obligations in respect of the Act are appropriately communicated to all staff within the Health Board. We recommend that the Health Board develop a	The Chair of the Steering Group met with UHB Director Communications and the UHB Engagement Lead in March to discuss the approach to raising awareness within the UHB. Draft Communications Plan to be brought to the next Steering Group on 4 June.	Director of Public Health	01.06.2018	Partially Complete	A draft Comms Plan has been brought to the WFG Steering Group, though a final version is outstanding	Audit open over 12 months
15	2017-18	Wellbeing of Future Generations Act	Director of Public Health	M	The Health Board should update their WFG internet page to ensure that it provides clear and cohesive information on the Health Board's responsibility in respect of the WFGA including how the Health Board's wellbeing objectives align to the WFGA wellbeing goals	UHB WFG Internet page to be updated to reflect the recommendations.	Director of Public Health	30.04.2018	Completed	Internet page has been updated	Audit open over 12 months

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16	2017-18	Children & Women Clinical Board – Medical Staff Rotas and Study	Chief Operating Officer	H	The Clinical Board will monitor the number of study days taken by medical staff in order to ensure that there is an improvement in the percentage uptake. Controls will also be established to prevent individuals exceeding their allowances.	Directorate Management Teams will be reminded to monitor the requests and approval of study leave for all medical staff. This will be reviewed as part of the monthly Directorate Performance Reviews and will provide an opportunity for Clinical Board involvement as necessary.	Chief Operating Officer	01.10.2018	Completed	Will be addressed at future schemes	Audit open over 12 months
17	2017-18	Children & Women Clinical Board – Medical Staff Rotas and Study	Chief Operating Officer	M	The profile and accountabilities in relation to study leave requirements needs to be reinforced.	Updated study leave procedures will be circulated to DMT and onwards to all medical staff in the Clinical Board. All staff will be reminded of their responsibilities in relation to this policy.	Chief Operating Officer	01.11.2017	Completed	Will be addressed at future schemes	Audit open over 12 months
18	2017-18	Children & Women Clinical Board – Medical Staff Rotas and Study	Chief Operating Officer	M	Staff will be reminded of their responsibilities when requesting and approving study leave.	Updated study leave procedures will be circulated to DMT and onwards to all medical staff in the Clinical Board. All staff will be reminded of their responsibilities in relation to this policy.	Chief Operating Officer	01.11.2017	Completed	Draft Meeting planned for November 2019. Audit undertaken in 2018/19.	Audit open over 12 months
19	2017-18	Children & Women Clinical Board – Medical Staff Rotas and Study	Chief Operating Officer	L	Proactive monitoring will be undertaken to ensure all appropriate staff are utilising the Intrepid system.	Assurance to be provided through Directorate Performance Reviews from each DMT that Intrepid is being used appropriately throughout each Directorate	Chief Operating Officer	01.11.2017	Completed	Audit undertaken in 2018/19.	Audit open over 12 months
20	2017-18	Children & Women Clinical Board – Medical Staff Rotas and Study	Chief Operating Officer	M	Staff will be reminded of the procedural requirements and updates to standard forms will be undertaken, where appropriate.	A review of the format of the claims forms used within C&W Clinical Board will be undertaken and changes made as required. All staff within the Clinical Board and Directorates will be reminded of the need to comply with procedures.Directorates have already been asked to remind all consultants to comply with timescales and a reminder will also be sent to junior staff reiterating the need to comply with timescales.	Chief Operating Officer	01.11.2017	Completed	Action agreed and Faciltiites keep a log and ask Clinical support on each audit. Audit undertaken in 2018/19.	Audit open over 12 months
21	2017-18	Children & Women Clinical Board – Medical Staff Rotas and Study	Chief Operating Officer	M	Guidance should be produced and made available throughout the Clinical Boardand this should reflect minimum personnel per shift and skill mix requirements.	The current document will be reviewed and consideration given to broadening its scope to include all specialties within the Clinical Board. This will cover the skill mix and number of personnel required per shift.	Chief Operating Officer	01.11.2017	Completed	Action agreed and Faciltiites keep a log and ask Clinical support on each audit. Audit undertaken in 2018/19.	Audit open over 12 months
22	2017-18	Children & Women Clinical Board – Medical Staff Rotas and Study	Chief Operating Officer	M	Management should remind staff around the requirements of the working time policy.	The current requirements of the working time policy will be shared with all DMT and compliance will be managed through Directorate Performance Reviews.	Chief Operating Officer	01.11.2017	Completed	Draft Plan and Paper exists and has been ratified by Dpty Dir of Nursing. Cleaning group to sign off when meeting takes place in Nov 2019 Audit undertaken in 2018/19.	Audit open over 12 months
23	2017-18	Serious Incidents Management	Executive Nurse Director	H	Management must ensure that closure forms are submitted to WG within the required timescales.	NHS Wales Audit & Assurance Services Page 11 of 17 Management Response Responsible Officer/ Deadline Welsh Government have set an All Wales target of 90% compliance in closing all Serious Incidents within the prescribed timescales. The UHB had made significant progress in reducing its backlog over the last 12 months from a position where we were reporting 230 serious incidents open in October 2016 to a position where we now have 74 open. The UHB has an agreed trajectory for improvement and each Clinical Board has agreed targets for serious incident closures which is	Director or Nursing	01.12.2017	COMPLETED	UHB is now working in line with the revised WG guidance on Serious Incident Reporting.	Audit open over 12 months
24	2017-18	Serious Incidents Management	Executive Nurse Director	M	The Patient Safety team should communicate the importance of uploading the action plans onto Datix so that they are easily accessible. All action plans should have an identified lead and signed approval.	Action plans will have been developed and signed off as part of the investigation process and these will be held within the Clinical Boards. However we agree that the complete audit trail needs to be maintained within the Datix system. Action: The Clinical Boards will be reminded of the importance of uploading associated action plans for all Sis Action: The Patient Safety team will put in place a programme of quarterly audits to ensure that all Sis that have been closed in the previous quarter have the associated action plan uploaded on Datix. Results of the audit will be shared with Clinical Boards for discussion at QSE meetings Action: The team will consider, in the medium term, whether the action planning field becomes mandatory on Datix.	Director of Nursing	31.01.2018	COMPLETED	Staff have been reminded of their responsibilities with regards to this requirement.	Audit open over 12 months
25	2017-18	Serious Incidents Management	Executive Nurse Director	L	Management should ensure that SIs are reported to WG within the required 24 hours wherever possible.	Whenever possible the Patient Safety team will attempt to report within 24 hours. The Datix system has been set up to trigger an email to the Patient Safety team if anything reported is graded at severity of 4 or 5 or is flagged as a potential SI. There are many easons why this is often not possible: Delay in reporting from the clinical area	Director of Nursing		COMPLETED	UHB is now working in line with the revised WG guidance on Serious Incident Reporting. **This appears on the log twice.**	Audit open over 12 months
26	2017-18	Serious Incidents Management	Executive Nurse Director	L	The Patient Safety Team should encourage management to use the feedback field within Datix to ensure an audit trail is available to show feedback has been provided. The Patient Safety Team may want to consider changing this to a mandatory field.	It is well recognised that the success of a reporting system depends on the level of feedback given to staff who report incidents so this is an important area for attention. The Patient Safety team have audited 20,267 reported patient safety incidents over a 12 month period; of those 17,614 indicated that staff had received feedback (86%) which we consider to be very high compliance. The Patient Safety team will consider whether to make the relevant field mandatory or not and this will be added to the Datix workplan The Patient Safety team will consider whether to carry out a random survey of staff who have reported incidents to validate they have had the feedback as indicated.	Director of Nursing	31.03.2018	COMPLETED	Random survey has been carried out. The importance of reporting feedback to staff is reinforced at all appropriate training.	Audit open over 12 months
27	2017-18	Mental Health Sickness Management and Rostering	Chief Operating Officer	H	Management should ensure that all sickness episodes are managed and documentation is completed in accordance with the Sickness Policy.	The MHCB has seen significant changes to the inpatient ward management structures within recent months, with several internal secondments into managerial positions. In order to equip the new managers the Practice Development Team have devised a leadership and Management Skills training programme for the existing and new managers. This programme covers good practice with regards to staff management. In addition the Operational HR team conduct sickness surgeries with	Chief Operating Officer	01.06.2018	Completed		Audit open over 12 months
28	2017-18	Mental Health Sickness Management and Rostering	Chief Operating Officer	M	Nursing staff should be reminded that all bank and agency time sheets should be retained on file. Management to issue reminder to all Nursing staff that all bank and agency shifts worked must be verified.	It was evidenced from our testing that there were a number of inconsistencies across all 4 wards with the recording of start and end sickness dates. There were different start and end sickness dates recorded on sickness documentation, ESR and Rosterpro. The majority of differences were only 1 or 2 days which suggests that there is an issue with correctly and consistently recording the dates that sickness ends and the actual dates of return to work.	Chief Operating Officer	01.09.2017	Completed	Business manager assigned to oversee pilot, reporting suite developed and final evalution on completion	Audit open over 12 months
29	2017-18	Mental Health Sickness Management and Rostering	Chief Operating Officer	L	NHS Wales Audit & Assurance Services Page 16 of 17 Recommendation Priority level Management should remind ward staff that the recording of sickness dates should reconcile between sickness documentation and ESR and Rosterpro and all sickness dates should be the same.	This issue will be monitored via the sickness surgeries.	Chief Operating Officer	01.06.2018	Completed		Audit open over 12 months
30	2017-18	Nurse Revalidation	Executive Nurse Director	M	The C&V UHB PADR form should be revised for Nursing Staff to include an appendix to ensure Nurse revalidation portfolio completion is discussed at each annual appraisal during the 3 year cycle.	The Senior Nurse for Nurse Education will work with the lead for PADR to create a section for revalidation for nurses within the pay progression document. Pay progression training continues, to assist nurses in the completion of documentation (through enhanced communication and coaching workshops).	Director of Nursing	01.03.2018	No action taken		Audit open over 12 months

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31	2017-18	Nurse Revalidation	Executive Nurse Director	L	Where nurses are using their line manager as their confirmer, the confirmers should be reminded of ESRs capability to make them aware that staff members in their hierarchy are approaching their nurse revalidation date.	An email via the Directors of Nursing will be issued to remind staff of ESR capability re revalidation/registration.	Director of Nursing	01.01.2018	No action taken	system rules setup to overide early clocking in. If staff clocks in early and work overtime supervisers amend early clocking in.	Audit open over 12 months
32	2017-18	University Hospital of Wales Neo Natal Development	Director of Planning	H	The design for the MRI new build will be concluded and frozen as soon as possible, including affirmation of structural issues and design elements for the MRI installation, so that the total costs and affordability of the project can be confirmed.	The design solution has been informed, as far as is practicable, by considering the specification information provided by potential MRI suppliers.	Director of Finance	31.05.2018	Partially complete		Audit open over 12 months
33	2017-18	University Hospital of Wales Ne	Director of Planning	L	The Capital Procedures Manual should be revised to include the requirement for a Project Director's Acceptance Certificate signed by the Chief Executive and Project Director.	Agreed	Director of Planning	31.05.2018	No action taken		Audit open over 12 months
34	2017-18	University Hospital of Wales Ne	Director of Planning	M	Requests for 'Single Tender Action' should be approved and reported to the Audit Committee in accordance with Standing Financial Instructions and the current UHB Scheme of Delegation. The Estates Department's Capital Projects Manual pro-forma, Single Tender Action Request form should be brought into line with the requirements of the Scheme of Delegation. Approval signatures for all Single Tender Actions should be obtained in accordance with the requirements of SFIs.	Agreed	Director of Planning	31.05.2018	Partially complete		Audit open over 12 months
35	2017-18	Business Continuity Planning Fo	Director of Planning	H	The significant, high priority, issue that remains from the original review can be summarised as follows: 🕿 The EPRR team have begun to accumulate BCPs from across the Health Board, but at the time of fieldwork these plans do not cover all areas of the Health Board. Where plans have been supplied, these are not in the prescribed format set out by the templates within the BC guidance. Our review of the 3 sampled Clinical Boards identified that none had any documented BCPs in place. The audit has noted that whilst plans are not formally documented, that does not mean that there are not processes in place to manage business continuity in the	Not Provided	Director of Planning		Partially complete	This action will be included for all future reports as appropriate so is partially completed.	Audit open over 12 months
36	2017-18	Mortality Reviews	Executive Medical Director	M	The Health Board must ensure that level 1 mortality reviews are completed for all inpatient deaths.	A review of the current paper trail will be undertaken and improved as necessary. Clinical Boards will be reminded of the need to complete the level one reviews at the time of death certification as acquiring the notes afterwards is often difficult due to the current process of managing case notes of deceased patients in medical records. A meeting will take place with the CD for Internal Medicine to review their processes as they have the most deaths in the UHB. The Medical Director will note the findings of the Internal Audit in the June HSMB Meeting to ensure the Clinical Boards are reminded of their responsibility to complete level one reviews.	Medical Director	01.06.2018	Partially complete	Approx 80% of inpatient deaths undergo level 1 review New process in development, superseeding this issue The MD is currently working with the AMD for patient safety and governance, and the patient safety team, to develop a new process for learning from death reviews. This will be aligned with the introduction of the National Medical Examiner process which is curently in development in Wales. The new delivery process has the same aspirations as outlined in this audit .	Audit open over 12 months
37	2017-18	Mortality Reviews	Executive Medical Director	M	The Universal Mortality Review form question pertaining to the need to trigger a Level 2 review should be revised and re-written to improve clarity and remove ambiguity as to its application.	The wording on the form and subsequent IT development was so that any 'yes' answer would trigger a level 2 review. The double negative was a calculated risk. Given this feedback we will review and revise it.	Medical Director	01.07.2018	Partially complete	Approx 80% of inpatient deaths undergo level 1 review New process in development, superceding this issue The MD is currently working wit the AMD for quality and safety, and the quality and safety team, to develop a new process for learning from new death reviews. This will be aligned with the introduction of the new Medical Examiner	Audit open over 12 months
38	2017-18	RTT Performance Reporting	Director of Transformation and Informatics	M	The Health Board should ensure there is a formalised policy that encompasses the operational procedures for data collection, monitoring and reporting of RTT.	We accept that there is a need to review the appropriateness of our RTT policy, ensuring it is live and covers our developing processes for managing patients as well as any rule and definitional changes. At the present time WG are reviewing RTT measures and we have received requirements from WG that have material impact and conflict with existing guidance, primarily around ophthalmology measures, but there are also changes to diagnostics, sleep, cancer and cardiac.	Director of Transformation & Informatics	01.09.2018	No action taken		Audit open over 12 months
39	2017-18	RTT Performance Reporting	Director of Transformation and Informatics	M	The Health Board should consider validating data of patients that are 'in target' due to the potential that these patients may have incorrectly applied suspensions and thus overall understating the amount of breaches.	We accept the point made in the context that data quality audits should extend to reported cancer waiting times – periodic audit of RTT pathways does already occur. Validation of all cancer pathways open and closed does occur at the weekly tracking meetings, and teams are reminded of the requirement to ensure that all management actions are accurately captured on the PMS system. A periodic audit, which will not be monthly, of data quality for cancer patients will be put in place as part of the new member of the cancer services team.	Director of Transformation & Informatics	01.11.2018	No action taken		Audit open over 12 months
40	2017-18	RTT Performance Reporting	Director of Transformation and Informatics	M	The Performance Report should include a note next to the SCP compliance figures to ensure the Board understands that these figures are not necessarily accurate and are not a true reflection of performance as data collection systems are currently not fit for purpose and data sets have not been defined.	Accepted	Director of Transformation & Informatics	01.05.2018	No action taken		Audit open over 12 months
41	2017-18	RTT Performance Reporting	Director of Transformation and Informatics	L	The Performance Report should include data on the related Cancer patient volumes in addition to percentage compliance as this will be a useful metric to aid the Board's understanding of scope (eg. Total number of USC/Non-USC and corresponding number of patients 'in target' and 'breached').	The reporting of volumes occurs infrequently. There is a balance to be had in the detail presented within the board report. The board have asked that they receive less granular information on the operational performance of the board and more detail on the strategic and tactical performance of the board. As such we will partially accept the recommendation and provide an infrequent update on volumes, unless of course it is a material factor in explaining performance.	Director of Transformation & Informatics		No action taken		Audit open over 12 months

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42	2017-18	Costing Review	Director of Finance	H	Management will look to increase the level of clinical engagement throughout the costing process.	The PCB platform provides the UHB with an effective dashboard for analysing costing data at a component level. Whilst the UHB can make greater use of the PCB tool, its utilisation is complex, requiring statistical, financial and service knowledge and the associated resource to support this level of analysis. Data and analysis outputs are used by the organisation to inform the transformation and CRP opportunities agenda and our IMTP. Evidence of this is available. The new osting system and efficiency framework provides the opportunity to re-engage with interested clinicians and efforts are ongoing to achieve this this through evised performance management processes. Finance delivery unit dashboard	Director of Finance Bob Chadwick, Director of Finance, will lead dissemination of Costing info including highlighting areas for potential improvement. This should lead to greater Clinical Engagement	01.04.2018	Partially Completed	There is an increased level of engagement with regard to the benchmarking and costing data. Working groups have been established with the transformation team and clinical boards. These have currently been suspended due to COVID-19	Audit open over 12 months
43	2017-18	Costing Review	Director of Finance	M	The concerns highlighted will be further investigated to ensure appropriate remedial action is taken and that there is increased accuracy to the costs that are allocated to individual HRGs.	Agreed. Costing is an exercise of mass data linkage reliant on basic administrative functions being undertaken to avoid numerous, single points of failure in record keeping systems. The prosthetic example relies on a single person in theatres keeping timely, accurate records and making them available. The accuracy of osting at an HRG level is dependent on multiple variables :- Good quality data coding at source Good quality data sources for cost inputsRobust allocation of cost to activity within the costing environment The costing team will continue to work with information and service colleagues to improve the	Director of Finance Bob Chadwick, Director of Finance & Sharon Hopkins, Director of Transformation & Informatics	01.12.2018	Completed	An administrative and data review post has been established within the costing team to provide the capacity to undertake additional checks and enhance controls.	Audit open over 12 months
44	2017-18	Costing Review	Director of Finance	M	Management will ensure the future accuracy of costing return.	We agree that the statement was misleading as submitted, indicating that aspecific internal audit review had been carried out. We will ensure that future statements within submissions are more accurate. There is a comprehensive suite of validation checks performed by the Costing Team to test the validity of the costing returns before submission and this will be clarified in future submissions	Director of Finance	01.12.2018	Completed	An administrative and data review post has been established within the costing team to provide the capacity to undertake additional checks and enhance controls.	Audit open over 12 months
45	2017-18	Costing Review	Director of Finance	M	Wider verification should be sought to ensure accuracy and increase engagement.	Agreed.There is an ongoing engagement with Clinical Boards to better understand costing methodologies which are relevant to Clinical Board service areas. We recognise that more value could be added with formal engagement throughout the year. Submission timescales and available resources mean that engagement immediately prior to	Director of Finance	01.12.2018	Completed	An administrative and data review post has been established within the costing team to provide the capacity to undertake further engagement with clinical boards with regard to the most appropriate allocation methods.	Audit open over 12 months
46	2017-18	Costing Review	Director of Finance	M	Mechanisms will be established to monitor and report more widely on costing data.	This point is noted and it is accepted that the relationship between the UHB IMTP and its Transformational Programme, including use of costing and benchmarking, should be better described. Costing information was used to support benchmarking and dentification of opportunities, which have been incorporated in to the plan.	Director of Finance	01.03.2019	Completed	Benchmarking data is sent to Clincal Boards in a timely manner to inform the IMTP.	Audit open over 12 months
47	2017-18	Internal Medicine Directorate Mandatory Training and PADRs	Chief Operating Officer	H	Management should ensure that all staff within Internal Medicine undertake a PADR, which is completed in full with both organisational and personal objectives agreed by the reviewing manager and employee. Management should create a personal development plan for each employee to help achieve each objective set. Management must ensure that when completing the annual review with staff they are completing the latest and most up to date version of the PADR format.	The Directorate has developed a Project Outline Document to support ward areas to complete PADR. This POD included timelines. The directorate has provided a trajectory of expected completion of PADRs. The directorate will share best practice to ensure learning. Bi-weekly operational meetings will now include PARD compliance as a standing agenda item. Implementation of Tier 1 target meetings chaired by Lead Nurse, this will include a robust discussion of actions required. Senior Nurses will support this robustly. *Note –the Directorate Team feels that the actual current position with regard to PADR compliance, since completion of the audit, is now more positive than the results of the sample testing within the report indicate.	Chief Operating Officer	01.03.2018	Partially complete	Update 24/06/20 - Monthly IM Directorate Performance Review meetings are held on a monthly basis where perfroamcne is monitored. There has been a challenge for the past four months with increased covid activity causing staff to be off sick and shielding to enable enough time. A plan is being developed by the Lead Nurses for the completion of all VBA and statutory and mandatory training to be completed over the next six months.	Audit open over 12 months
48	2017-18	Neurosciences - Patient Care IT System							Completed	Audit undertaken in 2018/19.	
52	2018-19	Specialist Services Follow up - Patientcare IT System	Chief Operating Officer	M	A process should be established to periodically test the backups.	Discussions are underway with IM&T and a test of the backup is due to be scheduled and undertaken following these.	Chief Operating Officer	01.11.2018	Completed		Audit open over 12 months
53	2018-19	Performance Reporting Data Q	Director of Public Health	M	Consideration should be given to aligning the Performance Report and Tier 1 scorecard to the NHS Delivery Measures.	Discussions at a national level are happening between Welsh Government and the NHS in Wales to ensure that the Health Boards are sighted on the data being submitted to Welsh Government to report on the Q&D framework targets. This is not the case at the moment and there is no mechanism other than via the NHS	Director or Transformation and Informatics		No action taken		Audit open over 6 months
54	2018-19	Performance Reporting Data Q	Director of Public Health	L	The Performance Report working spreadsheet should be linked to data sources and SOPs in order to aid collation and ensure the on-going robustness of the process.	As identified above – not all the data is available to achieve this. The UHB is actively contributing, via membership of WG & NHS Wales committees to changing and improving data flows and making the required data available.	Director or Transformation and Informatics		No action taken		Audit open over 6 months
55	2018-19	Performance Reporting Data Q	Director of Public Health	L	Consideration should be given to re-formatting the Performance Report to improve usability.	Accept	Director or Transformation and Informatics		No action taken		Audit open over 6 months
56	2018-19	Delayed Transfers of Care Reporting	Chief Operating Officer	L	The Medically Fit spreadsheet used to identify DToCs weekly is updated using the comments column. However, it is not always clear from this what date certain process started, eg, funding authorised, housing confirmation, package of care agreement. It therefore makes it difficult to decipher whether a DToC is apparent.	The date of referral and compliance with time scales is checked verbally within the weekly scrutiny meetings and is often times included in the clinical workstation entries. The spread sheet will be altered to include the agreed timescales and any divergence clearly noted	Chief Operating Officer	01.04.2019	Completed	Internal audit provided substantial assurance across all areas of DTOC processes. System now in place to record relevant information	Audit open over 6 months
57	2018-19	Delayed Transfers of Care Reporting	Chief Operating Officer	L	Due to the patient impact of delayed discharge, it would be beneficial to include DToC in the information presented to the Clinical Board's Quality, Safety and Patient Experience Groups.	Clinical Boards will be provided with the monthly DToC report Clinical Board Directors of Operations will be reminded of the necessity to include in Quality and Governance agenda	Chief Operating Officer	01.04.2019	Completed	WG have currently suspended DTOC submission. Prior to this all Clinical Boards were issued with regular monthly reports. Data continues being scrutinised weekly and feedback given to Clinical Boards	Audit open over 6 months

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58	2018-19	Strategic Planning/IMTP	Director of Planning	M	Management should ensure that the plans for Clinical Boards are produced on a timely basis to enable the Clinical Boards to report on their projects in a consistent manner and allow them to monitor them appropriately.	A revised monitoring process for reporting clinical board progress on IMTPs will be in place for 2019/20. This will utilise the Shaping Our Future Wellbeing- Annual Plan (X-Matrix) methodology to provide clarity on performance and accountability arrangements. Progress against key IMTP priorities as captured in the annual plan document will be reported to Management Executives on a monthly basis as agreed at Management Executives on 09/05/19.	Director of Planning	01.07.2019	No action taken		Audit open over 6 months
59	2018-19	Dental CB – Theatre Sessions	Chief Operating Officer	H	The Dental administration staff should ensure that Patient Dental files contain copies of all necessary documentation relating to the procedures undertaken.	Urgent meeting to be arranged with Clinical Lead and Peri-Operative Care Manager to define a process to manage documentation	Chief Operating Officer	01.09.2018	Partially complete	This action is partially complete but will be completed for 2019/20 report.This action is partially complete and will now be reaudited when green, amber zones are created in SSSU and main theatre - completion will be in September 2020	Audit open over 12 months
60	2018-19	Dental CB – Theatre Sessions	Chief Operating Officer	M	The majority of patients cancelled by Dental staff are due to oversubscribed and overrun lists. Therefore, list management should be monitored and improvements made where necessary.	Reviewed PasPlus regarding start and finish times. Clinical Lead to speak with Maxillofacial Consultants	Chief Operating Officer	01.09.2018	Completed	This action has been completed but will be refined for future reports to ensure key milestones are highlighted.	Audit open over 12 months
61	2018-19	Dental CB – Theatre Sessions	Chief Operating Officer	M	Dental management should ensure that cancelled operations are re-bookedwithin the required timescales.	Where possible this is always the case but many lists are held only on a monthly basis. Dental are limited in the number of lists that are dedicated to Dental Patients and therefore if a cancer patient requires theatre we have to utilise a dedicated list and cancelled patients will be re-listed at the next scheduled list.	Chief Operating Officer	01.09.2018	Completed	This action is complete.	Audit open over 12 months
62	2018-19	Dental CB – Dental Nurse Provision	Chief Operating Officer	M	The Dental Nurse Management team should consider formalising ratios of Dental Nurse staff per operators /patients/procedures. This should include reevaluation of any ratios that are currently in place in agreement with the University. When these ratios have been produced they should ensure that weekly numbers allocations are adhering to these staffing levels.	To reduce duplication of lists, a meeting will be set up with Senior Dental Nurse's and colleagues working in medical records to review the current clinical staffing allocated to each department on PMS.Once complete work will begin on allocating core numbers of DN to each department.	Chief Operating Officer	01.10.2018	Completed	This action will be included for all future reports as appropriate so is partially completed.	Audit open over 12 months
63	2018-19	Dental CB – Dental Nurse Provision	Chief Operating Officer	M	The Dental Nurse Management team should consider bringing forward the numbers allocation to mid-week. Consideration should be given to producing fortnightly numbers with weekly review once patient lists stabilise closer to the scheduled date.	To reduce duplication of lists, a meeting will be set up with Senior Dental Nurse's and colleagues working in medical records to review the current clinical staffing allocated to each department on PMS. Once complete work will begin on allocating core numbers of DN to each department.	Chief Operating Officer	01.10.2018	Completed	Draft Meeting planned for November 2019.	Audit open over 12 months
64	2018-19	Dental CB – Dental Nurse Provision	Chief Operating Officer	L	It is recommended that the Senior Dental Nurses maintain a log that documents changes to schedules or nursing allocations as they occur and discuss these at the Senior Dental Nurse meeting to establish patterns or identify root causes. These can also be escalated to the weekly meetings with Medical records, ie. Clinical Staffing and Performance Group.	Implement feedback tool; that will be used to collect weekly changes that take place on each department. This information will form part of the weekly SDN staff discussion meeting	Chief Operating Officer	01.10.2018	Completed	This action is completed	Audit open over 12 months
65	2018-19	Dental CB – Dental Nurse Provision	Chief Operating Officer	L	The Senior Dental Nurse weekly meeting should continue to function in order to force justification of requested allocation by each clinic.	The weekly Senior Dental Nurse meeting will continue to function, chaired by the Dental Nurse manager /Deputy Dental Nurse Manager A records of attendance will also be kept.	Chief Operating Officer	01.09.2018	Completed	This action is completed	Audit open over 12 months
66	2018-19	Dental CB – Dental Nurse Provision	Chief Operating Officer	L	Consideration should be given to adding in the Senior Dental Nurses into the ESR hierarchy to delegate responsibility and distribute the administrative task of approving and recording annual leave. The use of ESR self-service by Dental Nurses should be enforced.	Where appropriate, work will begin on rolling out ESR hierarchy access to Senior Dental Nurses	Chief Operating Officer	01.12.2018	Completed	This action is completed	Audit open over 12 months
67	2018-19	Environmental Sustainability Re	Director of Planning	M	Future Sustainability Reports should only report on water supply costs. This may be achieved by: using different subjective codes to pay water and sewerage charges; by maintaining a manual record of the split between water and sewerage charges; or by apportioning annual costs based on a sample of paid water and sewerage charges.	Future Sustainability reports will include water supply costs, but will be determined on an apportionment basis from the invoices we receive from Welsh Water. The calculations will be determined from a limited sample of Welsh Water invoices.	Director of Finance	01.04.2019	Partially complete		Audit open over 12 months
68	2018-19	Environmental Sustainability Re	Director of Planning	L	Future Sustainability Reports should include references / links to where further sustainability and estate management performance is published. For example this could include links to information such as the Estates Strategy, EMSG Terms of Reference and selected meeting minutes, ISO Certificate and audit reports / ISO website, Cost Reduction Programme, Re:fit programme, further information on CHP units and Solar PV Schemes and the Sustainable Travel Plan.	Consideration will be given to include references / links to where further sustainability and Estate management performance is published depending on its relevance.	Director of Finance	01.04.2019	Partially complete	Business manager assigned to oversee pilot, reporting suite developed and final evalution on completion	Audit open over 12 months
69	2018-19	Management of the Disciplinary	Director of Workforce and Organisational Development	M	Management will identify trends in delays and take appropriate action in order that performance improves.	The organisation of Appeals will be centralised within the HR Operations Centre in the Autumn with the ongoing support of the HR Governance Team; ▪ Greater focus has been placed on arranging appeal hearings in the last 2 months which has resulted in an improvement in timescales; ▪ The new HR Case Manager system will improve the Appeal process and ensure consistency and follow through. ▪ The way in which the HR administrator arrange both appeal and disciplinary hearings has been streamlined and we anticipate that this will result in timescale improvements.	Director of Workforce and Organisational Development	30.10.2018	COMPLETED	Appeals have been centralised, timeliness has improved.	Audit open over 12 months

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70	2018-19	Management of the Disciplinar	Director of Workforce and Organisational Development	M	Training will be undertaken by all investigators to help with the efficient running of the disciplinary process. A review of the roles the coaches play in investigation will be undertaken to ensure the most effective use of resource.	The HR team are currently reviewing the UHB list of IO's to ascertain their status, i.e. have they been trained, how experienced are they, have they completed an investigation recently, etc. This will ensure that we have an accurate list of both trained and xperienced IO's to choose from; ▪ The IO training is currently being enhanced to ensure that following the training IO's are capable to undertake investigations; ▪ It was evident following the review that HR practitioners are too involved in the investigation process. This has been rectified and roles have been clarified.	Director of Workforce and Organisational Development	30.11.2018	COMPLETED	List of IOs has been reviewed and HR are no longer too involved in cases	Audit open over 12 months
71	2018-19	Management of the Disciplinar	Director of Workforce and Organisational Development	M	Management should review their performance/ summary documents to ensure all information is included appropriately and a focus on outcomes.	The main ER tracker is being updated to ensure that we capture the performance data in a more streamlined way; ▪ Employee Relations reports will be reviewed to ensure that they are meaningful and outcome focused; ▪ The appeals monitoring spreadsheet has een amended and now captures the timescales; ▪ The department are currently exploring the implementation of an ER Tracker. There will be a system demonstration on 26th September, following which we will determine whether the system can deliver significant efficiency improvements and proceed to a business case proposal.	Director of Workforce and Organisational Development	30.10.2018	COMPLETED	1. ER Trackers have been amended to ensure that they capture performance data, i.e. length of investigation, duration to arrange hearing, etc.	Audit open over 12 months
72	2018-19	National Standards for Cleaning	Director of Planning	M	The Health Board should ensure that there is a Multi- Disciplinary Group in place in line with the requirements of the 'National Standards for Cleaning in NHS Wales' or that the Healthcare Environment Steering Group referred to in the Cleaning Strategy is reconvened.	Formerly add the Cleaning Standards requirement into one of the existing forums described above into the same agenda. This will save additional meetings and labour resources.	Director of Finance	01.01.2018	Partially complete	Draft Meeting planned for November 2019. Follow up audit confirmed	Audit open over 12 months
73	2018-19	PCIC CB – District Nursing Rotas	Chief Operating Officer	L	District Nurses should work in conjunction with the Rosterpro team to ensure details in Rosterpro are correct to enable use of the automated generation of rotas. Rotas should be entered into Rosterpro prior to shifts being worked.	District Nursing sisters will be expected to use Rosterpro to roster all staff, this will be reviewed through regular 1-1's with them and the Locality senior nurse.	Chief Operating Officer	28.11.2019	Partially complete		Audit open over 12 months
74	2018-19	PCIC CB – District Nursing Rotas	Chief Operating Officer	L	District Nurse Sisters should ensure rotas are prepared on a timely basis. Where rotas are prepared manually, these should be formally signed and the date of preparation recorded.	District Nursing sisters will be expected to use Rosterpro to roster all staff, rosters will be audited quarterly to ensure that rosters are provided 4-6 weeks in advance, and signed off, this will be reviewed through regular 1-1's with them and the Locality senior nurse	Chief Operating Officer	28.11.2019	Partially complete	interface developed and testing	Audit open over 12 months
75	2018-19	Mental Health Clinical Board – Section 17 Leave	Chief Operating Officer	M	The Guideline for Section 17 Leave of Absence Mental Health Act 1983 should be approved as soon as possible.	The Guideline for Section 17 Leave of Absence Mental Health Act 1983 will be presented for approval at the Clinical Board Quality and Safety Committee in December 2018.	Chief Operating Officer	13.12.2018	Completed		Audit open over 12 months
76	2018-19	Mental Health Clinical Board – Section 17 Leave	Chief Operating Officer	M	The Health Board should clarify if there is a requirement for specific risk assessments and intervention plans to be produced before patients go on leave. The Guideline should then be updated to reflect the clarified requirements and management should ensure that these are followed in all instances. Risk assessments and intervention plans should be updated and reviewed on a regular basis.	Consideration of the risk assessment and care and treatment plan will have taken place during a review with the Responsible Clinician prior to any Section 17 leave being granted. This is documented on the CPA 3 Review record and in the relevant case note entry. The Guideline for Section 17 Leave will be updated to remove the requirement for a specific Section 17 risk assessment and care plan. Wards have been reminded to ensure current contact details are correct prior to a patient commencing Section 17 leave.	Chief Operating Officer	01.12.2018	Completed		Audit open over 12 months
77	2018-19	Renal IT system	Chief Operating Officer	H	Both UNIX and MySQL should updated to a more recent, supported version.	Early investigations have taken place between Vitalpulse and Summerside. Monies will need to be found to either see how viable the MySQL version 5.7 is with a more recent AIX version. It may not be compatible and a Windows or Linux infrastructure (Live and DR) will need to be considered. Whilst the appropriate Hardware and Software vendor companies, who are contractually obliged to support and maintain the renal IT infrastructure (Summerside Computers Ltd and Vitalpulse Ltd	Chief Operating Officer	01.06.2019	No action taken	There has been ongoing discussions following the audit with both C&V UHB and with the Welsh Renal Clinical Network to move away from a UNIX/AIX environment, to Windows. Funding has been agreed through Transformation Funds with WAG to merge the two Renal IT Systems used in Wales and in order to accommodate this, a new IT infrastructure will	Audit open over 12 months
78	2018-19	Renal IT system	Chief Operating Officer	M	The minimum password length should be set to 8 and all users have a forced password change enacted.	The minimum length has now been amended to 8. With regard to forced change, this will be required when VitalData v1.7 is implemented across Wales this financial year. v1.7 has Active Directory authentication, which will mean Users will be required (and forced) to change their VitalData password every 90 days – the same as is required with User's everyday NADEX domain login.	Chief Operating Officer	01.06.2019	No action taken		Audit open over 12 months
79	2018-19	Renal IT system	Chief Operating Officer	M	Recommendation: The backups should be subject to periodic testing.	This has been brought to the attention of the IT Server Team but is outside of the Directorate's direct control. We will continue to seek an appropriate response	Chief Operating Officer	01.04.2019	Completed	The implementation of a new IT infrastructure (UNIX to Windows) in April 2020 which now enables a robust system to back-up arrangements and testing supported by the C&V UHB Server Team.	Audit open over 12 months
80	2018-19	Renal IT system	Chief Operating Officer	M	The DR plan should be revised to include contact details of support organisations, user departments and management. The DR plan should be tested and subject to subsequent review.	Dialogue with the Vendor parties has already started regarding the failback process. Action is underway to test and resolve, and identify an appropriate timetable for follow-up to ensure regular review. The BCP will be revised with immediate attention	Chief Operating Officer	01.04.2019	Partially complete	The BCP and DR plan have been revised. A new plan will be devised and tested following implementation of a new IT infrastructure, expected by July 2020	Audit open over 12 months
81	2018-19	Renal IT system	Chief Operating Officer	M	A review of users should be undertaken to ensures that leavers access is revoked.	Action has been taken as identified and a process implemented to regularly review leavers. This will ensure access is revoked at the earliest opportunity.	Chief Operating Officer	01.04.2019	Completed	A new System report trigger advises of affected Users (leavers) and then appropriate action to revoke access, is taken periodically	Audit open over 12 months
82	2018-19	Renal IT system	Chief Operating Officer	M	The local user group should seek to identify fields which could benefit from improved entry controls.	Communication with users is ongoing and agreed changes will be actioned where appropriate.	Chief Operating Officer	01.06.2019	Completed	Ongoing communication and feedback with users and agreed changes where appropriate. With the work on merging of the two Renal IT systems in Wales, this recommendation has been implemented in the development phase through mapping and merging exercises.	Audit open over 12 months

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83	2018-19	Renal IT system	Chief Operating Officer	M	A local user group should be established with leads from each of the user departments with the remit to: - Share knowledge over how departments use the system; - Identify areas where improvements to design or functionality could be made; - Identify areas where additional training should be provided to users. - identify areas where poor or late data entry has impacts on downstream departments.	Partially agree. There is an all Wales VitalData Group to which Users can feed into via their Renal IT lead or via each Health Board Clinical IT Lead. As the VitalData system is use within four out of the five Renal Units in Wales any developments or suggestions to change are to benefit all the renal community and a Request for Change process is in place in relation to any system improvements. In Cardiff, local drop-in How-To sessions were established but with little buy-in; they were soon disbanded.	Chief Operating Officer	01.06.2019	Completed	There are several forums and opportunities, (a) to share and feedback information on usage, (b) to identify areas where improvements to design or functionality could be made particularly moving to one system and where certain subforms are underused (view or edit) or tired looking, (c) to identify training needs as new developments are implemented and (d) to identify areas where poor or late data entry exists. These forums are both local and national, and generally led by the Project and Service Improvement Manager of the WRCN	Audit open over 12 months
84	2018-19	Clinical Diagnostic and Therape	Chief Operating Officer	H	The Clinical Board should develop a process to ensure that all overtime sessions worked in excess of 6 hours include a clearly documented 30 minute unpaid break. This process should then be communicated to all relevant managers and consistently implemented in the future.	All departments have received a communication instructing them to amend their current processes to include a documented 30 min break. This was done in advance of the production of a new Standard operating procedure which will include this guidance and elevant recording mechanisms as per finding 2	Chief Operating Officer	15.03.2019	Completed	Standard operating procedure has been written shared and implemented with all directorates	Audit open over 6 months
85	2018-19	Clinical Diagnostic and Therape	Chief Operating Officer	M	The department should ensure that all agency shifts worked are appropriately authorise prior to payment and evidence of authorisation should be retained.	The management team associated with this department has been requested to provide the relevant recording to the clinical board for review and the need for this on an ongoing basis will for part of the SOP.	Director of Planning	01.06.2019	Completed	Standard operating procedure has been written shared and implemented with all directorates	Audit open over 6 months
86	2018-19	Clinical Diagnostic and Therape	Chief Operating Officer	L	Where staff work less than the Agenda for Change hours of 37.5 hours any additional hours worked must be recorded as 'Additional Hours' on the Pay Card returned to Payroll Delegated Budget Holders should review the pay-cards submitted to Payroll to establish whether additional hours have been incorrectly classed as overtime.	This will form part of the SOP, and a reminder email will be sent to all departments	Director of Planning		Completed	Standard operating procedure has been written shared and implemented with all directorates	Audit open over 6 months
87	2018-19	Kronos Time Recording System	Director of Planning	H	Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system.	Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system.	Director of Finance	01.06.2019	Partially complete		Audit open over 6 months
88	2018-19	Kronos Time Recording System	Director of Planning	M	Where overtime has been worked this should be reflected in the start and finish times recorded in Kronos, and should be authorised on the timesheets. Management should investigate the feasibility of including a 'reason for overtime' or Notes field on timesheets with the system providers so that in future all overtime can be claimed and authorised	The issue will be considered as part of the system review although all overtime is authorised and recorded therefore the risk is low. Kronos has been updated to include overtime reasons.	Director of Planning	01.06.2019	No action taken		Audit open over 6 months
89	2018-19	Kronos Time Recording System	Director of Planning	M	Staff should be instructed to clock in no more than 27 minutes before the start of their shift. Where staff do clock in more than 27 minutes before the start of their shift, supervisors should amend the timesheet start time to the scheduled start time if the additional time is not to be paid as overtime. Supervisors should update	Staff clock in on arrival on site but are not paid from this point, unless authorisation is given for overtime. Staff will be advised not to clock in as suggested and this will be monitored but the risk associated with this practice is considered low.	Director of Finance	01.03.2019	No action taken	system rules setup to overide early clocking in. If staff clocks in early and work overtime supervisers amend early clocking in.	Audit open over 12 months
90	2018-19	PCIC Interface Incidents	Chief Operating Officer	L	Regular communicatoin with GPs should be undertaken to make them aware of the actions taken following their reporting of interface incidents. This will inform them of improvements ot processes as a result and encourage future engagement	A paragraph in relation to the interface process was included in the winter Patient Safety and Quality newsletter. The UHB Medical Director and LMC are kept up to date with the interface incident process through the regular Primary / Secondary Care interface meetings.	Chief Operating Officer	12.03.2019	Completed	This is a regular item for discussion at LMC meetings and shared with GPs.	Audit open over 12 months
91	2018-19	PCIC Interface Incidents	Chief Operating Officer	L	Consideration should be given to how feedback and incident reporting can be made a two way process with continued engagement between primary and secondary care. This will need to include training of secondary care professionals in the current process of interface incidents reporting	PCIC does not receive incident notification from internal depts within the UHB which are managed in line with the agreed UHB process for incident management/ PST - this issue has also been presented at the Datix Super User Gropu. Further information will be included on the Datix Intranet page.	Chief Operating Officer	01.04.2019	Completed	When information is provided then this is reviewed and action taken to avoid further recurrent. Key themes also reviewed and discussed at LMC meetings.	Audit open over 12 months
92	2018-19	Medicine CB - Sickness Absence Management	Chief Operating Officer	H	Management must ensure that all future sickness episodes are managed and documentation is completed in accordance with the requirements of the All Wales Managing Attendance at Work Policy. Management should ensure that a self-certificate is completed correctly and a return to work interview is held with the employee including the completion of the return to work form. Clinical Board management should consider introducing further periodic training on the sickness management process in order to increase awareness and compliance levels.	Re-circulate the All Wales Managing Attendance at Work Policy. ▪ Support and appraises have been set up for A6 South to ensure consistency in completing Self-certification. ▪ Review Ward Base sickness processes to ensure that they reflect current policy and provide efficiency to complete necessary actions.	Chief Operating Officer	01.04.2019	Completed	Update 24/06/20 Acute Stroke Ward has now moved to C4S. The management of sickness on the MCB Stroke ward has improved over the past year. Senior nurses are actively monitoring and measuring sickness absence and are regularly meeting and reporting performacne through the directorate and into the clinical board. The IM directorate regualrly monitor and challenge sickness absence figures.	Audit open over 12 months
93	2018-19	Medicine CB - Sickness Absence Management	Chief Operating Officer	M	Management should ensure that the sickness triggers are being managed correctly and all future required informal discussions and formal sickness interviews are carried out in accordance with the requirements of the All Wales Managing Attendance at Work Policy.	Support and appraises have been set up for A6 South to ensure consistency in completing Self-certification. ▪ Confirm management expectations with Ward Managers in following the All Wales Managing Attendance at Work Policy. ▪ Review Ward Base sickness processes to ensure that they reflect current policy and provide efficiency to complete necessary actions.	Chief Operating Officer	01.04.2019	Completed	Update 24/06/20 Confirmation of expectations and reiteration of policies has been shared with Ward Managers. Regular reviews of sickness are taking place at Ward, Directorate and Clinical Board level.	Audit open over 12 months
94	2018-19	Medicine CB - Sickness Absence Management	Chief Operating Officer	M	Management should ensure that the sickness triggers are being managed correctly and all future required informal discussions and formal sickness interviews are carried out in accordance with the requirements of the All Wales Managing Attendance at Work Policy.	▪ Support and appraises have been set up for A6 South to ensure consistency in completing Self-certification. ▪ Confirm management expectations with Ward Managers in following the All Wales Managing Attendance at Work Policy. ▪ Review Ward Base sickness processes to ensure that they reflect current policy and provide efficiency to complete necessary actions.	Chief Operating Officer	01.05.2019	Completed	Update 24/06/20 Confirmation of expectations and reiteration of policies has been shared with Ward Managers. Regular reviews of sickness are taking place at Ward, Directorate and Clincal Board level.	Audit open over 12 months
95	2018-19	Medicine CB - Sickness Absence Management	Chief Operating Officer	M	Management should ensure that all current ward managers are provided with appropriate training to enable them to effectively manage sickness absence. A robust process should also be implemented to ensure that timely training is provided to any new ward managers. Regular information on sickness absence levels should be consistently provided to all ward managers.	▪ Within Stroke Services, engaged with Human resources to provide further training for all members of the Leadership team. ▪ Discussed with HR and now regularly circulating sickness data. ▪ HR currently undertaking deep dives with high rate areas to provide useful supportive information about absence.	Director of Planning	22.05.2020	Partially complete		Audit open over 12 months

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96	2018-19	CRI Safeguarding Works	Director of Planning	M	Progression at risk should be fully documented, approved and recorded at the risk register (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Planning	22.05.2020	No action taken		Audit open over 12 months
97	2018-19	CRI Safeguarding Works	Director of Planning	L	A Project Execution Plan should be prepared at the outset of a project, in accordance with the Capital Projects Manual and best practice (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Planning	22.05.2019	No action taken		Audit open over 12 months
98	2018-19	CRI Safeguarding Works	Director of Planning	M	Sufficient contractual arrangements should be in place to safeguard the Health Board interests (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Planning	01.06.2019	no action taken		Audit open over 12 months
99	2018-19	CRI Safeguarding Works	Director of Planning	L	4) Project benefits should be clearly identified and documented in the business case, including: - Baseline value; - Method of measurement; - Target improvement; - Timing of when the benefit would be achieved; and - Lead responsibility for the benefit (D). (This recommendation being for implementation at future projects). Post project evaluations should be delivered in accordance with agreed Business Case requirements, or a revised approach should be appropriately approved (O).	Agreed. **ALL FUTURE PROJECTS**	Estates Manager	01.05.2019	No action taken		Audit open over 12 months
100	2018-19	CRI Safeguarding Works	Director of Planning	L	5) The required approach to post project evaluation and benefits assessment should be agreed with the Welsh Government, in relation to the CRI afeguarding project and wider investment at the CRI site (O).	Agreed.	Estates Manager	01.04.2020	No action taken		Audit open over 12 months
101	2018-19	Commissioning	Director of Transformation and Informatics	H	Strategic Commissioning Group Terms of Reference document should be revised and updated to state the quorate attendance level and its current membership. Additionally, its membership should include representation from the Clinical Boards to ensure a broad contribution and as such an improved strategic approach in full alignment with the Group's Terms of Reference.	The Strategic Commissioning Groups Terms of Reference, including membership was reviewed at a facilitated workshop on 20th Feb 2019. The first draft of a refreshed Terms of reference is scheduled for discussion at the May 2019 meeting of the Strategic Commissioning and Finance Group. Clinical Board representation will be fully considered.	Director of Transformation	01.04.2019	No action taken		Audit open over 12 months
102	2018-19	Commissioning	Director of Transformation and Informatics	M	The Commissioning Team should as part of its ongoing programme of work publicise their presence via their intranet pages and create an internet page thereby promoting the Commissioning Framework and Commissioning Intentions so as to maximise awareness of content to both internal/external stakeholders and the wider general public.	The development of the commissioning intranet pages, alongside commissioning toolkits, and awareness raising remains on the Commissioning Team's work plan. These actions were not progressed following publication of the Framework due to capacity of the team, and other urgent priorities. Progression of these actions will be included in the team's work plan for 2019-20, but capacity to implement remains an issue.	Director of Transformation	01.09.2019	Completed	Completed	Audit open over 12 months
103	2018-19	E IT Training	Director of Transformation and Informatics	M	An assessment of the impact of these measures should be carried out and procedures developed for actions in similar circumstances in the future.	An assessment of the reduced course duration is to be undertaken by the PARIS training senior officer at the point the team regain their second training staff member (long term sick, meant the two person PARIS training complement was reduced by half). The PARIS programme has service representation embedded in its 'change structure'. These staff have been asked for concerns and feedback regularly (to the fortnightly MHCS team meetings) since this 'new training model' was made necessary (due to long term loss of staff). No operational risks or concerns have been raised from scoped services to date.	Director of Transformation	30.06.2019	Completed	Completed	Audit open over 12 months
104	2018-19	E IT Training	Director of Transformation and Informatics	M	Relevant policies and procedures should be put in place to set out the circumstances under which this kind of drift can be allowed (if at all), any mitigation measures, how many versions the training system can be allowed to be behind and any other provisions to ensure adequate quality levels of training are preserved.	The 'relevance' of the PARIS training system is under constant review through both the fortnightly PARIS team meeting and the fortnightly PARIS Technical Design Team (TDT). The functionality that is 'trained' upon is a hugely limited subset of all the capability of PARIS 'live' (as there are, for example, c400 assessment types on PARIS LIVE, and c50 casenote types etc...). As such the Health Board trains on one or two examples, thus negating the necessity for	Director of Transformation	01.09.2019	Completed	Completed	Audit open over 12 months
105	2018-19	E IT Training	Director of Transformation and Informatics	L	To introduce a relevant pre-assessment process and procedures to ensure that staff with learning difficulties are able to learn the systems to the required level.	The Health Board will: 1. Agree a process for ensuring any LD is captured. 2. Develop the Training Booking system to include a mandatory Learning Difficulties field within the user profile screen. The LD will automatically display against the user when booking them in for training sessions. Initially the LD field will default to NONE however the IT Trainers are to check/update the LD field when requests for training received.	Director of Transformation	01.09.2019	Completed	Completed	Audit open over 12 months
106	2018-19	E IT Training	Director of Transformation and Informatics	L	Document control information to be standardised and completed in full on training documents.	Training documents are currently version controlled but not standardised. Standardising them would be a very low priority within the current resource.	Director of Transformation	01.09.2019	Completed	Completed	Audit open over 12 months
107	2018-19	E IT Training	Director of Transformation and Informatics	L	An impact assessment process should be introduced in order to gather and evaluate the feedback from training attendants after they have had the opportunity to use the relevant systems. The feedback emails should be reviewed on a regular basis.	An impact assessment process is in draft but has been suspended due to the Work Life Balance absence of the WCP trainer. This and the regular review of feedback emails will recommence once the trainer has returned to post.	Director of Planning	30.06.2019	No action taken		Audit open over 12 months
108	2018-19	E IT Training	Director of Transformation and Informatics	L	The training material should be updated to include a range of options for post learning support other than just helpdesk contact information.	It would not be appropriate to provide Service Coordinator details since these will be subject to change at effectively no notice. Training materials include contact information for the "IT User Support" team which is managed by the IT Trainers and Implementation Officer. Both e-mail and	Director of Planning	30.06.2019	No action taken		Audit open over 12 months
109	2018-19	Water Safety	Director of Planning	M	Attendances of the Water Safety Group should be reviewed, with staff reminded of their responsibilities to attend, to ensure key groups are appropriately represented (O).	Agreed	Director of Finance	30.07.2019	No action taken		Audit open over 6 months
110	2018-19	Water Safety	Director of Planning	M	The current position in respect of the backlog of remedial jobs, should be routinely reported to the Water Safety Group (O).	Agreed	Director of Finance	30.06.2019	No action taken		Audit open over 6 months
111	2018-19	Water Safety	Director of Planning	M	Training should be updated for all key staff with assigned water management responsibilities (O).	Agreed	Director of Finance	30.07.2019	No action taken		Audit open over 6 months

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112	2018-19	Water Safety	Director of Planning	M	a) An audit trail should be maintained where routine checks are not completed, in cases where risk-based decisions dictate alternative monitoring/testing schedules will be applied. b) Key person dependency should be reviewed and removed, where possible, to facilitate the timely identification and completion of	Agreed	Director of Finance	01.11.2019	No action taken		Audit open over 6 months
113	2018-19	Water Safety	Director of Planning	H	a) For those clinical boards identified in this audit as being non-compliant with required flushing practices, the Chair of the WSG should request assurance from the clinical boards that practices have been improved.	Agreed	Director of Finance	01.11.2019	No action taken		Audit open over 6 months
114	2018-19	Water Safety	Director of Planning	H	The risk assessment process, including preparation of appropriate prioritised action plans to address the identified risks, should be completed as soon as possible (D).	Agreed	Director of Finance	30.07.2019	No action taken		Audit open over 6 months
115	2018-19	Water Safety	Director of Planning	M	Progress, including highlighting of any delays, should be regularly reported to the Water Safety Group (O).	Agreed	Director of Finance	31.10.2019	No action taken		Audit open over 6 months
116	2018-19	UHB Core Financial Systems	Director of Finance	M	Management should inform responsible staff to promptly notify eEnablement of changes to the Purchasing Oracle hierarchy list. The required forms should be completed to process updates.	Recommendation Accepted. The UHB's current procedure will be updated to clarify the responsibility to review approvers at the Clinical Board level and within Corporate Finance.	Director of Finance	31.07.2019	Partially Completed	A list of actions were agreed with NWSSP Procurement eEnablement on the 21st June 2019. Actions included the establishment of a revised Oracle User Form which would include ESR position numbers which could be linked to Oracle responsibilities. **On the 15.06.2020 NWSSP confirmed that the user forms has been revised and are at the moment in the final stage of implementation**	Audit open over 6 months
117	2018-19	UHB Core Financial Systems	Director of Finance	M	Management should ensure that a standard procedural guide is produced to support staff in the maintenance of the Oracle Purchasing hierarchy. The guide should also state an appropriate agreed period for the review of the hierarchy.	Recommendation accepted. The UHB's current procedure will be updated to clarify respective responsibilities at the Clinical Board level and within Corporate Finance. The minimum expectation is that purchasing hierarchies will be reviewed quarterly.	Chief Operating Officer	01.04.2020	Partially Completed	A list of actions were agreed with NWSSP Procurement eEnablement on the 21st June 2019. Actions included the establishment of a revised Oracle User Form which would include ESR position numbers which could be linked to Oracle responsibilities & an agreement to investigate whether Finance staff could be provided with read only access to hierarchies. The read only access to hierarchies was sucessfully tested and an amended "CVT Finance Inquiry" responsibility in Oracle PROD was applied with the following and provision of access to hierarhcies (as per email 27.11.2019) ; • Purchase Order Summary (assigned 'View Invoices' and 'Manage Tax' read only access • PO Hierarchy Inquiry (Created Employees, Positions, Position Hierarchy, Approval Assignment, Approval Group and Define Location read only functionality) • Position Hierarchy Report added to the current 'Request' menu. • OM Inquiry (Order Organizer read only) The procedural guide will be published upon the implementation of the new oracle user form	Audit open over 6 months
118	2018-19	UHB Core Financial Systems	Director of Finance	M	Management should ensure that the required forms are completed, signed and forwarded to eEnablement for all additions to the Oracle Hierarchy. Management should also liaise with eEnablement to ensure there is an organised system for storing the Financial limit forms so they can be easily retrieved here an audit trail is required.	Recommendation accepted. The UHB's revised procedure will be updated to clarify respective responsibilities for establishing approvers and maintaining appropriate records for additions to the Oracle Hierarchy.	Chief Operating Officer	31.08.2019	Partially Completed	AA list of actions were agreed with NWSSP Procurement eEnablement on the 21st June 2019. Actions included the establishment of a revised Oracle User Form which would include ESR position numbers which could be linked to Oracle responsibilities & an agreement to investigate whether Finance staff could be provided with read only access to hierarchies. The read only access to hierarchies was sucessfully tested and an amended "CVT Finance Inquiry" responsibility in Oracle PROD was applied with the following and provision of access to hierarhcies (as per email 27.11.2019) ;	Audit open over 6 months
119	2018-19	Specialist Services Clinical Board – Medical Finance Governance	Chief Operating Officer	H	Management should carry out a comprehensive review of the current and future consultant staffing levels to ensure that the Critical Care service can be sustainably delivered in the future. This should include review of the current service model.		Chief Operating Officer	01.04.2019	No action taken		Audit open over 6 months
120	2018-19	Specialist Services Clinical Board – Medical Finance Governance	Chief Operating Officer	L	Each 20 week Consultant rota should be subject to formal approval by the Clinical Director and evidence of this approval should be retained on file.	A process to sign off the rota by the Clinical Director will be developed by the Directorate Management Team, and a record of which will be retained on file along with existing job planning information.	Director of Corporate Governance	31.12.2018	Completed		Audit open over 6 months
121	2018-19	Mental Health Clinical Board – Sickness Management	Chief Operating Officer	L	Long term sickness meetings should be held as required to ensure that the employee is receiving support and help.	Directorates to send all managers a general reminder of the need for formal sickness letters to be sent and for LTS forms to be signed and copied. Managers to be asked to ensure that where conversations have been held with HR / OH re: additional triggers, these are to be more clearly noted in sickness files	Director of Corporate Governance	31.12.2018	Completed	Re-audit revealed improvements in this area to reasonable assurance level	Audit open Over 12 months
122	2019-20	Legislative/Regulatory Complai	Director of Corporate Governance	H	The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Agreed	Director of Corporate Governance	01.02.2019	Partially complete	This action will be followed up by end of June	Audit open over 12 months
123	2018-19	Legislative/Regulatory Complai	Director of Corporate Governance	H	The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers.	Agreed	Director of Transformation and Informatics	30.06.2019	No action taken	This action will be followed up by end of June	Audit open over 12 months
124	2018-19	Information Governance: Gene	Director of Transformation and Informatics	H	The UHB should consider establishing a GDPR group with representation from all clinical boards. The function of the group should be to ensure appropriate compliance actions are taken and to provide assurance that the UHB has good processes to ensure compliance with the GDPR.	The UHB has adapted the all Wales IG policy. As part of the process to formal adoption, consultation and impact assessment will be taking place through which we anticipate identification of all clinical board requirements and prioritised action. The UHB sees placing responsibility and accountability as close as possible to the operational front line as the key to having an empowered and engaged workforce. Thus we see that the role of the corporate IG department is to design delivery of compliance and to provide specialist advice, rather than co-ordinate and deliver. It is accepted that as resources and expertise accumulate in line with expectation, there is more the central team can do on communication and engagement including the creation of a virtual mutually supporting networking of IAOs / IAAs. As recommended this will include setting up a GDPR group for a year.	Director of Transformation and Informatics	01.03.2019	Partially complete	IG representation at CB Q&A groups being trialed.	Audit open over 12 months

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125	2018-19	Information Governance: Gene	Director of Transformation and Informatics	H	The resource requirement for the Information Governance team should be fully assessed and resource provided appropriately.	In the context of the UK wide economy growing at a lower rate than: patient expectation, demand and health care cost inflation, the UHB has had to take business decisions in order to deliver a financially balanced plan. We recognise these have had significant consequences on many of our staff and resulted in high levels of sickness which have only made the position harder for all. We fully appreciate that a once in a generational change to IG legislation coincided with difficult financial circumstances has presented us with a challenge, but we would contend that this was a short sharp shock to the system which is now being adopted into routine ways of working as knowledge and awareness builds from experiential learning. As such we anticipate that by the end of Q1 2019/20 we will have increased the number of whole time equivalents in place and working by a whole time equivalent, taking the operational staffing levels to 4.8 wte, which will continue to be complimented by specialist advice from both Welsh Health Legal and Risk and a local legal firm. To confirm the financial resource for this external support is available within the UHB's budget.	Director of Transformation and Informatics	30.09.2019	Partially Complete	IG function strengthened as part of the DH&I restructure.	Audit open over 12 months
126	2018-19	Information Governance: Gene	Director of Transformation and Informatics	H	A revised Subject Access Procedure should be completed, placed on the intranet and flagged to all staff.	Accepted	Director of Transformation and Informatics	itional Implementati	Partially Complete	SAR procedure live	Audit open over 12 months
127	2018-19	Information Governance: Gene	Director of Transformation and Informatics	M	The IG webpages should be updated to ensure they present current, accurate information.	The contact details will be updated shortly. As noted above the department has been short staffed and there has needed to be a prioritisation between designing and mitigating significant risks to noncompliance and making general information available. The UHB has engaged widely on the DPA 2018 and is intending to use the consultation on the IG policy as a further vehicle for promoting awareness and setting out	Director of Transformation and Informatics	01.03.2019	Partially Complete	Website has been updated	Audit open over 12 months
128	2018-19	Information Governance: Gene	Director of Transformation and Informatics	M	The UHB should seek to ensure all staff complete the IG training module.	Management Response Accept – The UHB is engaged nationally in the development of the e-learning package and has licenses for its use. We intend to make use of this national initiative in line with its roll out plan.	Director of Transformation and Informatics	30.09.2019	Partially Complete	This has been consolidated into a single IG action plan which is being updated in preparation for the Digital & Health Intelligence Committee meeting on 3 December 2019	Audit open over 12 months
129	2018-19	Information Governance: Gene	Director of Transformation and Informatics	M	Training on GDPR should be enhanced and provided to all staff acting in an IAO or IAA role. Further information should be passed to Directorates on the specific actions to be undertaken following GDPR.	Training is via the mandatory training route described in recommendation 5. The UHB will take actions to ensure we have asset registers and awareness of GDPR within dermatology and across the medicine clinical board as an early priority. Within clinical boards there will be further emphasis and engagement on the responsibilities and requirements for IAO/IAA roles, in order to enable appropriate senior staff to be allocated/trained, following implementation of enhanced training programme	Director of Transformation and Informatics	30.09.2019	Partially Complete	IAR completed. TNA should be undertaken as recommended by recent ICO audit.	Audit open over 12 months
130	2018-19	Information Governance: Gene	Director of Transformation and Informatics	M	A reminder should be sent to all staff to ensure that all IG breaches are entered onto Datix immediately.	National policy is being discussed at IGMAG and Medical Directors (Caldicott Guardians) groups. Given the advent of digital and the opportunities presented by 'big data' analysis the proposal is that digital records containing the core clinical record will be kept for 100 years. The UHB is an advocate of this position The paper record is being retained on instruction of the NHS Wales Chief Executive for the reasons	Director of Transformation and Informatics	30.09.2019	Compleetd	Memo sent out by Medical Director & Director of Nursing	Audit open over 12 months
131	2018-19	Information Governance: Gene	Director of Transformation and Informatics	M	This issue should be raised with WG to confirm that the requirement to keep overrides the stated retention guidelines. This issue should be entered onto the UHB risk registers.	National policy is being discussed at IGMAG and Medical Directors (Caldicott Guardians) groups. Given the advent of digital and the opportunities presented by 'big data' analysis the proposal is that digital records containing the core clinical record will be kept for 100 years. The UHB is an advocate of this position The paper record is being retained on instruction of the NHS Wales Chief Executive for the reasons stated in the findings. **NO ACTION REQUIRED**	Director of Transformation and Informatics		Completed		Audit open over 12 months
132	2018-19	Information Governance: Gene	Director of Transformation and Informatics	M	The IAR process should pick up information flows and also consider the basis for processing.	In line with the approach taken across NHS Wales which has been discussed openly with the ICO's office a phased approach to the development of IARs has been adopted. Presently the UHB is in the process of mapping flows, with the initial focus having been on mapping new flows, those concerning R&D (potentially higher risk) and those into NWIS. The legal basis for processing in the majority of cases is patient care as set out in our privacy notice. The UHB is using the requirement to get the documentation right for all new flows as a tool for	Director of Transformation and Informatics	26.02.2019	Completed	IARs completed.	Audit open over 12 months
133	2018-19	Information Governance: Gene	Director of Transformation and Informatics	M	The UHB should make clear the requirement to gain explicit consent for these transfers.	As above – there is no requirement for consent where the data processing by a non EEA 3rd party has a EEA 'kitemark'. Information around this is being shared and informed by work reporting into IG MAG **Continuation of existing practice**	Chief Operating Officer	30.03.2019	Completed	Continuation of existing practice	Audit open over 12 months
134	2018-19	Information Governance: Gene	Director of Transformation and Informatics	L	Directorates should be reminded to display the GDPR information.	Accept – SIRO will write to Directorate Managers & CDs to remind them of this requirement	Chief Operating Officer	30.03.2019	Completed	CBs written to by SIRO	Audit open over 12 months
135	2018-19	Surgery Clinical Board – Medical Finance Governance Tolley, Laura 07/06/2020 11:07:49	Chief Operating Officer	H	The Directorate should ensure that consultants carry out all planned sessions wherever possible and appropriate reasons are recorded for the cancellation of clinics and theatres. Colorectal Consultants should ensure that they cover and backfill the other Consultants lists if they are unable to carry out the planned session.	▪ A new system to accurately record consultant activity in theatre is being developed with a clear desktop procedure. ▪ Through job planning each consultants expected activity will be agreed in weeks and monitored accordingly by the Directorate ▪ Expectation around backfill sessions will be agreed and signed by consultants and a system to monitor this will be managed by the Directorate team ▪ Systems will be put in place by end of March 2019	Chief Operating Officer	30.03.2019	Partially complete	Theatre sessions reviewed on a weekly basis by the specialty manager for General Surgery. Improve annual leave data base has been developed for General Surgery which includes reason for absence. Joint job planning meeting is scheduled for the end of August, at which discussions will be held in relation to backfilling. The Directorate have seen improvements in terms of backfilling.	Audit open over 12 months
136	2018-19	Surgery Clinical Board – Medical Finance Governance	Chief Operating Officer	M	Management should produce desk top procedures to ensure that Consultants medical staff time and costs are being managed appropriately and consistently	Standardised procedure notes to be created and shared with key personnel (March 2019)	Chief Operating Officer	01.09.2019	Completed	Improved capturing of leave has identified some poor practice amongst some consultants on INTREPID. This again will be re-emphasised at the joint job planning meeting. All leave requests come directly through the Directorate, no activity will be cancelled without the Directorates team being notified.	Audit open over 12 months

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137	2018-19	Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up	Chief Operating Officer	H	Management should ensure that all members of staff within the directorate are fully compliant and up to date with their mandatory training. If staff members believe that ESR is not tracking when a module is completed, staff should print out the certificate available to provide proof and store it within their personal file.	Improved compliance for 85% of staff with completion of 100% mandatory and statutory training modules (44% improvement over 6 months). Staff to be allocated onto study leave planner and compliance monitored monthly via ESR and discussed with ward managers at 121s.	Director of Transformation and Informatics	01.07.2019	Partially complete	Work has commenced to cleanse ESR which will mean that Ward Managers receive accurate monthly data from workforce. Ward Managers are held to account for the training compliance of their team and this is discussed monthly with the Senior Nurse Plan to be compliant by Sept 2019	Audit Open over 12 months
138	2018-19	Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up	Chief Operating Officer	M	Management must ensure that the staff database is regularly maintained, with the deletion of staff that have left the directorate and the inclusion of new employees. Management must look to tie in the mandatory training dates with the ESR matrices to ensure they tie back to LED.	No Longer Applicable No database is maintained by the directorate office. They are now reliant on reports from ESR therefore consistent figures are being used and reported.	Director of Transformation and Informatics	01.09.2019	Completed	No longer applicable	Audit open over 12 months
139	2018-19	Cyber Security	Director of Transformation and Informatics	H	A review of the resources available within IM&T and the requirements of the organisation should be undertaken to ensure that the department can appropriately meet the demands. Additional investment should be considered in order to provide a cyber security function.	A review of the current IT and Information departments has been completed and a restructure proposal created. This includes additional cyber security resources to manage and deliver the NESSUS and SIEM requirements, utilising the additional funding being made available by Welsh Government.	Director of Transformation and Informatics	01.09.2019	Partially complete	Welsh Government are reviewing the £25m Capital and Revenue which will include funding to recruit cyber security staff. The UHB continues to address highest cyber security risk on a priortised basis within existing resources. In anticipation of receiving WG funding, resourced are being recruited to in November 2019	Audit open over 6 months
140	2018-19	Cyber Security	Director of Transformation and Informatics	H	An active monitoring process which feeds into KPI reporting should be developed and maintained within IM&T.	The restructure of the directorate includes additional resource to manage cyber security issues. A key role for this function will be the development of a monitoring system that supports the KPI reporting against cyber security.	Director of Transformation and Informatics	01.09.2019	no action taken	Subject to Digital Funding from WG	Audit open over 6 months
141	2018-19	Cyber Security	Director of Transformation and Informatics	H	Resources should be provided to allow for a cyber security role to be properly defined and operating appropriately.	The restructure of the IT and information functions being proposed will result in the establishment of cyber security roles which will monitor and respond to cyber incidents and will develop policy, processes and procedures to reduce the likelihood of a cyber security incident	Director of Transformation and Informatics	01.09.2019	no action taken	Subject to Digital Funding from WG which is still awaited In anticipation of WG funding resources are being recruited to in November 2019	Audit open over 6 months
142	2018-19	Cyber Security	Director of Transformation and Informatics	H	Active monitoring should be established. A Cyber response plan should be developed.	The creation of new cyber security roles in the restructured directorate will mean that a proactive stance on monitoring of cyber security is created as part of a wider Cyber response plan, which will also incorporate use of the NESSUS and SIEM solutions.	Director of Transformation and Informatics	01.09.2019	No action taken	Subject to Digital Funding from WG which is still awaited In anticipation of WG funding resources are being recruited to in November 2019	Audit open over 6 months
143	2018-19	Cyber Security	Director of Transformation and Informatics	M	A formal, resourced plan for the removal of old software and devices should be established.	A formal plan is in the early stages of production and will address removal of aged and insecure software as well as devices. This will be implemented by the cyber security team proposed in the new directorate structure.	Director of Transformation and Informatics	01.07.2019	Partially complete	A contract is in place with incumbent supplier which documents the processes and form sthe basis of the plane	Audit open over 6 months
144	2018-19	Cyber Security	Director of Transformation and Informatics	M	A formal patch management procedure should be developed that sets out the mechanisms for patching / updating all items within the Health Board.	Patching of PCs is being investigated as time allows to identify the scale of the risk. A patch management procedure will be developed to address patching of all devices. This procedure will describe how patches and updates will be managed, with reference to the national standards and alerts managed through NWIS.	Director of Transformation and Informatics	01.09.2019	Partially complete	A deployment programme is underway and patching / updated are included as part of this programme.	Audit open over 6 months
145	2018-19	Cyber Security	Director of Transformation and Informatics	M	The IT Security Policy should be reviewed and updated.	The current IT security policy is scheduled to be reviewed to reflect changes in legislation, IT architecture and national policy.	Chief Operating Office	30.06.2019	Completed	This has been consolidaed into a single IG action plan which is being updaetd in preparation for the Digital and Health Intelligence Committee meeting on 3 December 2019	Audit open over 6 months
146	2018-19	MHRA Compliance	Chief Operating Officer	H	The current tracker should be effectively updated to ensure that the outstanding deficiencies are retified and an appropriate audit trail is maintained	The UHL (PSU) tracker has now been updated (3 June 2019) in future, accepted practice will be for any deficiencies identified through self-inspection, audit or via business inelligence e.g. regulatory inspection of other units or via a formal directice from MHRA (where new standards are implemented) will be raised as a new issue and tracked accordingly	Chief Operating Office	30.06.2019	Completed		Audit open over 6 months
147	2018-19	MHRA Compliance	Chief Operating Officer	M	Management will amend the tracker to ensure an appropirate audit trail on how actions are progressing.	The SMPU internal tracker has been amended to include the revised target date(s) for the 6 deficiences noted above. They will be annotated to include narrative for the reasons for delay and updated target date.	Chief Operating Office	31.07.2019	Completed		Audit open over 6 months
148	2018-19	MHRA Compliance	Chief Operating Officer	M	The terms of reference should be reviewed for appropriateness and staff should be reminded of the importance of attending and contributing to the compliaince and governance meetings. Management should also consider setting up an equivalent meeting for the Llandough site or extending the remit of the current meeting to cover SMPU and Llandough.	A single Compliance and Governance group for Pharmacy Technical Service i.e. UHL and SMPU had been agreed. The terms of refernce were orginally agreed before the establishment of a Clinical Diagnostic and Therapeutics	Director of Transformation and Informatics	01.06.2019	Completed		Audit open over 6 months
149	2018-19	MHRA Compliance	Chief Operating Officer	M	The risk register should be assessed for appropriateness and updated accordingly.	The Pharmacy Directorate Risk Register has been reviewed and ownership of individual sections clarified. This includes the technical services components and a monthly review/update included in the senior team meeting agenda. In addition, our internal process for handling and escalating risks associated with pharmacy and medicines management activities and review through the Clinical Board has been agreed.	Director of Transformation and Informatics	01.07.2019	Completed		Audit open over 6 months
150	2018-19	E-Advice	Director of Transformation and Informatics	M	Management should undertake an exercise to review and quantify benefits from the ongoing use of the e-Advice system to ensure benefits are maximised and the system is sufficiently supported and resourced.	With the resource available an exercise will be carried out to review and quantify the original key benefit identified in the project outline document 'a minimum of 10% avoidance of attendance in Outpatients is likely to be achieved by GPs implementing an e-advice service'. As part of the restructure process of the wider Digital team, we will look to increase our capacity for benefits realisation and evaluation. A wider benefits review will be carried as our service users recognise the benefits that e-Advice brings.	Director of Transformation and Informatics	01.07.2019	No action taken		Audit open over 6 months
151	2018-19	E-Advice	Director of Transformation and Informatics	M	Management should document the approach to testing and implementing changes. This should include documentation of requirements around change categorisation, the extent of testing required, the approval process, the approach to rolling back changes, and criteria to be used when assigning a severity to changes.	There are processes in place to manage testing, approvals, roll back and assigning a severity to changes which allow for a quick response. It is recognised that these processes have lacked some formality due to the resource available. However work has already started on formal cumentation to support ease of handover to other members of the department. This will be light-touch, with minimum documentation, aimed at supporting the change and testing process without being overly bureaucratic.	Director of Transformation and Informatics	01.06.2019	No action taken		Audit open over 6 months
152	2018-19	E-Advice	Director of Transformation and Informatics	M	A regular, at least annual, exercise should be undertaken to confirm the validity of user accounts and ensure any leavers accounts are identified and disabled.	A report to identify account inactivity of 90 days will auto-run daily following which inactive accounts will be closed. Accounts can be reactivated on request.	Director of Digital and Health Intelligence	24.05.2019	Partially complete		Audit open over 6 months
153	2018-19	E-Advice	Director of Transformation and Informatics	L	Management should consider the use of local e-Advice super users.	The team are looking at ways to relieve the administration workload on them. A service announcement will be sent out to all super users reminding them of the actions that they can carry out e.g. authorising of accounts, closing accounts. New users are now able to self-register. Super users will be encouraged to take an increased role in user acceptance testing.	Director of Digital and Health Intelligence	30.09.2019	Partially complete		Audit open over 6 months

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154	2018-19	UHB Transformation Process	Director of Digital and Health Intelligence	M	The Transformation Enabler Steering Group should consider including nominated Clinical Board Leads to contribute directly into each Enabler where appropriate and actively inform the development of progress.	Each enabler task and finish group links with Clinical Boards and have involvement of staff . We will review this with the Boards in order to improve engagement. We will consider whether a lead or link person from each Board would improve engagement.	Director of Digital and Health Intelligence	24.05.2019	Partially complete	Engagement across all of the transformation enablers is ongoing. Each lead for the enablers report on progress regularly at HSMB (which the clinical board leads attend). A good deal of engagement activities are taking place particularly around culture and digital transformation/strategy. Engagement around this whole program should be under constant review.	Audit open over 6 months
155	2018-19	UHB Transformation Process	Director of Digital and Health Intelligence	M	The Accessible Information Enabler should implement a formal Task and Finish Group that oversees and provides governance of delivery of the Enabler's objectives and interfaces with the Transformation Enablers Steering Group.	The Accessible information enabler work is being reported to a number of different groups, which ensures oversight and assurance. These include HSMB, the "signals from Noise" steering group chaired by the CEO and the new Digital Design Group being established in October 2019 which will include membership from the Executive Management team and Clinical Boards. In addition, the accessible information enabler work will be reported into the new Digital & Health Intelligence committee, a new formal committee of the Board.			Partially complete		Audit open over 6 months
156	2018-19	UHB Transformation Process	Director of Digital and Health Intelligence	M	Progress relating to the Accessible Information Enabler should be recorded and reported via a monthly Highlight Report to the Transformation Enablers Steering Group in parity with the four other Enablers.	Following discussion between the ADI of Information and the steering group project manager, it is proposed that given the breadth and complexity of the accessible information enabler, the monthly reporting continues to be provided in the format that conveys the issues, actions and updates previously shared. This has been agreed with the AD of organisational change/transformation.	Director of Nursing	31.12.2019	Completed		Audit open over 6 months
157	2019-20	Standards of Business Conduct (DoI & GH&S) Follow-up	Director of Corporate Governance				Director of Planning	30.09.2019			
158	2019-20	Annual Quality Statement	Executive Nurse Director	L	The department should consider incorporating an accuracy check of all data into the AQS timetable, which should be done as late as possible in the AQS process.	The Patient Safety and Quality team will introduce a process whereby there is time set aside (and included within the timetable) to undertake all the necessary data quality checks, before the final version is agreed. This will be included in the paper to the December 2019 QSE Committee.	Chief Operating Officer	01.04.2019	COMPLETED	This is carried out as a matter of routine before the final draft is approved.	audit open over 12 months
159	2019-20	Carbon Reduction Commitment	Director of Planning	M	The UHB should ensure that the strategy is agreed as soon as possible so that the surplus allowances can be sold for the best achievable price.	The UHB will be agreeing the strategy regarding the course of action to be adopted for surplus allowances during August 2019.	Director of Planning	Immediately	No action taken		Audit open over 6 months
160	2019-20	Mental Health Clinical Board - Sickness Management Follow-up	Chief Operating Officer	H	Management should ensure that the sickness triggers are being managed correctly with informal discussions and formal sickness interviews being carried out in accordance with the All Wales Sickness Policy.	Directorates to send "trigger table" out to all managers, reminding them to check with line managers if they have any doubt or queries with individual cases. Senior Nurse Managers to conduct random sickness file checks as part of 1:1 with managers.	Director of Planning	31.10.2019	Partially complete		Audit open over 6 months
161	2019-20	Specialist Clinical Board - Rosterpro	Chief Operating Officer	H	Management should ensure employees contracted hours are managed appropriately.	As a Directorate Management Team we welcome the audit and accept its recommendations. As we recognise we can't change some of the findings detailed above, our focus has been upon implementing new systems and	Chief Operating Officer	01.09.2019	Complete - monthly review and remedial action if required in place		Audit open over 6 months
162	2019-20	Specialist Clinical Board - Rosterpro	Chief Operating Officer	M	A process map should be devised and distributed to appropriate staff. This should include a robust system for utilising staff with negative balances prior to booking bank or agency staff.	Process map will be devised and distributed to all Critical Care Flow Coordinators by Lead / Senior Nurse.	Chief Operating Officer	27/08/19 30/09/19	Complete -process map written, sharted and used across the Directorate	Review scheduled for December 2019	Audit open over 6 months
163	2019-20	Specialist Clinical Board - Rosterpro	Chief Operating Officer	M	Management should remind staff that accurate and up to date records are to be kept at all times.	New ways of working have been instigated across Critical Care since May 2019, with Band 7's having clearly defined duties and accountability for the production and maintenance of accurate records. Oversight of the records and rostering is now a key component of the Senior Nurse and Band 7 1:1 meetings that occur on a monthly basis, with review of the efficacy and impact of the new system scheduled for December 2019.	Director of Corporate Governance	01.02.2019	Completed	Review scheduled for December 2019	Audit open over 12 months
164	2019-20	Specialist Clinical Board - Rosterpro	Chief Operating Officer	L	Optimum requirements for Llandough will be reviewed and if necessary updated appropriately.	Staffing levels at Llandough have been reviewed since the time of the audit. As a result a 1wte Band 7 has been added to the establishment for UHL.	Director of Corporate Governance	01.02.2019	Complete - ITU no longer provide a service at UHL		Audit open over 6 months
165	2019-20	Legislative / Regulatory Compliance	Director of Corporate Governance	M	The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Agreed	Director of Corporate Governance	01.02.2019	Partially complete		Audit open over 6 months
166	2019-20	Legislative / Regulatory Compliance	Director of Corporate Governance	M	The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers.	Agreed	Chief Operating Officer	01.05.2019	Partially complete		Audit open over 6 months
167	2019-20	Legislative / Regulatory Compliance	Director of Corporate Governance	M	The Corporate Team should re-evaluate the Report to ensure that all the necessary information required to maintain a comprehensive list is in place. The Corporate Team should also review the standard email that is sent out to ensure that all the required information is requested. They should also pursue those who have not provided the relevant information.	Recommendation agreed	Director of Planning	Immediately	Partially complete		Audit open over 6 months
168	2019-20	Mental Health Clinical Board - Sickness Management Follow-up	Chief Operating Officer	L	Management should remind ward staff that the recording of sickness dates should reconcile between sickness documentation and ESR, and all sickness dates should be accurately and consistently recorded.	All band 6 / 7 managers to attend refresher sickness training.	Director of Planning	31.10.2019	Completed		Audit open over 6 months
169	2019-20	Sustainability Reporting	Director of Planning	M	Evidence of the retrospective approval of the sustainability report by the Environmental Steering Group / Health & Safety Group and sign off by the Director of Capital Estates and Facilities should be provided to audit each year. The documented procedural guidance should be updated to reflect the actual review and approval process currently in place.	Future Sustainability reports will be approved and signed off at the Capital Estates and Facilities Health & Safety Group. Depending on timescales retrospective approval may need to be provided, however the approval and sign off of the report shall be documented in the relevant minutes of the group.	Director of Planning	Immediately	No action taken		Audit open over 6 months
170	2019-20	Sustainability Reporting	Director of Planning	M	The staff roles and responsibilities highlighted in the procedural guidance should be reviewed and updated as necessary. The guidance should be supplemented with detailed information on how to prepare each of the three mandatory tables.	Future Sustainability report guidance will be reviewed and updated for staff roles and responsibilities as necessary. Where necessary guidance will be supplemented with detailed information on how to prepare each of the three mandatory tables.	Chief Operating Officer	Completed	No action taken		Audit open over 6 months
171	2019-20	Sustainability Reporting	Director of Planning	M	Management should draw up a timetable each year to help ensure appropriate time is allocated for the sustainability report preparation, review process, audit, approval and submission to the Communications Team. The requirement to produce a timetable each year should be incorporated into the procedural guidance.	Once the timescale for the Sustainability report submission is known an indicative timetable will be developed. Timings however may change depending on when information is available for inclusion in the report and the availability of Officers to verify and audit information and data.	Chief Operating Officer	01.06.2020	No action taken		Audit open over 6 months

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172	2019-20	Mental Health CB - Third Sector Contractors	Chief Operating Officer	M	Third Sector Mental Health Providers – Contracting and Performance Management Arrangements' document and 'Mental Health Third Sector Commissioning Guide' should be revised to state the processes in place in respect of escalation of unresolved performance and/or service delivery issues in the event of non-compliance of terms stated within provider contacts.	Third Sector Commissioning Guide and Framework (revised) to reflect recommendation (Attached with this report)			Completed		Audit open over 3 months
173	2019-20	Mental Health CB - Third Sector Contractors	Chief Operating Officer	L	All future stakeholder engagement and consultation documentation should be retained and held with the contract specification documentation.	A new cycle of commissioning will begin in 2020 and the recommendation is noted and will be included in all future commissioning/tender processes. Commissioning tender process June 2020	Executive Medical Director	01.12.2019	Completed		Audit open over 3 months
174	2019-20	Claims Reimbursement	Executive Nurse Director				Executive Medical Director	01.11.2019			Audit open over 3 months
175	2019-20	Private and Overseas Patients	Executive Medical Director	H	All Directorates should be informed of the current Private Patient Agreement and Charging Forms that include 2019/20 tariffs and ensure that their respective Consultants who undertake private work should be using these forms and not those that relate to previous financial years so as to ensure accurate billing and recovery of Directorate costs incurred.	The UHB updates the private patient tariffs and agreement forms on its intranet and internet sites on an annual basis. Past changes to private patient requirements have been communicated through the UHB News Service and the Medical Directors Bulletin. The UHB's internet page has recently been updated to include the 2019/20 Private Patient Tariff. Moving forwards all Directorates will be notified of the current Private Patient Agreement and Charging Forms that include up to date tariffs on an annual basis to ensure that their respective Consultants who undertake private work are using the correct forms and not those that relate to previous financial years. A note will be relayed to all Directorates and the UHB News Service by the end of December 2019 to confirm where the relevant private patient forms and tariffs for 2019/20 can be found.	Executive Medical Director	01.03.2020	Complete and ongoing	Internet pages amended on October 7 2019. Revised tariff place on UHB intranet site. Intranet site has since been updated with the 2020/21 Tariff & Consultant Guide.	Audit open over 3 months
176	2019-20	Private and Overseas Patients	Executive Medical Director	M	The Private and Overseas Patients Office should promote and increase awareness relating to the existence of its intranet and internet web pages if it is to ensure that all UHB Directorates/Departments are conversant with the contents of its policy, procedures and their supporting documentation.	The Private and Overseas Patients Office will promote the existence of its intranet and internet web pages directly to Directorates by the end of November 2019 and annually thereafter. In addition a short note providing an overview of policy and procedures will be produced by the end of 2019/20 for distribution to Directorates on an annual basis.	Executive Medical Director	01.12.2019	Complete and ongoing	PC - Chart illustrating current overseas process relayed to Obstrtrics and Dermatology Directorates. Further update via News Service to be considered.	Audit open over 3 months
177	2019-20	Private and Overseas Patients	Executive Medical Director	M	The UHB Overseas and Private Patient internet pages should be updated to include the 2019/20 Private Patient Tariffs. and Given that a review of overseas and private patient tariffs has not been completed for a number of years, it is advisable that the UHB's Costing Team and Clinical Boards should liaise to undertake this exercise as soon as is practicable so as to ensure that service delivery costs are fully recovered.	The UHB Overseas and Private Patient internet page has now been updated to include the 2019/20 Private Patient Tariffs. The UHB's Costing Team and Clinical Boards should will be engaged so that a scope for the review of all tariffs can be agreed by the end 2019/20 with the aim of implementing the reviewed tariffs at the beginning of 2020/21.	Executive Medical Director	01.11.2019	Complete and ongoing	Complete - Internet pages amended on October 7 2019. The UHB's Costing Team has been engaged in a review of the current Private Patient Tariff. The review indicates that the UHB is recovering the costs of private patient treatment ; however recommended amendments to the Tariff were complete in time for incorpoartion within the 2020/21 Tariff.	Audit open over 3 months
178	2019-20	Private and Overseas Patients	Executive Medical Director	M	Private and Overseas Patients Office should ensure that fee information is made known to Directorates/Department at the commencement of each new financial year so as to maximise an increased awareness of its existence and use when required.	Moving forwards all Directorates will be notified of the current Private Patient Agreement and Charging Forms that include up to date tariffs on an annual basis ensure that their respective Consultants who undertake private work are using the correct forms and not those that relate to previous financial years. In addition a general notice will be published via the UHB news service.	Executive Medical Director	01.12.2019	Complete and ongoing	Process and revised 2020/21 Tariff identified on intranet and internet.	Audit open over 3 months
179	2019-20	Private and Overseas Patients	Executive Medical Director	M	The Private patient office should ensure that the Dermatology Directorate introduce formal processes to identify, ascertain and confirm overseas patient eligibility to access healthcare if they attend the clinics.	The Private patient office should ensure that the Dermatology Directorate introduce formal processes to identify, ascertain and confirm overseas patient eligibility to access healthcare if they attend the clinics.	Executive Medical Director	01.12.2019	Complete and ongoing	Complete. Email realying Audit findings sent to Directorate on 28.11.2018. Follow up relayed on February 24 2020.	Audit open over 3 months
180	2019-20	Private and Overseas Patients	Executive Medical Director	M	The Private and Overseas Patients Office should remind Directorates that an Overseas Patients Notification Form must be completed by the Consultant and submitted to the Private and Overseas Patients Office for each overseas patient seen, supported with documentary evidence of their residency entitlement to access free NHS treatment. The Private and Overseas Patients Office should formalise and regularly timetable the current processes to monitor and follow up on letters sent to those overseas patients that have received treatment and have not provided appropriate residency documentation to evidence their entitlement to free NHS care.	The Private and Overseas Patients Office will write to remind all Directorates that an Overseas Patients Notification Form along with any documentary evidence of their residency entitlement or insurance details must be completed by the Care Team and submitted to the Private and Overseas Patients Office for each overseas patient seen. The Private and Overseas Patients Office will formalise and regularly timetable the current processes to monitor and follow up on letters sent to those overseas patients that have received treatment and have not provided appropriate residency documentation to evidence their entitlement to free NHS care.			Complete and ongoing	All outstanding issues marked via brought forward column on Private patient - Oversea Database.	Audit open over 3 months
181	2019-20	Private and Overseas Patients	Executive Medical Director	M	The Private and Overseas Patients Office should implement and evidence documented quarterly reconciliation exercises in respect of its MS Access database to PMS and the debtors' ledger and of the database to activity data or review of aged debt statements as per the stated requirements of the Private Patients Procedure.	The Private and Overseas Patients Office will implement a Control Pack that evidences: quarterly reconciliation exercises in respect of the MS Access database; PMS and the debtors' ledger; the database to activity data; and a review of aged debt statements.			Complete and ongoing	All outstanding issues marked via brought forward column on Private patient - Oversea Database.	Audit open over 3 months

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182	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	H	Clinical Boards must ensure that all consultants complete a job plan or have their existing job plan reviewed on an annual basis.	1. Processes are in place to support the completion and reporting of job planning activity. There is monthly reporting of the annual job planning process via the Clinical Board Performance reviews. There has been recent improvement in a small number of Clinical Boards. Immediate steps will be taken by the Medical Director and the Director of Workforce to target those Clinical Boards with poor performance and those not significantly improving (5 out of 8) to request an improvement plan which will ask for reported improvement in annual job planning review rates over a period of three months. Clinical Board Directors should ensure that the Clinical Directors take responsibility for these being undertaken and have internal Clinical Board systems to monitor improvement. 2. The Medical Director and Workforce Director will present to the HSMB in June 2018 the outcome of the Internal Audit Report - outlining the actions to be taken and re-emphasise the information available to the Clinical Boards and Clinical Directorates.	Executive Medical Director		no action taken	25.06.20 - due to the Covid Pandemic progress has been frozen until now - new Task and finish group established to implement e Job Planning solution	Audit open over 6 months
183	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	H	The UHB job planning guidance should require consultants to use the standard Job Plan template contained within the guidance unless they can provide a valid reason for not doing so. Job Planning documentation should be completed in full and should include full details of the activities to be undertaken in each session. Line managers should ensure that the number and split of sessions recorded in ESR agrees to and is supported by a fully completed job plan.	1. Clinical Board Directors and Clinical Directors should ensure that summary job plans data are submitted to the Medical Workforce Team on a regular basis so that updates can be made in the ESR system. This will be recognised by implementation of actions in Management Recommendation 1 in terms of outcomes. 2. Medical Workforce to update ESR system with summary job plan data – this has been already reviewed by the Medical Director and Director of Workforce recently and there is no back-log of data to currently input into the system (maximum wait two weeks). Clinical Directors/DM will be able to submit to ESR and their data will be entered in a timely way. The previous guidance issued will be immediately reissued to Clinical Board Senior Teams for cascade to their Clinical Directorates.	Executive Medical Director		no action taken	25.06.20 - due to the Covid Pandemic progress has been frozen until now - new Task and finish group established to implement e Job Planning solution	Audit open over 6 months
184	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	H	Clinical Board management must ensure that all consultants complete the outcome measures template contained within the UHB Job Planning guidance as part of the job planning process.	1. Review of job planning guidance with regard to job plan template and re-issue to Clinical Board Senior Teams for cascade to their Clinical Directorates. 2. The Medical Director and Workforce Director will present to the HSMB in June 2018 the outcome of the Internal Audit Report - outlining the actions to be taken and re-emphasise the information available to the Clinical Boards and Clinical Directorates.	Executive Medical Director		no action taken	due to the Covid Pandemic progress has been frozen until now - new Task and finish group established to implement e Job Planning solution	Audit open over 6 months
185	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	H	In accordance with the guidance, Clinical Board management should ensure that individual, personalised schedules are completed for all consultants that are on Team or Annualised Hours Job Plans.	Review of job planning guidance with regard to job plan template and re-issue to Clinical Board Senior Teams for cascade to their Clinical Directorates. This will emphasise the need for all members of a team to complete individually the team job plan.	Executive Medical Director		no action taken	25.06.20 - due to the Covid Pandemic progress has been frozen until now - new Task and finish group established to implement e Job Planning solution	Audit open over 6 months
186	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	L	The UHB should consider developing additional methods of communication and / or training for both line managers and consultants to improve the completion rate and quality of consultant job plans.	A planned schedule for training should be refreshed and communicated, including sources of information available to Clinical Directors. **Implemented.** Evidence was provided to confirm that a series of training sessions detailing the findings from the original audit was delivered by the Assistant Medical Director (Medical Workforce and Revalidation).	Executive Medical Director		no action taken	25.06.20 - due to the Covid Pandemic progress has been frozen until now - new Task and finish group established to implement e Job Planning solution	audit open over 6 months
187	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	M	All completed job plans must be signed by the Consultant and the clinical manager responsible for agreeing them. The standard Job Plan documentation included in the UHB Job Planning guidance should be updated to incorporate the use of digital signatures.	1. The job plan review does not require an actual signature but there does need to be a record of the job plan being agreed by all parties and signed. 2. An electronic job planning system will be trialled in Cardio Thoracic should provide a seamless and electronic system solution in the future, pending evaluation of the pilot and consideration of costs. This will include the ability for electronic sign off.	Executive Medical Director		no action taken	25.06.20 - due to the Covid Pandemic progress has been frozen until now - new Task and finish group established to implement e Job Planning solution	Audit open over 6 months
188	2019-20	Tentacle IT System	Director of Transformation and Informatics	H	The database should be updated to the latest, supported version.	Due to the work ongoing to replace Tentacle, Management do not agree with the recommendation to update the database to the latest version given the fact thata formal project is underway to replace Tentacle within the next 18 months. Whilst not accepting the recommendation to upgrade to the latest version, it is accepted that the database should be on a version that is supported. The data base has recently been updated, therefore, to version 2013 – where the end date of mainstream support is 10/04/2023.	Director of Transformation		Completed		Audit open over 6 months
189	2019-20	Tentacle IT System	Director of Transformation and Informatics	M	The level of recording of developments and changes to Tentacle should be improved. At a minimum the record should record what change was made, the date of testing, staff involved with UAT and a formal agreement of user acceptance.	Agreed. A record is now maintained of changes made. The User Acceptance Testing process will be agreed and added into this record.	Director of Transformation		Completed		Audit open over 6 months
190	2019-20	Tentacle IT System	Director of Transformation and Informatics	M	The use of generic accounts should be restricted. Staff who have left the UHB should be removed from the system.	Generic Accounts – Generic Accounts for Tentacle are already restricted. They are tied to an individual PC in a controlled room – for MDT purposes. Management agree that staff who have left the UHB should be removed from having access to the Tentacle system.	Director of Transformation		Completed		Audit open over 6 months

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191	2019-20	Tentacle IT System	Director of Transformation and Informatics	M	Tentacle and its associated databases should held in a secure location on UHB network.	Management partially accept this recommendation due to the technicalities of access to Tentacle. Tentacle users need access to the folder where the database is stored to be able to access Tentacle. It is, therefore, not possible to restrict access completely. It should also be noted that the database is password protected – therefore affording security around inappropriate access to the system. Given the technicalities, Management will explore whether access to the folder can be limited to Tentacle Users only.	Director of Transformation		Completed		Audit open over 6 months
192	2019-20	Tentacle IT System	Director of Transformation and Informatics	M	The future use of office software should be established to ensure Tentacle remains viable until a replacement is developed.	The use of Tentacle will be considered as part of the roll out of updated office software.	Director of Transformation		Completed		Audit open over 6 months
193	2019-20	Tentacle IT System	Director of Transformation and Informatics	M	The process for loading information into Tentacle on a daily basis should be set out in a procedure, together with the required passwords for access. This should be available to key staff in the event of the Tentacle leads being absent.	Agreed. A Standard Operating procedure will be developed.	Director of Transformation		Completed		Audit open over 6 months
194	2019-20	Tentacle IT System	Director of Transformation and Informatics	M	The load process should be amended to identify items that have not loaded. E.g. by including a batch check against items to load and loaded items in order to identify instances where items have not successfully loaded.	Agreed. The process will be amended and Standard Operating procedure will also include the process for error checks.	Director of Transformation		Completed		Audit open over 6 months
195	2019-20	Tentacle IT System	Director of Transformation and Informatics	L	If the system is to be continued to be used, then system documentation should be developed.	The system is being replaced within a planned 18 month timescale. Management do not feel resource should be expended on writing documentation. It should be noted that code within the system has been annotated as a back-up.	Director of Transformation		Completed		audit open over 6 months
196	2019-20	Tentacle IT System	Director of Transformation and Informatics	L	Brief user guides should be developed for the system.	The system is being replaced within a planned 18 month timescale. Management do not feel resource should be expended on writing a detailed user guide. A brief user guide will be developed for the interim period.	Director of Transformation		Partially complete	Tentacle system on PMS - access controlled	audit open over 6 months
197	2019-20	Budgetary Control	Director of Finance	M	Delegated Budget Holders should sign-up to their delegated budget annually.	This specific issue was considered as part of the Deloitte's Financial Governance review and was not supported due to anticipated unintended consequences.	Director of Finance		No action taken		Audit open over 3 months
198	2019-20	Brexit Planning	Director of Planning	H	The business continuity arrangements within Mental Health should be further reviewed, scrutinised, approved and embedded within the Clinical Board.	Draft business continuity plans completed and circulated within Mental Health, and shared with EPRR Team. The Clinical Board is holding a Business Continuity Exercise for mental health leads, facilitated by EPRR (30.03.20); with aims to review local preparedness planning and enhance organisational resilience in case of disruption to the organisation's critical services. Business continuity also a standing agenda item on the MHCB Health and Safety meetings.	Director of Finance		No action taken		Audit open over 3 months
199	2019-20	Brexit Planning	Director of Planning	M	Management information surrounding areas of lower compliance should be distributed to the clinical/service boards and staff should be encouraged to complete the nationality section on ESR.	Work will continue to address the information gap by encouraging Clinical and Service Boards to encourage their staff to update their information. The Head of Workforce Governance will provide, if required, information on a Directorate or Department basis of staff whose nationality is blank on ESR. In addition, Workforce and Organisational Development have determined the email addresses of 2,148 of the 4,467 staff. Individual emails, with a step by step guide, have been sent to the 2,148 staff encouraging them to update their nationality on ESR.	Director of Finance		No action taken		Audit open over 3 months
200	2019-20	Brexit Planning	Director of Planning	M	Staff should be reminded to the importance for attending meetings.	Group members are committed to attending meetings. However, existing work commitments, no-notice issues and winter pressures have all contributed to a slight reduction in the expected attendance. If/when the group reconvenes later in 2020, the membership will be reviewed, deputies nominated, and the importance of regular representation emphasized again.	Director of Finance		No action taken		Audit open over 3 months
201	2019-20	Brexit Planning	Director of Planning	L	Going forward, if there is a requirements for daily reporting in the future; all required areas of the Health Board should complete the required forms.	UK/Welsh Government reporting focussed on the key areas of Medical Devices/Clinical Consumables, General Supplies and Workforce. As such – the key areas for concern were primarily Clinical Boards – hence the requirement for daily reporting. However, the recommendation is noted.	Director of Finance		No action taken		audit open over 3 months
202	2019-20	Safeguarding Adults and Children	Executive Nurse Director	H	Management should ensure that Clinical Boards put the appropriate actions in place with a view to ensuring compliance rates are improved to meet the 85% compliance rate that has been set by Welsh Government. Management should also ensure that actions taken are reported back to the Safeguarding Steering Group and appropriately recorded.	Safeguarding Training is a standard item on the agenda at the Safeguarding Steering Group Meeting (SSG). Training figures are circulated with the agenda prior to the meeting and discussed at the meeting. Poor Clinical Board representation at the meeting may account for the lack of improvement in the overall figures for each Clinical Board, this will be addressed by the Deputy Executive Nurse Director at a meeting with the Clinical Board Directors of Nursing in January. Furthermore the implementation of the Value Based Appraisal from April 2020 should ensure that staff are compliant with their Mandatory Training to receive any pay awards through annual increments. Compliance will continued to be monitored within the SSG meeting with an expectation that improvements be made. Ownership of the Mandatory Training must be the responsibility of Clinical Boards to ensure compliance. Head of Safeguarding to monitor through SSG. This will be on-going and escalated to the Executive Team if no improvement is evident. It is noted that the compliance to all Statutory and Mandatory training is a will documented risk to the UHB due to the challenge of releasing clinical staff.	Executive Nurse Director		COMPLETED		Audit open over 3 months
203	2019-20	Safeguarding Adults and Children	Executive Nurse Director	H	Management should ensure that all Clinical Boards are reminded of the requirement to provide appropriate representation at Safeguarding Steering Group Meetings. On-going attendance should then continue to be monitored to ensure appropriate attendance is maintained.	The Deputy Executive Nurse Director will address this with Directors of Nursing (DON) in January 2020. DON's will be reminded that safeguarding should be a standard item at Quality & Safety meetings to ensure information is shared and disseminated within each directorate of the Clinical Board. Clinical Boards will be asked to provide evidence of a sample agenda from their Q & S meeting to share at the SSG. Improved attendance noted at January 2020 meeting. All but one Clinical Board represented. Deputy Executive Nurse Director to re contact Clinical Board representation.	Executive Nurse Director		COMPLETED		Audit open over 3 months

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1	Financial Year Fieldwork Undertaken	Audit Title	Executive Lead for Report	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update	Status of Report Overall
204	2019-20	Safeguarding Adults and Children	Executive Nurse Director	L	Management should ensure that evidence to support safeguarding responsibilities is readily accessible should it be required at a future point in time.	Each Clinical Board is responsible for ensuring that safeguarding information is available to staff employed within their area. Staff should have access to a computer to access UHB safeguarding pages and training resources on the intranet, where this is not available other arrangements should be made by departments within the Clinical Board. The UHB Safeguarding Team has shared an information poster with Clinical Boards in the last two years and undertaken a small audit of staff and student awareness of their understanding of safeguarding themes, UHB responsibilities and awareness of the Regional Safeguarding Board previously. This audit will be repeated during 2020 to ensure awareness is maintained. However the Safeguarding Team cannot take responsibility for information included in practitioner roles and responsibilities identified in individual job descriptions. Safeguarding is everybody's responsibility. Directors of Nursing for each Clinical Board and HR representatives ensure that individual job descriptions have safeguarding included as part of roles and responsibilities for all staff.	Executive Nurse Director		COMPLETED		audit open over 3 months
205	2019-20	Safeguarding Adults and Children	Executive Nurse Director	L	Management should ensure that the Terms of Reference for the Safeguarding Steering Group are reviewed and approved on an annual basis and appropriately evidenced.	The Head of Safeguarding acknowledges that there was no evidence in the minutes to support that the ToR had been discussed at the January 2019 SSG meeting, although a copy was available along with other papers to be discussed at the meeting. It is also acknowledged that the footnote for the ToR had not been updated to evidence that the copy held in the folder was a new copy. This will be addressed at the January 2020 meeting. Head of Safeguarding will ensure that the ToR are signed off for 2020 at the SSG meeting in January 2020 and evidenced in the minutes.	Executive Nurse Director		COMPLETED		audit open over 3 months
206	2019-20	Freedom of Information	Director of Transformation and Informatics	H	The Health Board should take steps to ensure the continuity of the FoI management function, and that all necessary knowledge and expertise currently being utilised is able to be retained, especially if/when personnel changes occur.	Both of the fixed term contracts are being addressed and are being made permanent in the new Digital structures.	Director of Transformation		Partially complete	JDs agreed - recruitment to perm posts being done in July (Covid-19 caused delay)	Audit open over 6 months
207	2019-20	Freedom of Information	Director of Transformation and Informatics	H	NHS Wales Audit & Assurance Services Page | 11 Finding 2–Quality Control (Control design) Risk There are weaknesses in the collation and release of responses ▪ there is no formal approval to release the response by a senior officer as set out in the SOP; and ▪ there is no formally described quality assurance process operating that includes a review of response prior to approval and ensures the completion of all necessary records. This increases the risk that inaccurate, incomplete, or inappropriate responses are issued to the public. Non-compliance with FoI Recommendation Priority level The disclosure log is fully complete; and ▪ The QA is digitally signed and dated. All responses should be formally approved prior to release.	QA process has now been created by the UHB's FOI lead and is in use, with all the noted bullet points incorporated into the QA process.	Director of Transformation	COMPLETE	Completed		Audit open over 6 months
208	2019-20	Freedom of Information	Director of Transformation and Informatics	M	The FoI Policy and Written Procedures documents should be reviewed and updated as necessary to fully comply with current legislation, and ratified and accepted by the Board.	FOI Procedure approved and uploaded to both internet and intranet. IG Policy submitted for ratification at DHIC.	Director of Transformation	COMPLETE	Completed		Audit open over 6 months
209	2019-20	Freedom of Information	Director of Transformation and Informatics	M	The tracking and monitoring process should be improved by the addition of: ▪ a 'triage' process for all requests, initial consideration of likely exemptions, redactions, and time and cost; ▪ categorisation of requests by main topic areas; ▪ record of time taken to complete for each stage of the request; ▪ recording names of internal staff contacted, dates of contact, response, 'chase up'; and ▪ clear identification and 'linking' of linked or follow up requests on the control sheet.	▪ Incorporated into QA process created for 2b. ▪ FOI Log lists the relevant department and a brief description of topic. ▪ The IG team catalogues all correspondence relating to FOI requests. ▪ The IG team catalogues all emails relating each FOI, using a convention that enables the team to pick up where others have left off. ▪ Incorporated into QA process created	Director of Transformation	COMPLETE	Completed		Audit open over 6 months
210	2019-20	Freedom of Information	Director of Transformation and Informatics	M	Service departments / Clinical Boards should be reminded of the legal obligation to provide information. The timescales for providing information should be monitored by the FoI lead and should responses not be received this should be escalated promptly. Where departments are consistently delaying the process this should be reported to the DHIC.	FOI lead has an email drafted to go to HODs, DMs and frequent info providers stating the ICO's intent to use enforcement to implement Openness by Design. Compliance is monitored by the FOI lead and discussed in weekly IG meeting (along with problematic requests). Escalation is incorporated into the QA process.	Director of Transformation	COMPLETE	Completed		Audit open over 6 months
211	2019-20	Freedom of Information	Director of Transformation and Informatics	L	A simple numbering scheme should be applied where multiple documents are posted in response to a request. E.G. FoI/19/174-1 FoI/19/174-2 FoI/19/174-3	The IG team has adopted a numbering convention as suggested.	Director of Transformation	COMPLETE	Completed		audit open over 3 months
212	2019-20	Freedom of Information	Director of Transformation and Informatics	L	FoI certification or additional FoI training should be available for team members whose role involves processing and answering FoI requests.	FOI lead in discussion with NWIS re national approach to training.	Director of Transformation		No action taken		audit open over 3 months
213	2019-20	Consultant Annual Leave - CW CB	Chief Operating Officer	M	The UHB Annual Leave Policy for Career Grade Medical & Dental Staff should be reviewed and revised. The policy should more clearly specify: ▪ roles and responsibilities; ▪ treatment of consultants different working practices (see Recommendation 3); ▪ monitoring and reporting arrangements ▪ extending detail on leavers, sickness, bank holidays etc. ▪ update the manual leave form to include entitlement and days taken to date.	UHB Annual Leave Policy will be reviewed in light of these comments and taken back to LNC for agreement	Chief Operating Officer		Completed		Audit open over 3 months

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214	2019-20	Consultant Annual Leave - CW CB	Chief Operating Officer	M	Pro-forma procedures for administering annual leave and study leave should be drawn up and shared with Directorates for them to customise to their particular circumstances. Such procedures could also include good practice, dos & donts and other useful advice as well as designate an administrative back-up.	Further guidance to ensure consistency will be agreed with Directorates and overseen by the Intrepid User Group and overseen by the Medical Workforce Advisory Group	Chief Operating Officer		Completed		Audit open over 3 months
215	2019-20	Consultant Annual Leave - CW CB	Chief Operating Officer	M	Review and evaluate the impact of compressed annual leave. If arrangements are changed build in to Policy	Discuss with LNC and build guidance in to the policy to reflect best practice around compressed leave and entitlement within intrepid	Chief Operating Officer		Completed		Audit open over 3 months
216	2019-20	Consultant Annual Leave - CW CB	Chief Operating Officer	M	Directorate administrative arrangements should be reviewed and strengthened in line with the revised Policy and as a part of producing operational procedures. Procedures should include the checking of core data on an annual or rolling basis.	Intrepid User Group will oversee implementation of revised guidelines in the Areas highlighted in this report	Chief Operating Officer		Completed		Audit open over 3 months
217	2019-20	Consultant Annual Leave - CW CB	Chief Operating Officer	M	Directorates should identify and assess the use of all local spreadsheets of operational services making sure access is available via shared drives	Clinical board Head of Operations will ensure Directorates utilise appropriate ancillary spreadsheets if Intrepid does not align with local requirement and ensure Shared drive access is appropriately implemented.	Chief Operating Officer	01.07.2020	Completed		Audit open over 3 months
218	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	M	The UHB Study Leave Procedure for Medical & Dental Staff should be reviewed and revised. The policy should more clearly specify: ▪ roles and responsibilities – of Directorates, Managers, Consultants; ▪ funding and budget guidance. ▪ monitoring and compliance arrangements including KPIs; and ▪ reporting arrangements. Once updated, the procedure flow chart that is appended should also be updated accordingly.	UHB Study Leave procedure document will be reviewed and strengthened in the areas outlined in the report. This will require agreement with the Local Negotiating Committee (LNC) of the UHB.	Director of Workforce and Organisation Development	01.07.2020	No action taken	No progress due to COVID-19 - proposed new date 01/09/20	Audit open over 3 months
219	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	M	Pro-forma procedures for administering consultants study leave and annual leave should be drawn up and shared with Directorates for them to customise to their particular circumstances. Such procedures could also include good practice, dos & don'ts and other useful advice as well as designate an administrative back-up.	Enhanced Guidance will be provided for Directorates on interpretation of types of leave and their level and status of approval. This can then be consistently applied and adapted to local circumstances and will need to be agreed with the LNC.	Director of Workforce and Organisation Development	01.07.2020	No action taken	No progress due to COVID-19	Audit open over 3 months
220	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	M	Directorate administrative arrangements should be reviewed and strengthened in line with the revised Health Board Procedure and as a part of producing local operational procedures, particularly the recording of clinical authorisation on Intrepid. Procedures should include the checking of core data on an annual or rolling basis	Comprehensive Review of local processes Directorate by Directorate will take place to ensure consistency of process with UHB Procedures and guidance	Director of Workforce and Organisation Development	01.09.2020	No action taken	No progress due to COVID-19	Audit open over 3 months
221	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	M	The following arrangements are reviewed and strengthened:- ▪ budget setting, monitoring and reporting; ▪ payment of honorary staff expenses; and ▪ ability to access Trust funds to support study leave budgets.	Capped annual or triannual budget allocations are to be introduced after discussion with the LNC. Honorary Academic Consultants are contractually entitled to 0.6 of this annual or triannual allocation as per contract terms and conditions. Once capped allocation agreed consistent budget line allocation will be anticipated against which spend can be measured.	Director of Workforce and Organisation Development	01.09.2020	No action taken	No progress due to COVID-19	Audit open over 3 months
222	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	M	Assess and review the use of Intrepid as a tool for managing activities other than junior doctors and formulate a plan going forward.	Intrepid approval system enables approver to view a 'team' leave view that facilitates approval only where cover for clinical services can be managed and Intrepid will not allow leave application unless cover has been agreed by a named colleague. The UHB is currently considering options for e rostering of Medical Staff etc within the Medical Productivity Project alongside e job planning.	Director of Workforce and Organisation Development	01.12.2020	No action taken	No progress due to COVID-19	Audit open over 3 months
223	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	M	Develop the Intrepid User Group to co-incide with the introduction of the updated Health Board Procedure and local operational procedures. Besides regularising practices, the group could be a forum to identify development opportunities and good practice. The ability of the system to generate 'team views' and reports should be considered as well. Once updated, the authorisations should be checked annually. A Terms of Reference should be put in place and all meetings should have minutes and action plans.	Intrepid User Group will be refreshed with revised TOR and membership. Minutes of meetings and associated Action plans will be reviewed by the Medical Workforce Advisory Group	Director of Workforce and Organisation Development	01.07.2020	No action taken	No progress due to COVID-19 - proposed new date 01/09/20	Audit open over 3 months
224	2019-20	Control of Contractors	Director of Finance	M	RAMS (where applicable) should be requested and retained prior to the contractor commencing the relevant activity on site (O)	Accepted. RAMS will now be incorporated within the database implemented in January 2020. It will be the Engineering Manager's responsibility to review the database on a weekly basis to ensure the required suite of RAMS is evident. A sample check of the database will be undertaken on a monthly basis by the Health & Safety and Asbestos Manager, to ensure compliance and reported to the Capital, Estates & Facilities Department Health & Safety Meeting. The first compliance check will be reported to the March 2020 meeting.	Director of Finance	01.03.2020	No action taken		Audit open over 3 months
225	2019-20	Control of Contractors	Director of Finance	L	Management should undertake a data cleansing exercise of the Backtraq system (O)	Accepted. An initial review of the database, in consultation with the relevant officers within the Capital, Estates & Facilities department, will be undertaken to remove any contractors that have not been used in the past three years. The remaining contractors will then be reviewed accordingly.	Director of Finance	01.10.2020	No action taken		audit open over 3 months
226	2019-20	Control of Contractors	Director of Finance	M	Induction content should be reviewed and updated to reflect current practice (O)	Accepted. The presentation will be updated to reflect current practice. The audit-visual presentation will be audible version of the induction will be removed from use until any ambiguities in the narrative have been addressed. In the interim, physical presentations by UHB staff will be undertaken.	Director of Finance	01.03.2020	No action taken		Audit open over 3 months
227	2019-20	Control of Contractors	Director of Finance	M	Management should formally implement the database, across Capital, Estates & Facilities, as the main control for completion and retention of JRFs (D)	Accepted. The database was formally implemented in January 2020	Director of Finance		Complete		Audit open over 3 months
228	2019-20	Control of Contractors	Director of Finance	M	Management should roll-out appropriate training on JRF guidance including requirements for delegation of responsibility during periods of absence (O)	Accepted. All relevant Supervising Officers within the Capital, Estates & Facilities department have been trained on the usage of the database.	Director of Finance		Complete		Audit open over 3 months
229	2019-20	Control of Contractors	Director of Finance	M	The functionality of the Backtraq system should be reviewed for the timeliness and detail of the management information provided. (D).	Accepted. Initial discussions have been held with the software provider re: potential enhancements to the existing system. However, it is accepted that a standalone system for sign in/out would be more effective. Different options will need to be reviewed to determine an appropriate direction of travel.	Director of Finance	01.09.2020	No action taken		Audit open over 3 months

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1	**Financial Year Fieldwork Undertaken**	**Audit Title**	**Executive Lead for Report**	**Rec. Rating**	**Recommendation Narrative**	**Management Response**	**Executive Lead for Recommendation**	**Agreed Implementation Date**	**Please confirm if completed (c), partially completed (pc), no action taken (na)**	**Executive Update**	**Status of Report Overall**
230	2019-20	Control of Contractors	Director of Finance	H	A sign in/out system should be in place at each community site, using measures appropriate to the site, with ALL contractors required to action daily (O).	Accepted. As asbestos registers are maintained at each community site, these have been updated to include a requirement to evidence the date/time all contractor's sign in and out of the respective site.	Director of Finance		No action taken		Audit open over 3 months
231	2019-20	Control of Contractors	Director of Finance	L	A Permit to Work procedure should be developed, ratified and communicated to all relevant officers (D)	Accepted. The procedure is currently out for consultation and will be presented to the Capital, Estates & Facilities department Health & Safety meeting for ratification at the March 2020 meeting.	Director of Finance	01.03.2020	No action taken		audit open over 3 months
232	2019-20	Control of Contractors	Director of Finance	M	Management should collate the output of the contractor monitoring forms for reporting to an appropriate forum; for actions to be taken where required. (O)	Accepted. In the role of Framework Manager, the Head of Discretionary Capital & Compliance, will initially hold six-monthly review meetings with all contractors addressing the recommendation requirements; and subsequent frequency will be dependent on how often the contractor is used by the UHB. However, all will have an annual review meeting.	Director of Finance	01.09.2020	No action taken		Audit open over 3 months
233	2019-20	Control of Contractors	Director of Finance	M	Formal post completion review meetings of contractor performance should be undertaken in accordance with HSE guidance (O)	Accepted, as per the response to recommendation 9.Accepted, as per the response to recommendation 9.	Director of Finance	01.09.2020	No action taken		Audit open over 3 months
234	2019-20	Control of Contractors	Director of Finance	M	An annual audit of compliance with the policy should be completed and reported to an appropriate forum. (O)	Accepted. Discussions will be held with the Head of Health & Safety with a view to enhance the data that is reported to the Health & Safety Committee within the Annual Report.	Director of Finance	01.06.2020	No action taken		Audit open over 3 months

Audit	(All)
Audit Log Ref No.	(All)

Audit Title	Rec No.	Executive Lead for Report	Recommendation Narrative	Management Response	Status of Report Overall
Annual Quality Statement	R1/1	Executive Nurse Director	The department should consider incorporating an accuracy check of all data	The Patient Safety and Quality team will introduce a process whereby there is time s	(blank)
Business Continuity Planning Follow-Up	R1/1	Director of Planning	The significant, high priority, issue that remains from the original review can	Not Provided	Audit open over 12 months
Children & Women Clinical Board – Medical Staff Rotas a	R1/7	Chief Operating Officer	The Clinical Board will monitor the number of study days taken by medical s	Directorate Management Teams will be reminded to monitor the requests and appr	Audit open over 12 months
	R2/7	Chief Operating Officer	The profile and accountabilities in relation to study leave requirements need	Updated study leave procedures will be circulated to DMT and onwards to all medica	Audit open over 12 months
	R3/7	Chief Operating Officer	Staff will be reminded of their responsibilities when requesting and approvir	Updated study leave procedures will be circulated to DMT and onwards to all medica	Audit open over 12 months
	R4/7	Chief Operating Officer	Proactive monitoring will be undertaken to ensure all appropriate staff are u	Assurance to be provided through Directorate Performance Reviews from each DMT	Audit open over 12 months
	R5/7	Chief Operating Officer	Staff will be reminded of the procedural requirements and updates to stand	A review of the format of the claims forms used within C&W Clinical Board will be ur	Audit open over 12 months
	R6/7	Chief Operating Officer	Guidance should be produced and made available throughout the Clinical Bc	The current document will be reviewed and consideration given to broadening its sc	Audit open over 12 months
	R7/7	Chief Operating Officer	Management should remind staff around the requirements of the working t	The current requirements of the working time policy will be shared with all DMT and	Audit open over 12 months
Claims Reimbursement	(blank)	Executive Nurse Director	(blank)	(blank)	Audit open over 3 months
Clinical Diagnostic and Therapeutic Clinical Board – Banl	R1/4	Chief Operating Officer	The Clinical Board should develop a process to ensure that all overtime sessi	All departments have received a communication instructing them to amend their cu	Audit open over 6 months
	R3/4	Chief Operating Officer	The department should ensure that all agency shifts worked are appropriate	The management team associated with this department has been requested toprovi	Audit open over 6 months
	R4/4	Chief Operating Officer	Where staff work less than the Agenda for Change hours of 37.5 hours any a	This will form part of the SOP, and a reminder email will be sent to all departments	Audit open over 6 months
Commissioning	R1/3	Director of Transformation and Informatics	Strategic Commissioning Group Terms of Reference document should be rev	The Strategic Commissioning Groups Terms of Reference, including membership wa	Audit open over 12 months
	R2/3	Director of Transformation and Informatics	The Commissioning Team should as part of its ongoing programme of work	The development of the commissioning intranet pages, alongside commissioning toc	Audit open over 12 months
Continuing Health Care (CHC)	R2/8	Chief Operating Officer	A timescale should be set to ensure the Head of Service Agreement is agree	The Heads of Service agreement is being reviewed following the Operation Jasmin w	PARTIALLY COMPLETE
	R4/8	Chief Operating Officer	The Children CHC team should develop a local procedure that sets out how t	The Community Child Health Directorate will develop a local Operational Policy base	Audit open over 12 months
	R5/8	Chief Operating Officer	Individual Service User Agreements should be produced to cover health asp	The Community Child Health Directorate will agree a process for KPI's to be measur	Audit open over 12 months
Costing Review	R1/6	Director of Finance	Management will look to increase the level of clinical engagement througho	The PCB platform provides the UHB with an effective dashboard for analysing costin	Audit open over 12 months
	R2/6	Director of Finance	The concerns highlighted will be further investigated to ensure appropriate	Agreed.Costing is an exercise of mass data linkage reliant on basic administrative fur	Audit open over 12 months
	R4/6	Director of Finance	Management will ensure the future accuracy of costing return.	We agree that the statement was misleading as submitted, indicating that aspecific i	Audit open over 12 months
	R5/6	Director of Finance	Wider verification should be sought to ensure accuracy and increase engage	Agreed.There is an ongoing engagement with Clinical Boards to better understand cc	Audit open over 12 months
	R6/6	Director of Finance	Mechanisms will be established to monitor and report more widely on costi	This point is noted and it is accepted that the relationship between the UHB IMTP an	Audit open over 12 months
CRI Safeguarding Works	R1/5	Director of Planning	Progression at risk should be fully documented, approved and recorded at tl	Agreed.ALL FUTURE PROJECTS	Audit open over 12 months
	R2/5	Director of Planning	A Project Execution Plan should be prepared at the outset of a project, in ac	Agreed.ALL FUTURE PROJECTS	Audit open over 12 months
	R3/5	Director of Planning	Sufficient contractual arrangements should be in place to safeguard the Hea	Agreed.ALL FUTURE PROJECTS	Audit open over 12 months
	R4/5	Director of Planning	4) Project benefits should be clearly identified and documented in the busin	Agreed.ALL FUTURE PROJECTS	Audit open over 12 months
	R5/5	Director of Planning	5) The required approach to post project evaluation and benefits assessmen	Agreed.	Audit open over 12 months
Cyber Security	R1/8	Director of Transformation and Informatics	A review of the resources available within IM&T and the requirements of th	A review of the current IT and Information departments has been completed and a r	Audit open over 6 months
	R2/8	Director of Transformation and Informatics	An active monitoring process which feeds into KPI reporting should be devel	The restructure of the directorate includes additional resource to manage cyber secu	Audit open over 6 months
	R3/8	Director of Transformation and Informatics	Resources should be provided to allow for a cyber security role to be proper	The restructure of the IT and information functions being proposed will result inthe	Audit open over 6 months
	R4/8	Director of Transformation and Informatics	Active monitoring should be established.A Cyber response plan should be de	The creation of new cyber security roles in the restructured directorate will mean th	Audit open over 6 months
	R5/8	Director of Transformation and Informatics	A formal, resourced plan for the removal of old software and devices should	A formal plan is in the early stages of production and will address removal of aged ar	Audit open over 6 months
	R6/8	Director of Transformation and Informatics	A formal patch management procedure should be developed that sets out tl	Patching of PCs is being investigated as time allows to identify the scale of the risk. A	Audit open over 6 months
	R8/8	Director of Transformation and Informatics	The IT Security Policy should be reviewed and updated.	The current IT security policy is scheduled to be reviewed to reflect changes in legisla	Audit open over 6 months
Delayed Transfers of Care Reporting	R2/2	Chief Operating Officer	Due to the patient impact of delayed discharge, it would be beneficial to incl	Clinical Boards will be provided with the monthly DToC reportClinical Board Director	Audit open over 6 months
Delayed Transfers of Care Reporting	R1/2	Chief Operating Officer	The Medically Fit spreadsheet used to identify DToCs weekly is updated usin	The date of referral and compliance with time scales is checked verbally within the w	Audit open over 6 months
Dental CB – Dental Nurse Provision	R1/6	Chief Operating Officer	The Dental Nurse Management team should consider formalising ratios of D	To reduce duplication of lists, a meeting will be set up with Senior Dental Nurse's an	Audit open over 12 months
	R2/6	Chief Operating Officer	The Dental Nurse Management team should consider bringing forward the r	To reduce duplication of lists, a meeting will be set up with Senior Dental Nurse's an	Audit open over 12 months
	R4/6	Chief Operating Officer	It is recommended that the Senior Dental Nurses maintain a log that docum	Implement feedback tool; that will be used to collect weekly changes that take place	Audit open over 12 months
	R5/6	Chief Operating Officer	The Senior Dental Nurse weekly meeting should continue to function in orde	The weekly Senior Dental Nurse meeting will continue to function, chaired by the De	Audit open over 12 months
	R6/6	Chief Operating Officer	Consideration should be given to adding in the Senior Dental Nurses into the	Where appropriate, work will begin on rolling out ESR hierarchy access to Senior Der	Audit open over 12 months
Dental CB – Theatre Sessions	R1/2	Chief Operating Officer	The Dental administration staff should ensure that Patient Dental files conta	Urgent meeting to be arranged with Clinical Lead and Peri-Operative Care Manager t	Audit open over 12 months
	R2/3	Chief Operating Officer	The majority of patients cancelled by Dental staff are due to oversubscribed	Reviewed PasPlus regarding start and finish times. Clinical Lead to speak with Maxillc	Audit open over 12 months
	R3/3	Chief Operating Officer	Dental management should ensure that cancelled operations are re-booked	Where possible this is always the case but many lists are held only on a monthly basi	Audit open over 12 months
E IT Training	R1/7	Director of Transformation and Informatics	An assessment of the impact of these measures should be carried out and p	An assessment of the reduced course duration is to be undertaken by the PARIS trair	Audit open over 12 months
	R2/7	Director of Transformation and Informatics	Relevant policies and procedures should be put in place to set out the circur	The 'relevance' of the PARIS training system is under constant review through both t	Audit open over 12 months
	R3/7	Director of Transformation and Informatics	To introduce a relevant pre-assessment process and procedures to ensure tl	The Health Board will:1. Agree a process for ensuring any LD is captured.2. Develop t	Audit open over 12 months
	R4/7	Director of Transformation and Informatics	Document control information to be standardised and completed in full on t	Training documents are currently version controlled but not standardised.Standardis	Audit open over 12 months
	R6/7	Director of Transformation and Informatics	An impact assessment process should be introduced in order to gather and e	An impact assessment process is in draft but has been suspended due to the Work Li	Audit open over 12 months
	R7/7	Director of Transformation and Informatics	The training material should be updated to include a range of options for po	It would not be appropriate to provide Service Coordinator details since these will be	Audit open over 12 months
Environmental Sustainability Report	R1/4	Director of Planning	Future Sustainability Reports should only report on water supply costs. This	Future Sustainability reports will include water supply costs, but will be determined	Audit open over 12 months
	R4/4	Director of Planning	Future Sustainability Reports should include references / links to where furtl	Consideration will be given to include references / links to where further sustainabili	Audit open over 12 months
Information Governance: General Data Protection Regul	R1/12	Director of Transformation and Informatics	The UHB should consider establishing a GDPR group with representation fro	The UHB has adapted the all Wales IG policy. As part of the process to formal adopti	Audit open over 12 months
	R10/12	Director of Transformation and Informatics	The IAR process should pick up information flows and also consider the basi	In line with the approach taken across NHS Wales which has been discussed openly	Audit open over 12 months
	R11/12	Director of Transformation and Informatics	The UHB should make clear the requirement to gain explicit consent for thes	As above – there is no requirement for consent where the data processing by a non	Audit open over 12 months
	R12/12	Director of Transformation and Informatics	Directorates should be reminded to display the GDPR information.	Accept – SIRO will write to Directorate Managers & CDs to remind them of this requi	Audit open over 12 months
	R2/12	Director of Transformation and Informatics	The resource requirement for the Information Governance team should be f	In the context of the UK wide economy growing at a lower rate than: patient expecta	Audit open over 12 months
	R3/12	Director of Transformation and Informatics	A revised Subject Access Procedure should be completed, placed on the intr	Accepted	Audit open over 12 months
	R4/12	Director of Transformation and Informatics	The IG webpages should be updated to ensure they present current, accurat	The contact details will be updated shortly.As noted above the department has been	Audit open over 12 months
	R5/12	Director of Transformation and Informatics	The UHB should seek to ensure all staff complete the IG training module.	Management Response Accept – The UHB is engaged nationally in the development	Audit open over 12 months
	R6/12	Director of Transformation and Informatics	Training on GDPR should be enhanced and provided to all staff acting in an I	Training is via the mandatory training route described in recommendation 5.The UHI	Audit open over 12 months
	R8/12	Director of Transformation and Informatics	A reminder should be sent to all staff to ensure that all IG breaches are ente	National policy is being discussed at IGMAG and Medical Directors (Caldicott Guardia	Audit open over 12 months
	R9/12	Director of Transformation and Informatics	This issue should be raised with WG to confirm that the requirement to kee	National policy is being discussed at IGMAG and Medical Directors (Caldicott Guardia	Audit open over 12 months
Internal Medicine Directorate – Mandatory Training & P	R2/6	Chief Operating Officer	Management should ensure that all members of staff within the directorate	Improved compliance for 85% of staff with completion of 100% mandatory and statu	Audit open over 12 months
	R5/6	Chief Operating Officer	Management must ensure that the staff database is regularly maintained, w	No Longer ApplicableNo database is maintained by the directorate office. They are n	Audit open over 12 months
Internal Medicine Directorate Mandatory Training and F	R1/6	Chief Operating Officer	Management should ensure that all staff within Internal Medicine undertake	The Directorate has developed a Project Outline Document to support ward areas to	Audit open over 12 months
Kronos Time Recording System - Estates	R1/6	Director of Planning	Suitably qualified and experienced staff should be assigned specific responsi	Suitably qualified and experienced staff should be assigned specific responsibility for	Audit open over 6 months
	R4/6	Director of Planning	Where overtime has been worked this should be reflected in the start and fi	The issue will be considered as part of the system review although all overtime is au	Audit open over 6 months
	R5/6	Director of Planning	Staff should be instructed to clock in no more than 27 minutes before the st	Staff clock in on arrival on site but are not paid from this point, unless authorisation	Audit open over 12 months
Legislative/Regulatory Complaince	R5/7	Director of Corporate Governance	The Senior Fire Safety Office should ensure that sufficient evidence is availal	Agreed	n/a
	R6/7	Director of Corporate Governance	The Senior Fire Safety Officer should ensure that there is appropriate attend	Agreed	n/a
Management of the Disciplinary process.	R4/6	Director of Workforce and Organisational Development	Management will identify trends in delays and take appropriate action in or	The organisation of Appeals will be centralised within the HR Operations Centre in th	(blank)
	R5/6	Director of Workforce and Organisational Development	Training will be undertaken by all investigators to help with the efficient run	The HR team are currently reviewing the UHB list of IO's to ascertain their status, i.e.	(blank)
	R6/6	Director of Workforce and Organisational Development	Management should review their performance/ summary documents to ens	The main ER tracker is being updated to ensure that we capture the performance da	(blank)
Medicine CB - Sickness Absence Management	R1/5	Chief Operating Officer	Management must ensure that all future sickness episodes are managed an	Re-circulate the All Wales Managing Attendance at Work Policy. ▪ Support and appr	Audit open over 12 months
	R2/5	Chief Operating Officer	Management should ensure that the sickness triggers are being managed co	Support and appraises have been set up for A6 South to ensure consistency in compl	Audit open over 12 months
	R3/5	Chief Operating Officer	Management should ensure that the sickness triggers are being managed co	▪ Support and appraises have been set up for A6 South to ensure consistency in cor	Audit open over 12 months
	R4/5	Chief Operating Officer	Management should ensure that all current ward managers are provided w	▪ Within Stroke Services, engaged with Human resources to provide furthertraining	Audit open over 12 months
Mental Health Clinical Board – Section 17 Leave	R1/4	Chief Operating Officer	The Guideline for Section 17 Leave of Absence Mental Health Act 1983 shou	The Guideline for Section 17 Leave of Absence Mental Health Act 1983 will be preser	Audit open over 12 months
	R2/4	Chief Operating Officer	The Health Board should clarify if there is a requirement for specific risk asse	Consideration of the risk assessment and care and treatment plan will have taken pl	Audit open over 12 months
Mental Health Clinical Board – Sickness Management	R3/4	Chief Operating Officer	Long term sickness meetings should be held as required to ensure that the e	Directorates to send all managers a general reminder of the need for formal sicknes	Audit Over 12 months
Mental Health Sickness Management and Rostering	R1/5	Chief Operating Officer	Management should ensure that all sickness episodes are managed and doc	The MHCB has seen significant changes to the inpatient ward management structure	Audit open over 12 months
	R4/5	Chief Operating Officer	Nursing staff should be reminded that all bank and agency time sheets shou	It was evidenced from our testing that there were a number of inconsistencies acros	Audit open over 12 months
	R5/5	Chief Operating Officer	NHS Wales Audit & Assurance Services Page 16 of 17 Recommendation Prior	This issue will be monitored via the sickness surgeries.	Audit open over 12 months
Mortality Reviews	R2/3	Executive Medical Director	The Health Board must ensure that level 1 mortality reviews are completed	A review of the current paper trail will be undertaken and improved as necessary. Cl	Audit open over 12 months
	R3/3	Executive Medical Director	The Universal Mortality Review form question pertaining to the need to trig	The wording on the form and subsequent IT development was so that any 'yes' answ	Audit open over 12 months

National Standards for Cleaning in NHS Wales Follow-up	R1/6	Director of Planning	The Health Board should ensure that there is a Multi- Disciplinary Group in p	Formerly add the Cleaning Standards requirement into one of the existing forums de	Audit open over+AA89 12 months
Neurosciences - Patient Care IT System	(blank)	(blank)	(blank)	(blank)	(blank)
Nurse Revalidation	R2/3	Executive Nurse Director	The C&V UHB PADR form should be revised for Nursing Staff to include an a	The Senior Nurse for Nurse Education will work with the lead for PADR to create a se	Audit open over 12 months
	R3/3	Executive Nurse Director	Where nurses are using their line manager as their confirmer, the confirmer	An email via the Directors of Nursing will be issued to remind staff of ESR capability r	Audit open over 12 months
PCIC CB – District Nursing Rotas	R2/5	Chief Operating Officer	District Nurses should work in conjunction with the Rosterpro team to ensur	District Nursing sisters will be expected to use Rosterpro to roster all staff, this will b	Audit open over 12 months
	R3/5	Chief Operating Officer	District Nurse Sisters should ensure rotas are prepared on a timely basis. WI	District Nursing sisters will be expected to use Rosterpro to roster all staff, rosters wi	Audit open over 12 months
PCIC Interface Incidents	R8/9	Chief Operating Officer	Regular communicatoin with GPs should be undertaken to make them awar	A paragraph in relation to the interface process was included in the winter Patient Sa	Audit open over 12 months
	R9/9	Chief Operating Officer	Consideration should be given to how feedback and incident reporting can b	PCIC does not receive incident notification from internal depts within the UHB which	Audit open over 12 months
Performance Reporting Data Quality - Non RTT	R1/3	Director of Public Health	Consideration should be given to aligning the Performance Report and Tier 1	Discussions at a national level are happening between Welsh Government and the N	Audit open over 6 months
	R2/3	Director of Public Health	The Performance Report working spreadsheet should be linked to data sour	As identified above – not all the data is available to achieve this.The UHB is actively c	Audit open over 6 months
	R3/3	Director of Public Health	Consideration should be given to re-formatting the Performance Report to ii	Accept	Audit open over 6 months
Pilot Model Ward Review	R2/5	Director of Planning	For future projects the plans for financial costing should be more detailed w	As this was a clear pilot and proof of concept. Costings were genuinely not known. W	Audit open over 12 months
	R3/5	Director of Planning	For future projects a defined terms of reference that identifies membership,	Agreed for applicable future projects.	Audit open over 12 months
Progress against findings from the Human Tissue Autho	R1/1	Chief Operating Officer	Management must ensure that the terms of reference of the HTA Licence Cc	The Human Tissue Authority compliance group is currently running in parallel to HTA	Audit open over 12 months
Renal IT system	R1/10	Chief Operating Officer	Both UNIX and MySQL should updated to a more recent, supported version.	Early investigations have taken place between Vitalpulse and Summerside. Monies v	Audit open over 12 months
	R2/10	Chief Operating Officer	The minimum password length should be set to 8 and all users have a forcec	The minimum length has now been amended to 8. With regard to forced change, thi	Audit open over 12 months
	R3/10	Chief Operating Officer	Recommendation: The backups should be subject to periodic testing.	This has been brought to the attention of the IT Server Team but is outside of the Dir	Audit open over 12 months
	R4/10	Chief Operating Officer	The DR plan should be revised to include contact details of support organisa	Dialogue with the Vendor parties has already started regarding the failback process.	Audit open over 12 months
	R5/10	Chief Operating Officer	A review of users should be undertaken to ensures that leavers access is rev	Action has been taken as identified and a process implemented to regularly review la	Audit open over 12 months
	R7/10	Chief Operating Officer	The local user group should seek to identify fields which could benefit from i	Communication with users is ongoing and agreed changes will be actioned where ap	Audit open over 12 months
	R8/10	Chief Operating Officer	A local user group should be established with leads from each of the user d	Partially agree. There is an all Wales VitalData Group to which Users can feed into vi	Audit open over 12 months
Residences	R10/10	Director of Planning	The UHB should refer to the PFI contract/SLA to consider whether expectant	Currently being reviewed by PFI Manager.	Audit open over 12 months
	R6/10	Director of Planning	The UHB should document future plans for the provision and utilisation of re	The UHB is currently embarking on a significant master planning exercise for the UHI	Audit open over 12 months
RTT Performance Reporting	R1/4	Director of Transformation and Informatics	The Health Board should ensure there is a formalised policy that encompas	We accept that there is a need to review the appropriateness of our RTT policy, ensu	Audit open over 12 months
	R2/4	Director of Transformation and Informatics	The Health Board should consider validating data of patients that are 'in targ	We accept the point made in the context that data quality audits should extend to re	Audit open over 12 months
	R3/4	Director of Transformation and Informatics	The Performance Report should include a note next to the SCP compliance f	Accepted	Audit open over 12 months
	R4/4	Director of Transformation and Informatics	The Performance Report should include data on the related Cancer patient v	The reporting of volumes occurs infrequently. There is a balance to be had in the det	Audit open over 12 months
Serious Incidents Management	R4/5	Executive Nurse Director	The Patient Safety team should communicate the importance of uploading t	Action plans will have been developed and signed off as part of the investigation pro	Audit open over 12 months
	R5/5	Executive Nurse Director	Management should ensure that SIs are reported to WG within the required	Whenever possible the Patient Safety team will attempt to report within 24 hours. Th	Audit open over 12 months
	(blank)	Executive Nurse Director	The Patient Safety Team should encourage management to use the feedbac	It is well recognised that the success of a reporting system depends on the level of fe	Audit open over 12 months
Specialist Services Clinical Board – Medical Finance Gov	R1/2	Chief Operating Officer	Management should carry out a comprehensive review of the current and fu	(blank)	Audit open over 6 months
	R2/2	Chief Operating Officer	Each 20 week Consultant rota should be subject to formal approval by the C	A process to sign off the rota by the Clinical Director will be developed by the Directc	Audit open over 6 months
Specialist ServicesFollow up - Patientcare IT System	R1/1	Chief Operating Officer	A process should be established to periodically test the backups.	Discussions are underway with IM&T and a test of the backup is due to be scheduled	Audit open over 12 months
Statutory Compliance	R1/1	Director of Planning	Processes will be implemented to reduce the exposure to human/transposit	Agreed. As outlined, a software solution is presently being piloted through August ar	Audit open over 12 months
Strategic Planning/IMTP	R1/1	Director of Planning	Management should ensure that the plans for Clinical Boards are produced i	A revised monitoring process for reporting clinical board progress on IMTPs will be ir	Audit open over 6 months
Surgery Clinical Board - Anaesthetist Rota Management	R1/1	Chief Operating Officer	Standard Operating Procedure notes covering the administration of the CLW	It is accepted by the Directorate that there is no written SOP for staff, although all th	Audit open over 12 months
Surgery Clinical Board – Medical Finance Governance	R1/6	Chief Operating Officer	The Directorate should ensure that consultants carry out all planned session	A new system to accurately record consultant activity in theatre is being develop	Audit open over 12 months
	R4/6	Chief Operating Officer	Management should produce desk top procedures to ensure that Consultan	Standardised procedure notes to be created and shared with key personnel (March 2	Audit open over 12 months
Sustainability Reporting	R1/3	Director of Planning	Evidence of the retrospective approval of the sustainability report by the En	Future Sustainability reports will be approved and signed off at the CapitalEstates an	Audit open over 6 months
	R2/3	Director of Planning	The staff roles and responsibilities highlighted in the procedural guidance sh	Future Sustainability report guidance will be reviewed and updated for staff rolesanc	Audit open over 6 months
	R3/3	Director of Planning	Management should draw up a timetable each year to help ensure appropri	Once the timescale for the Sustainability report submission is known an indicativetin	Audit open over 6 months
UHB Core Financial Systems	R3/5	Director of Finance	Management should inform responsible staff to promptly notify eEnablemer	Recommendation Accepted. The UHB's current procedure will be updated to clarify t	Audit open over 6 months
	R4/5	Director of Finance	Management should ensure that a standard procedural guide is produced to	Recommendation accepted. The UHB's current procedure will be updated to clarify r	Audit open over 6 months
	R5/5	Director of Finance	Management should ensure that the required forms are completed, signed a	Recommendation accepted. The UHB's revised procedure will be updated to clarify r	Audit open over 6 months
University Hospital of Wales Neo Natal Development	R6/7	Director of Planning	The Capital Procedures Manual should be revised to include the requiremen	Agreed	Audit open over 12 months
	R7/7	Director of Planning	Requests for 'Single Tender Action' should be approved and reported to the	Agreed	Audit open over 12 months
Water Safety	R1/7	Director of Planning	Attendances of the Water Safety Group should be reviewed, with staff remi	Agreed	Audit open over 6 months
	R2/7	Director of Planning	The current position in respect of the backlog of remedial jobs, should be ro	Agreed	Audit open over 6 months
	R3/7	Director of Planning	Training should be updated for all key staff with assigned water managemer	Agreed	Audit open over 6 months
	R4/7	Director of Planning	a) An audit trail should be maintained where routine checks are not complet	Agreed	Audit open over 6 months
	R5/7	Director of Planning	a) For those clinical boards identified in this audit as being non-compliant wi	Agreed	Audit open over 6 months
	R6/7	Director of Planning	The risk assessment process, including preparation of appropriate prioritisec	Agreed	Audit open over 6 months
	R7/7	Director of Planning	Progress, including highlighting of any delays, should be regularly reported t	Agreed	Audit open over 6 months
Wellbeing of Future Generations Act	R1/5	Director of Public Health	The Health Board/ Management should produce an Action Plan to provide a	The Steering Group agreed the need to develop an Action Plan at its meeting on 12 M	Audit open over 12 months
	R2/5	Director of Public Health	The Terms of Reference for the WFG Steering Group should be formalised a	Draft Terms of Reference were discussed at the meeting of the Steering Groupon 12	Audit open over 12 months
	R3/5	Director of Public Health	The Health Board should formalise and approve the role and responsibility o	A draft WFG Champion role was discussed at the Steering Group on 12 March. Final v	Audit open over 12 months
	R4/5	Director of Public Health	The Health Board must ensure that its obligations in respect of the Act are a	The Chair of the Steering Group met with UHB Director Communications and the UH	Audit open over 12 months
WLI Payments Follow-Up	R1/2	Chief Operating Officer	The UHB has produced a WLI Payments Policy /Procedure and this has been	Not Provided	Audit open over 12 months
	R2/2	Chief Operating Officer	Testing identified that whilst Cardiac Surgery make the appropriate checks a	Not Provided	Audit open over 12 months
(blank)	(blank)	(blank)	(blank)	(blank)	(blank)
Wellbeing of Future Generations Act	R5/5	Director of Public Health	The Health Board should update their WFG internet page to ensure that it p	UHB WFG Internet page to be updated to reflect the recommendations.	Audit open over 12 months
Serious Incidents Management	R1/5	Executive Nurse Director	Management must ensure that closure forms are submitted to WG within th	NHS Wales Audit & Assurance Services Page 11 of 17 Management Response Respor	Audit open over 12 months
University Hospital of Wales Neo Natal Development	R1/7	Director of Planning	The design for the MRI new build will be concluded and frozen as soon as pc	The design solution has been informed, as far as is practicable, by considering the sp	Audit open over 12 months
MHRA Compliance	R1/4	Chief Operating Officer	The current tracker should be effectively updated to ensure that the outstar	The UHL (PSU) tracker has now been updated (3 June 2019) in future, accepted pract	Audit open over 6 months
	R2/4	Chief Operating Officer	Management will amend the tracker to ensure an appropirate audit trail on	The SMPU internal tracker has been amended to include the revised target date(s) fc	Audit open over 6 months
	R3/4	Chief Operating Officer	The terms of reference should be reviewed for appropriateness and staff sh	A single Compliance and Governance group for Pharmacy Technical Service i.e. UHL a	Audit open over 6 months
	R 4/4	Chief Operating Officer	The risk register should be assessed for appropriateness and updatedaccord	The Pharmacy Directorate Risk Register has been reviewed and ownership ofindividu	Audit open over 6 months
E-Advice	R1/4	Director of Transformation and Informatics	Management should undertake an exercise to review and quantify benefits	With the resource available an exercise will be carried out to review and quantify tha	Audit open over 6 months
	R2/4	Director of Transformation and Informatics	Management should document the approach to testing and implementing c	There are processes in place to manage testing, approvals, roll back and assigning a s	Audit open over 6 months
	R3/4	Director of Transformation and Informatics	A regular, at least annual, exercise should be undertaken to confirm the valic	A report to identify account inactivity of 90 days will auto-run daily followingwhich ir	Audit open over 6 months
	R4/4	Director of Transformation and Informatics	Management should consider the use of local e-Advice super users.	The team are looking at ways to relieve the administration workload on them. A sen	Audit open over 6 months
UHB Transformation Process	R1/3	Director of Digital and Health Intelligence	The Transformation Enabler Steering Group should consider including nomir	Each enabler task and finish group links with Clinical Boards and have involvement ol	Audit open over 6 months
	R2/3	Director of Digital and Health Intelligence	The Accessible Information Enabler should implement a formal Task and Fini	The Accessible information enabler work is being reported to a number of different g	(blank)
	R3/3	Director of Digital and Health Intelligence	Progress relating to the Accessible Information Enabler should be recorded a	Following discussion between the ADI of Information and the steering group project	(blank)
Standards of Business Conduct (DoI & GH&S) Follow-up	0	Director of Corporate Governance	(blank)	(blank)	(blank)
Carbon Reduction Commitment	R1/1	Director of Planning	The UHB should ensure that the strategy is agreed as soon as possible so tha	The UHB will be agreeing the strategy regarding the course of action to be adopted f	(blank)
Mental Health Clinical Board - Sickness Management Fc	R2/4	Chief Operating Officer	Management should ensure that the sickness triggers are being managed co	Directorates to send "trigger table" out to all managers, reminding them to check wi	(blank)
			Management should remind ward staff that the recording of sickness dates a	All band 6 / 7 managers to attend refresher sickness training.	Audit open over 6 months
Specialist Clinical Board - Rosterpro	R1/5	Chief Operating Officer	Management should ensure employees contracted hours are managedappro	As a Directorate Management Team we welcome the audit and accept its recommer	(blank)
	R3/5	Chief Operating Officer	A process map should be devised and distributed to appropriate staff. This s	Process map will be devised and distributed to all Critical Care Flow Coordinators by	(blank)
	R4/5	Chief Operating Officer	Management should remind staff that accurate and up to date records are t	New ways of working have been instigated across Critical Care since May 2019, with	(blank)
	R5/5	Chief Operating Officer	Optimum requirements for Llandough will be reviewed and if necessary upd	Staffing levels at Llandough have been reviewed since the time of the audit. As a resu	Audit open over 6 months
Legislative / Regulatory Compliance	R5/7	Director of Corporate Governance	The Senior Fire Safety Office should ensure that sufficient evidence is availat	Agreed	Audit open over 9 months
	R6/7	Director of Corporate Governance	The Senior Fire Safety Officer should ensure that there is appropriate attend	Agreed	Audit open over 6 months
	R7/7	Director of Corporate Governance	The Corporate Team should re-evaluate the Report to ensure that all the nec	Recommendation agreed	Audit open over 6 months
Mental Health CB - Third Sector Contractors	R1/2	Chief Operating Officer	Third Sector Mental Health Providers – Contracting and Performance Manag	Third Sector Commissioning Guide and Framework (revised) to reflect recommendat	Audit open over 3 months
	R2/2	Chief Operating Officer	All future stakeholder engagement and consultation documentation should	A new cycle of commissioning will begin in 2020 and the recommendation isnoted ar	Audit open over 3 months
Private and Overseas Patients	R1/7	Executive Medical Director	All Directorates should be informed of the current Private Patient Agreemen	The UHB updates the private patient tariffs and agreement forms on its intranetand	Audit open over 3 months
	R2/7	Executive Medical Director	The Private and Overseas Patients Office should promote and increase awar	The Private and Overseas Patients Office will promote the existence of its intranetan	Audit open over 3 months
	R3/7	Executive Medical Director	The UHB Overseas and Private Patient internet pages should be updated to i	The UHB Overseas and Private Patient internet page has now been updated toinclud	Audit open over 3 months
	R4/7	Executive Medical Director	Private and Overseas Patients Office should ensure that fee information is m	Moving forwards all Directorates will be notified of the current Private PatientAgreei	Audit open over 3 months
	R5/7	Executive Medical Director	The Private patient office should ensure that the Dermatology Directorate ir	The Private patient office should ensure that the Dermatology Directorateintroduce	Audit open over 3 months

	R6/7	Executive Medical Director	The Private and Overseas Patients Office should remind Directorates that an	The Private and Overseas Patients Office will write to remind all Directorates thatan	Audit open over 3 months
	R7/7	Executive Medical Director	The Private and Overseas Patients Office should implement and evidencedo	The Private and Overseas Patients Office will implement a Control Pack thatevidence	Audit open over 3 months
Consultant Job Planning Follow-up	R1/6	Executive Medical Director	Clinical Boards must ensure that all consultants complete a job plan or have	1. Processes are in place to support the completion and reporting of job planning ac	(blank)
	R2/6	Executive Medical Director	The UHB job planning guidance should require consultants to use the standa	1. Clinical Board Directors and Clinical Directors should ensure that summary job pla	(blank)
	R4/6	Executive Medical Director	In accordance with the guidance, Clinical Board management should ensure	Review of job planning guidance with regard to job plan template and re-issue to Clir	(blank)
	R5/6	Executive Medical Director	The UHB should consider developing additional methods of communication	A planned schedule for training should be refreshed and communicated, including sc	(blank)
	R6/6	Executive Medical Director	All completed job plans must be signed by the Consultant and the clinicalma	1. The job plan review does not require an actual signature but there does need to b	(blank)
	R3/6	Executive Medical Director	Clinical Board management must ensure that all consultants complete the o	1. Review of job planning guidance with regard to job plan template and re-issue to	(blank)
Tentacle IT System	R8/9	Director of Transformation and Informatics	If the system is to be continued to be used, then system documentation sho	The system is being replaced within a planned 18 month timescale. Management do	(blank)
	R9/9	Director of Transformation and Informatics	Brief user guides should be developed for the system.	The system is being replaced within a planned 18 month timescale. Managementdo	(blank)
	R1/9	Director of Transformation and Informatics	The database should be updated to the latest, supported version.	Due to the work ongoing to replace Tentacle, Management do not agree with the rei	(blank)
	R2/9	Director of Transformation and Informatics	The level of recording of developments and changes to Tentacle should be ir	Agreed.A record is now maintained of changes made. The User Acceptance Testingp	(blank)
	R3/9	Director of Transformation and Informatics	The use of generic accounts should be restricted.Staff who have left the UHE	Generic Accounts – Generic Accounts for Tentacle are already restricted. They are tie	(blank)
	R4/9	Director of Transformation and Informatics	Tentacle and its associated databases should held in a secure location on UH	Management partially accept this recommendation due to the technicalities of acces	(blank)
	R5/9	Director of Transformation and Informatics	The future use of office software should be established to ensure Tentacle n	The use of Tentacle will be considered as part of the roll out of updated office softw	(blank)
	R6/9	Director of Transformation and Informatics	The process for loading information into Tentacle on a daily basis should be	Agreed.A Standard Operating procedure will be developed.	(blank)
	R7/9	Director of Transformation and Informatics	The load process should be amended to identify items that have not loaded.	Agreed.The process will be amended and Standard Operating procedure will also inc	(blank)
Budgetary Control	R1/1	Director of Finance	Delegated Budget Holders should sign-up to their delegated budget annuall	This specific issue was considered as part of the Deloitte's Financial Governancerevie	(blank)
Brexit Planning	R1/4	Director of Planning	The business continuity arrangements within Mental Health should be furth	Draft business continuity plans completed and circulated within Mental Health, and :	(blank)
	R2/4	Director of Planning	Management information surrounding areas of lower compliance should be	Work will continue to address the information gap by encouraging Clinical andServic	(blank)
	R3/4	Director of Planning	Staff should be reminded to the importance for attending meetings.	Group members are committed to attending meetings. However, existing work comr	(blank)
	R4/4	Director of Planning	Going forward, if there is a requirements for daily reporting in the future; all	UK/Welsh Government reporting focussed on the key areas of Medical Devices/Clini	(blank)
Safeguarding Adults and Children	R1/4	Executive Nurse Director	Management should ensure that Clinical Boards put the appropriate actions	Safeguarding Training is a standard item on the agenda at the SafeguardingSteering (	(blank)
	R2/4	Executive Nurse Director	Management should ensure that all Clinical Boards are reminded of the req	The Deputy Executive Nurse Director will address this with Directors of Nursing (DON	(blank)
	R3/4	Executive Nurse Director	Management should ensure that evidence to support safeguarding responsi	Each Clinical Board is responsible for ensuring that safeguarding information is availa	(blank)
	R4/4	Executive Nurse Director	Management should ensure that the Terms of Reference for the Safeguardir	The Head of Safeguarding acknowledges that there was no evidence in the minutes t	(blank)
Freedom of Information	R1/7	Director of Transformation and Informatics	The Health Board should take steps to ensure the continuity of the Folmana	Both of the fixed term contracts are being addressed and are being madepermanent	(blank)
	R2/7	Director of Transformation and Informatics	NHS Wales Audit & Assurance Services Page | 11Finding 2–Quality Control (	QA process has now been created by the UHB's FOI lead and is in use, with allthe not	(blank)
	R3/7	Director of Transformation and Informatics	The FoI Policy and Written Procedures documents should be reviewed andu	FOI Procedure approved and uploaded to both internet and intranet. IG Policysubmi	(blank)
	R4/7	Director of Transformation and Informatics	The tracking and monitoring process should be improved by the addition of:	Incorporated into QA process created for 2b. FOI Log lists the relevant departm	(blank)
	R5/7	Director of Transformation and Informatics	Service departments / Clinical Boards should be reminded of the legal obliga	FOI lead has an email drafted to go to HODs, DMs and frequent info providersstating	(blank)
	R6/7	Director of Transformation and Informatics	A simple numbering scheme should be applied where multiple documents a	The IG team has adopted a numbering convention as suggested.	(blank)
	R7/7	Director of Transformation and Informatics	FoI certification or additional FoI training should be available for team mem	FOI lead in discussion with NWIS re national approach to training.	(blank)
Consultant Annual Leave - CW CB	R1/5	Chief Operating Officer	The UHB Annual Leave Policy for Career Grade Medical & Dental Staff shoul	UHB Annual Leave Policy will be reviewed in light of these comments and takenback	(blank)
	R2/5	Chief Operating Officer	Pro-forma procedures for administering annual leave and study leave shoul	Further guidance to ensure consistency will be agreed with Directorates andoversee	(blank)
	R3/5	Chief Operating Officer	Review and evaluate the impact of compressed annual leave. If arrangemen	Discuss with LNC and build guidance in to the policy to reflect best practicearound cc	(blank)
	R4/5	Chief Operating Officer	Directorate administrative arrangements should be reviewed and strengthe	Intrepid User Group will oversee implementation of revised guidelines in theAreas hi	(blank)
	R5/5	Chief Operating Officer	Directorates should identify and assess the use of all local spreadsheets of o	Clinical board Head of Operations will ensure Directorates utilise appropriateancillar	(blank)
Medical Staff Study Leave	R1/6	Director of Workforce and Organisational Development	The UHB Study Leave Procedure for Medical & Dental Staff should be review	UHB Study Leave procedure document will be reviewed and strengthened in the are:	(blank)
	R2/6	Director of Workforce and Organisational Development	Pro-forma procedures for administering consultants study leave and annual	Enhanced Guidance will be provided for Directorates on interpretation of typesof lea	(blank)
	R4/6	Director of Workforce and Organisational Development	The following arrangements are reviewed and strengthened:- budget sett	Capped annual or triannual budget allocations are to be introduced afterdiscussion v	(blank)
	R5/6	Director of Workforce and Organisational Development	Assess and review the use of Intrepid as a tool for managing activities other	Intrepid approval system enables approver to view a 'team' leave view that facilitate	(blank)
	R6/6	Director of Workforce and Organisational Development	Develop the Intrepid User Group to co-incide with the introduction of the uj	Intrepid User Group will be refreshed with revised TOR and membership.Minutes of	(blank)
	R3/6	Director of Workforce and Organisational Development	Directorate administrative arrangements should be reviewed and strengthe	Comprehensive Review of local processes Directorate by Directorate will takeplace t	(blank)
Control of Contractors	R1/11	Director of Finance	RAMS (where applicable) should be requested and retained prior to the con	Accepted. RAMS will now be incorporated within the database implemented in Janu	(blank)
	R2/11	Director of Finance	Management should undertake a data cleansing exercise of the Backtraq sy	Accepted. An initial review of the database, in consultation with the relevant officers	(blank)
	R3/11	Director of Finance	Induction content should be reviewed and updated to reflect current practic	Accepted. The presentation will be updated to reflect current practice. The audit-visi	(blank)
	R4/11	Director of Finance	Management should formally implement the database, across Capital, Estat	Accepted. The database was formally implemented in January 2020	(blank)
	R5/11	Director of Finance	Management should roll-out appropriate training on JRF guidance including	Accepted. All relevant Supervising Officers within the Capital, Estates & Facilities dep	(blank)
	R6/11	Director of Finance	The functionality of the Backtraq system should be reviewed for the timelin	Accepted. Initial discussions have been held with the software provider re: potential	(blank)
	R7/11	Director of Finance	A sign in/out system should be in place at each community site, using meas	Accepted. As asbestos registers are maintained at each community site, these have t	(blank)
	R8/11	Director of Finance	A Permit to Work procedure should be developed, ratified and communicat	Accepted. The procedure is currently out for consultation and will be presented to th	(blank)
	R9/11	Director of Finance	Management should collate the output of the contractor monitoring forms f	Accepted. In the role of Framework Manager, the Head of Discretionary Capital & Co	(blank)
	R10/11	Director of Finance	Formal post completion review meetings of contractor performance should	Accepted, as per the response to recommendation 9.Accepted, as per the response t	(blank)
	R11/11	Director of Finance	An annual audit of compliance with the policy should be completed and rep	Accepted. Discussions will be held with the Head of Health & Safety with a view to er	(blank)
Grand Total					

Audit	(All)

Audit Log Ref No.	Financial Year Fieldwork Under	Audit Title	Audit Rating	Executive Lead for Report	Status of Report Overall	Age Group
IA 03_1718	2017-18	Progress against findings from the Human Tissue Authority (HTA) Inspection of UHW	Substantial	Chief Operating Officer	Audit open over 12 months	Over One Year
IA 11 _1718	2017-18	WLI Payments Follow-Up	Reasonable	Chief Operating Officer	Audit open over 12 months	Over One Year
IA 11 _1718	2017-18	WLI Payments Follow-Up		Chief Operating Officer	Audit open over 12 months	Date not Specified
IA 12_1718	2017-18	Residences	Reasonable	Director of Planning	Audit open over 12 months	Over One Year
IA 12_1718	2017-18	Residences		Director of Planning	Audit open over 12 months	Date not Specified
IA 13_1718	2017-18	Surgery Clinical Board - Anaesthetist Rota Management	Reasonable	Chief Operating Officer	Audit open over 12 months	Date not Specified
IA 14_1718	2017-18	Pilot Model Ward Review	Reasonable	Director of Planning	Audit open over 12 months	Date not Specified
IA 17_1718	2017-18	Wellbeing of Future Generations Act	Reasonable	Director of Public Health	Audit open over 12 months	Over One Year
IA 17_1718	2017-18	Wellbeing of Future Generations Act		Director of Public Health	Audit open over 12 months	Closed/Not Open
IA 17_1718	2017-18	Wellbeing of Future Generations Act	Reasonable	Director of Public Health	Audit open over 12 months	Over One Year
IA 18_1718	2017-18	Children & Women Clinical Board – Medical Staff Rotas and Study	Reasonable	Chief Operating Officer	Audit open over 12 months	Over One Year
IA 19_1718	2017-18	Serious Incidents Management	Reasonable	Executive Nurse Director	Audit open over 12 months	Over One Year
IA 19_1718	2017-18	Serious Incidents Management		Executive Nurse Director	Audit open over 12 months	Closed/Not Open
IA 19_1718	2017-18	Serious Incidents Management	Reasonable	Executive Nurse Director	Audit open over 12 months	Closed/Not Open
IA 21_1718	2017-18	Mental Health Sickness Management and Rostering	Reasonable	Chief Operating Officer	Audit open over 12 months	Over One Year
IA 22_1718	2017-18	Nurse Revalidation	Reasonable	Executive Nurse Director	Audit open over 12 months	Over One Year
IA 27 1718	2017-18	University Hospital of Wales Neo Natal Development	Reasonable	Director of Planning	Audit open over 12 months	Over One Year
IA 27 1718	2017-18	University Hospital of Wales Neo Natal Development	Reasonable	Director of Planning	Audit open over 12 months	Over One Year
IA 29 1718	2017-18	Business Continuity Planning Follow-Up	Reasonable	Director of Planning	Audit open over 12 months	Closed/Not Open
IA 30 1718	2017-18	Mortality Reviews	Reasonable	Executive Medical Director	Audit open over 12 months	Over One Year
IA 32 1718	2017-18	RTT Performance Reporting	Reasonable	Director of Transformation and Informatics	Audit open over 12 months	Over One Year
IA 32 1718	2017-18	RTT Performance Reporting		Director of Transformation and Informatics	Audit open over 12 months	Date not Specified
IA 32 1718	2017-18	RTT Performance Reporting		Director of Transformation and Informatics	Audit open over 12 months	Over One Year
IA 33 1718	2017-18	Costing Review	Reasonable	Director of Finance	Audit open over 12 months	Closed/Not Open
IA 35 1718	2017-18	Internal Medicine Directorate Mandatory Training and PADRs	Limited	Chief Operating Officer	Audit open over 12 months	Closed/Not Open
IA 36 1718	2017-18	Neurosciences - Patient Care IT System	Limited	(blank)	(blank)	Closed/Not Open
Grand Total						

Status	Open
Rec. Rating	(All)
Status of Report Overall	(All)

Count of Audit Log Ref No.		**Age Group**					
Financial Year Fieldwork Undertaken	**Audit**	**Date not Specified**	**Less Than 3 Months**	**Over 3 Months**	**Over 6 Months**	**Over One Year**	**Grand Total**
2017-18	IA 1718	6				26	32
2018-19	IA 1819	6	4	1	32	48	91
2019-20	IA 1819					1	1
2019-20	IA 1920					5	5
Grand Total		**12**	**4**	**1**	**32**	**80**	**129**

Report Title:	**External Audit Recommendation Tracking Report and Regulatory Tracker Report**								
Meeting:	Audit Committee						**Meeting Date:**	7th July 2020	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

The purpose of the report is to provide Members of the Audit Committee with assurance on the implementation of recommendations which have been made by Wales Audit Office by means of an external audit recommendation tracking report.

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

The External Audit tracker is demonstrating that actions are being completed, although there has been a slow down due to COVID 19, with a further 34% of outstanding recommendations completed since March 2020. However, there are also 34% of recommendations where there has been no action and 32% where the recommendation is partially completed. Of all the actions 72% are over 1 year old, 23% are over 6 months old and 4% are over 3 months old.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

A review of all outstanding recommendations has been undertaken since March 2020 and this will now continue and will be reported to the Audit Committee each quarter providing a quarterly update in movement of recommendations completed.

The Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken in **17/18, 18/19 and 19/20** as at 27th June 2020.

Reports will, in future, be discussed at Management Executives and HSMB which includes the entire leadership team of the organisation. This has not been taking place over recent months due to COVID 19 however, the organization is now returning to a more business as usual situation.

Recommendation:

The Audit Committee Members are asked to:

(a) Note the progress which has been made in relation to the completion of WAO recommendations.

(b) To note the continuing development of the WAO Recommendation Tracker.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	~~Yes / No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

External Audit (WAO) Recommendations 2017/18 – 2019/20 (July 2020)

External Audit	Complete	No action	Partially complete	< 3 mths	> 3 mths	+6 mths	+ 1 year	Total
Structured Assessment 2018	2	6	6	-	2	2	10	14
Clinical Coding Follow Up	-	3	-	-	-	-	3	3
Discharge Planning	-	-	1	-	-	-	1	1
Review of Medical Equipment	6	-	2	-	-	-	8	8
Audit of Financial Statements	7	-	3	-	-	-	10	10
Structured Assessment 2019	1	-	1	-	-	-	2	2
Implementation of the Wellbeing of Future Generations Act	-	7	2	-	-	9	-	9
Total	**16**	**16**	**15**	**-**	**2**	**11**	**34**	**47**

From the above table it can be seen that since the last report to Committee in March 2020 34% of outstanding WAO recommendations have been completed. However, there are also 34% of recommendations where there has been no action (likely to be due to COVID 19) and 32% where the recommendation is partially completed. Of all the actions 72% are over 1 year old, 23% are over 6 months old and 4% are over 3 months old.

Financial Year Fieldwork Undertaken	Final Report Issued on	Audit Title	Executive Lead for Report	Rec No.	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Operational Lead for Recommendation	Agreed Implementation Date	Committee Implementation Monitored by	Please confirm if completed (c), partially completed (pc), no action taken (na)	Age Group
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R1/11	The Health Board should complete our 2017 structured assessment recommendations by the end of 2019.	Agreed and these will be monitored to ensure this happens through Management Executives and reported to Audit Committee	Director of Corporate Governance	Head of Corporate Governance	Dec-19	Audit and Assurance Committee	Partially complete	Over 3 Months
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R1b/11	R2 [2017] To ensure compliance with the NHS planning framework, the Health Board needs to ensure that the Strategy and Engagement Committee regularly scrutinises progress on delivery of the Annual Operating Plan, and subsequent three year integrated medium term plans.	The new S&D Committee's work plan includes scrutiny of key elements of the Annual Operating Plan, 10-year strategy and transformation programme. The Committee and the Board still need to receive appropriate progress updates against the Annual Operating Plan deliverables to ensure they are on track.	Director of Corporate Governance	Head of Corporate Governance	Dec-16	Audit and Assurance Committee	Complete	Over One Year
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R1c/11	R3 [2017] To enable effective scrutiny, the Health Board needs to improve the quality of its papers to Board and Committees by ensuring that the length and content of the papers presented is appropriate and manageable.	The length of Board and committee papers has improved compared to last year, but inconsistencies and variation remain. The Health Board's introduction in September 2018 of a revised cover report template should encourage more succinct reporting	Director of Corporate Governance	Head of Corporate Governance	Dec-16	Audit and Assurance Committee	Complete	Over One Year
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R1f/11	R6 [2017] The Health Board needs to focus its attention on strengthening its information governance arrangements in readiness for the General Data Protection Regulations, which come into force in May 2018. This should include: • updating the information governance strategy; • putting in place arrangements for monitoring compliance of the primary care information governance toolkit; and • developing and completing an Information Asset Register; • ensuring that an identified data protection officer is in place; and • improving the uptake of information governance training.	Progress to date: • An up-to-date Information Governance strategy does not yet exist. The Health Board has drafted its strategic approach in the Information Governance Policy. The Health Board plans to agree and implement this approach later in 2018. • NWIS has developed the information governance toolkit for primary care GP's and intend to monitor compliance at a GP cluster level. These compliance monitoring arrangements for are still being developed. The Primary Care Clinical Board is liaising with the NHS Wales Informatics Service to confirm and agree these arrangements. • Information asset registers have been developed within the corporate directorates and clinical boards, but further work is required to fully complete this. The Health Board is planning further work to: identify personal information held; identify information flows; and identify information sharing arrangements. • An interim Data Protection Officer (DPO) is in post as required under the GDPR. The Health Board expects to appoint an experienced and senior information governance manager to the statutory DPO function in early 2019. • More staff have completed information governance training. However, compliance with information governance training (69%) is well below the national target (95%).	Director of Transformation and Informatics		Dec-16	Audit and Assurance Committee	no action taken	Over One Year
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R1g/11	R7 [2017] The Health Board needs to ensure that the level of information reported to the Resource and Delivery Committee on its performance is sufficient to enable the Committee to scrutinise effectively. This should include: • ensuring that the Committee receives more detailed performance information than that received by the Board. Consideration should be made to including a summary of the Clinical and Service Board dashboards used in the monthly executive performance management reviews; • expanding the range of performance metrics to include a broader range of key performance indicators relating to workforce. Consideration should be made to revisiting the previous workforce KPIs reported to the previous People, Planning and Performance Committee.	Overall this recommendation has been partly addressed. • The S&D Committee continues to receive a high-level performance dashboard, which is less detailed than the performance report received by the Board. • Since September 2018, the S&D Committee receives six-monthly updates against the workforce plans, including key workforce metrics.	Director of Transformation and Informatics		Dec-16	Audit and Assurance Committee	Partially complete	Over One Year

2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R1h/11	R9 [2017] To ensure resilience to security issues, such as cyber-attacks, the Health Board should consider identifying a dedicated resource for managing IT security.	In early 2018, the Health Board received an external review of cyber security arrangements. The review recommended improvements to cyber security arrangements. In response the Health Board is developing a formal cyber security improvement action plan. It plans to bring in specialist cyber security skills in early 2019 to address these recommendations and establish a specialist cyber security team.	Director of Transformation and Informatics		Dec-16	Audit and Assurance Committee	no action taken	Over One Year
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R1i/11	R10 [2017] To improve scrutiny of the Health Board's informatics service, the Health Board should expand the range of key performance indicators relating to informatics to include the cause and impact of informatics incidents.	The Health Board plans to review in early 2019 the structure and governance of its information and information technology functions to deliver the digital strategy.	Director of Transformation and Informatics		Dec-16	Audit and Assurance Committee	no action taken	Over One Year
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R3b/11	b. Review and update the Standing Orders and Standing Financial Instructions, ensuring these documents are reviewed and approved on an annual basis;	Agreed and timetabled to be undertaken on an annual basis going forward	Director of Corporate Governance		Mar-19	Audit and Assurance Committee	Partially complete	Over One Year
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R3d/11	d. Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date;	Agreed	Director of Corporate Governance		Oct-19	Audit and Assurance Committee	Partially complete	Over 6 Months
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R4/11	The Health Board should update its performance management framework to reflect the organisational changes that have taken place since 2013.	We accept that the performance management framework should be reviewed to ensure it fully supports the organisational business.	Director of Transformation and Informatics		Sep-19	Audit and Assurance Committee	Partially complete	Over 6 Months
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R7/11	The Health Board should complete the outstanding actions from the Information Commissioner's Office (ICO) 2016 review of the Health Board's data protection arrangements.	CAV UHB is committed to continually improving mitigation of its risks of non-compliance. We are taking an improvement approach in line with the rest of Wales and in regular discussion with the ICO's office. Progress has been made on the registering of major assets and new flows of information. We intend to progress the assessment of our existing significant flows, adopting a risk based approach.	Director of Transformation and Informatics		Jun-19	Audit and Assurance Committee	Partially complete	Over One Year
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R8/11	The Health Board should achieve full compliance with the General Data Protection Requirement by May 2019.	Delivery of the CAV UHB's updated action plan will reduce the risks we carry in relation to noncompliance with GDPR. Prioritisation of risks and mitigating actions are part of our continuous improvement plan, aimed at achieving full GDPR compliance during 2019.	Director of Transformation and Informatics		Dec-19	Audit and Assurance Committee	no action taken	Over 3 Months
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R9/11	The Health Board should improve its response times to requests for information from Freedom of Information Act and Data Protection Subject Access Requests.	CAV UHB has recently appointed additional staff resulting in a positive impact on response times for FOI and Subject Access Requests. This will be monitored as we continue to move towards achieving fully compliant response times.	Director of Transformation and Informatics		Mar-19	Audit and Assurance Committee	no action taken	Over One Year
2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	R11/11	The Health Board should routinely update IT Disaster Recovery plans after key changes to IT infrastructure and networks and at scheduled intervals and test plans to ensure they are effective	The CAV IT Disaster Recovery plan is reviewed annually at a minimum and in response to specific circumstances. Testing is undertaken (both Check list and Technical) and multiple system restores are performed successfully annually. Additional infrastructure and software have been put in place to improve this process. A schedule of testing is being developed as part of the technical roadmap work.	Director of Transformation and Informatics		Mar-19	Audit and Assurance Committee	no action taken	Over One Year
2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science	R1/8	R1 Review the effectiveness of the Medical Equipment Group, focusing on: • Membership of the group • Attendance • Executive Support • Reporting lines	Review and Refresh ToR based on recommendations of this report. Set out reporting mechanisms within UHB governance framework and reporting lines.	Director of Therapies & Health Science		Sep-18	Strategy and Delivery	Completed	Over One Year
2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science	R2/8	R2 Improve the effectiveness of the Medical Device Safety Officer role, by: • providing clarity on the purpose of the role; • ensuring attendance at Medical Equipment Group meetings; • ensuring attendance at Clinical Board Quality, Safety and Experience meetings; • ensuring that MDSOs engage with their respective Clinical Board on medical equipment risks and issues; • ensuring MDSOs have the necessary time and resources to perform the role; and • giving MDSOs access to potential learning and development opportunities.	Fully embed MDSO in CB QSE structures. Review MDSO role profile and resourcing and communicate requirements of the role with Clinical Boards. Develop MDSO dashboard to include: • Attendance at MEG & QSE meetings • QSE Med Equip reports, CB Datix reports, • CB med equipment risks Take learning from comprehensive specialist services' CB compliance audit against the UHB's Medical Equipment Management Policy to all CBs and audit as part of annual self-assessment process.	Director of Therapies & Health Science		Mar-19	Strategy and Delivery	Completed	Over One Year

2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science	R3/8	R3 Review medical equipment risk management throughout the organisation, ensuring alignment between the corporate and operational approach.	Ensure CBs capture medical equipment risks as part of their risk management processes. These will be monitored via MEG, and escalated through relevant strategic committees, eg Strategy and Resources/Capital Management/QSE/Management Executive as required.	Director of Therapies & Health Science	Deputy Director of Therapies & Health Science	Apr-19	Strategy and Delivery	Partially Completed	Over One Year
2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science	R4/8	R4 The Health Board should determine how it can develop an effective medical equipment inventory with available resources.	The MEG will review the WHO good practice guidance and determine what is feasible to introduce, with resources available, to improve medical equipment inventory.	Director of Therapies & Health Science		Apr-19	Strategy and Delivery	Completed	Over One Year
2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science	R5/8	R5 The Medical Equipment Group should assure itself that clinical boards operate effective systems and processes for the monitoring, purchase and replacement of medical equipment below £5,000.	Ensure MSDOs include key under £5,000 items on their risk log and escalate replacement needs within the CB. Ensure medical devices procurement officer scrutinises under £5,000 items to identify opportunities for standardisation and efficiency	Director of Therapies & Health Science	MSDOs Medical devices procurement officer	Jan-19	Strategy and Delivery	Completed	Over One Year
2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science	R6/8	R6 Ensure that Clinical Boards include the Medical Device Safety Officer report as a standing agenda item at the Quality, Safety and Experience meetings to discuss and address any medical equipment risks and incidents that arise.	Develop MDSO metrics for reporting to their CB QSE meetings, and MEG reporting.	Director of Therapies & Health Science	Director of Therapies & Health Science	Nov-18	Strategy and Delivery	Completed	Over One Year
2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science	R7/8	R7 Ensure all relevant service areas collaborate, consult and engage on medical equipment issues. It should give particular attention to the arrangements in place for maintenance and replacement of beds and hoists.	Monitor attendance and engagement of CB MSDOs and other members at MEG, escalate non-attendance or lack of engagement. Monitor progress of action plan developed by Health and Safety Advisor following the Arjo Proact 2017 survey Health and Safety Committee 18/005 minute (25 January 2018). Maintain hoists within the Clinical Engineering Department at the end of external supplier contract. Ensure Clinical Engineering is represented at the Bed Management Group	Director of Therapies & Health Science	Deputy Director of Therapies & Health Science	Dec-18	Strategy and Delivery	Partially Completed	Over One Year
2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science	R8/8	R8 Evaluate the medical equipment arrangements in place within Pathology Services (Laboratory Medicine).	Agree Pathology MDSO role with CD&T with same CB functions at a directorate level reporting through to CB MDSO.	Director of Therapies & Health Science	Director of Therapies & Health Science	Nov-18	Strategy and Delivery	Completed	Over One Year
2017-18	Dec-17	Discharge Planning	Chief Operating Officer	R4a	Explore developing an e-learning course for discharge planning which ward staff may find more accessible.	Work is ongoing with LED colleagues to develop a discharge planning focused e-learning resource.	Chief Operating Officer	Head of Integrated Care	Dec-18	Strategy and Delivery	Partially complete	Over One Year

2019-20	Jun-19	Clinical Coding Follow-up From 2014 not yet completed	Director of Transformation and Informatics	R1	**Clinical Coding Resources:** Strengthen the management of the clinical coding team to ensure that good quality clinical coding data is produced. This should include: c) ensuring that there is capacity to allow band 4 coders to undertake mentoring and checking of coding of band 3 staff in line with job descriptions; d) revisiting the allocation of specialities across staff to ensure that there is sufficient flexibility within the existing capacity to cover periods of absence and succession planning is in place for staff who are due to retire in the next five to ten years; g) increasing levels of engagement between the different teams within the Health Board, to provide opportunities to raise issues, develop peer support arrangements and share knowledge; h) updating the clinical coding policy to reflect the current operational management arrangements; and k) increasing the range of validation and audit processes, including the consideration of the appointment of an accredited clinical coding auditor.				Digital Health Information	no action taken	Over 1 year
2019-20	Jun-19	Clinical Coding Follow-up From 2014 not yet completed	Director of Transformation and Informatics	R2	**Medical Records:** R2 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include: a) reinforcing the Royal College of Physician (RCP) standards across the Health Board and developing a programme of audits which monitors compliance with the RCP standards; b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS); c) putting steps in place to ensure that notes that require coding are clearly identified at ward level and that clinical coding staff have early access to medical records, particularly at UHW; e) reducing the level of temporary medical records in circulation; f) considering the roll out of the digitalisation of health records to the Teenage Cancer Unit to allow easier access to clinical information for clinical coders; and g) revisiting the availability of training on the importance of good quality medical records to all staff.				Digital Health Information	no action taken	over 1 year
2019-20	Jun-19	Clinical Coding Follow-up From 2014 not yet completed	Director of Transformation and Informatics	R3	Board Engagement: Build on the good level of awareness of clinical coding at Board to ensure members are fully informed of the Health Board's clinical coding performance. This should include: c) raising the awareness amongst Board members of the wider business uses of clinically coded data.					Digital Health Information	no action taken	Over 1 year
2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	R1	**1: the 'retire and return' arrangements require strengthening** The Health Board should strengthen its current guidance so that it clearly sets out all the key elements of the DoH guidance. The revised guidance should include all the DoH's employer-checks, which the Health Board should always apply and clearly evidence when assessing a business case for an employee to retire and return. The Health Board should ensure that its updated guidance is shared with all Clinical Boards and Departmental Heads.	The Health Board is currently reviewing the Retire and Return Procedure in partnership with Trade Unions. The purpose of this review is to reduce inconsistencies in the way that it is applied across the UHB by reducing the level of manager's discretion involved and ensuring that applications can only be rejected for robust business reasons. Reference will be made to the DoH guidance and checklist as appropriate. Reference will also be made to the other flexible retirement options to raise awareness of the flexibilities available.			Feb-20	Audit and Assurance	Partially complete	over 1 year
2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	R2	**2: the quality of the draft 'Remuneration and Staff Report' requires improvement** The Health Board should review why the level of error increased for 2018-19; and it should strengthen the management review and 'sign-off' of the Remuneration and Staff Report prior to its submission to us for audit.	Prior to the end of the financial year a co-ordinating meeting will be held between the appropriate staff in finance, governance and HR to ensure that the information presented in all sections of the annual report is consistent and accurate.			Mar-20	Audit and Assurance	Complete	over 1 year

2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	R3	**3: the Annual Governance Statement requires a revamp** The Health Board should review the style, structure and content of its 2019-20 AGS. The Health Board should look to complete the review by early 2020 so that it has an agreed basis for its preparation and submission for audit. If the Health Board wishes, we could provide audit input into its early review of the style, structure and content of the 2019-20 AGS.	Accept this finding and agreed to do a much more concise document for 2019/20 and also agree to get early input from WAO into the document. It would be useful if WAO could sign post Cardiff and Vale to a LHB who have developed a good document which meets all the requirements			May-20	Audit and Assurance	Complete	over 1 year
2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	R4	**4: the Phase 2 and Phase 3 continuing healthcare claims require concluding** The Health Board should establish the reason for the ongoing delay with each of the remaining Phase 2 and Phase 3 claims and it should seek to conclude them promptly	Phase 2 – awaiting grant of probate for one claim. Face to face meetings required for both claims Phase 3 –Work during the first quarter of 2019-20 has left 61 cases open; 6 are planned for reimbursement imminently, 25 have been reviewed but are not yet ready for reimbursement due to requiring further meetings, negotiation, panels etc.,30 are not yet reviewed, Good progress continues to be made as agreed within the available resource which includes additional staff employed, with the intent to continue to conclude cases promptly			Mar-20	Audit and Assurance	Partially Complete	over 1 year
2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	R5	**5: some of the related party declarations require more detail** The Health Board should review its guidance to IMs and SOs to ensure that it is clear on the level of detail required in their annual related party declarations. The Health Board's Finance Team should promptly return any inadequate information to the relevant IM / SO, and request their prompt clarification.	Agreed and in future we will ensure that there is clarity in relation to the detail provided so checks can be made			Mar-20	Audit and Assurance	Complete	over 1 year
2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	R6	**6: some of the arrangements around the year-end stocktake require improving** The Health Board should ensure that all officers who undertake and record stock counts are regularly trained so that they fully understand the procedures and key requirements that are in in place.	Your findings will sent out with the annual stock taking instructions at the end of January 2020, with clear instructions that all Clinical Boards comply with your recommendation.			Mar-20	Audit and Assurance	Partially complete	over 1 year
2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	R7	**7: there is no contract for the GHX electronic invoicing system** The Health Board should confirm with NWSSP whether a contract with the supplier is now in place. If there is still no contract with the supplier, the Health Board should evaluate any associated risks and if necessary consider suspending its use of the portal until a suitable contract is in place.	The GHX system was developed by the Main Medical Consumable Suppliers and NWSSP pay an annual fee to use the system on behalf of NHS Wales. It is a system that is used widely throughout the NHS and represents the only mechanism which NHS Wales can pay a number of the major NHS Suppliers. GHX are based on the G cloud framework and NWSSP will look to enter into a more formal arrangement for the service in the future			31-Dec-19	Audit and Assurance	Complete	over 1 year
2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	R8	**8: there is an absence of classifying prepayments between short term and long term** The Health Board should remind all relevant officers of the importance of considering the classification of prepayments, in terms of the period that they cover and whether any of the year-end prepayments extend beyond two months after 31 March year-end. The Health Board should ensure that its review of the draft financial statements is sufficiently robust in this area, prior to the submission of the statements for our audit.	The Head of Financial Accounting will request an amendment to the All Wales Coding Structure to set up a new code for prepayments due > 1 year. Your recommendation will then be shared with all finance staff with a clear instruction to use the new code as appropriate.			01-Sep-19	Audit and Assurance	Complete	over 1 year
2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	R9	**9: the accounting for purchase-order accruals requires improvement** The Health Board should review its arrangements for the identification and assessment of the year-end purchase order accruals. The review should consider the adequacy of the accruals process in place, and whether the relevant staff receive adequate training each year.	The Health Board will provide additional guidance to staff and implement additional training and review processes to ensure that the accuracy of the accrual in 2019-20.			Mar-20	Audit and Assurance	Complete	over 1 year
2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	R9	**A Senior Officer has been underpaid** The Health Board should ensure that the officer's salaray is corrected and paid accordingly. The Health Board should also review, and if necessary strengthen, its process for the appointment of new or promoted staff to pay scales.	The correction has been processed accordinly. The situation arose to to a mis-communication between NHS organisations. The processes in place are sufficient and this is not deemed a systemic issue.			COMPLETE	Audit and Assurance	Complete	over 1 year

2019-20	Nov-19	Structured Assessment	Chief Executive Officer	R1	**Committee meeting frequency and timing** R1 We found scope to review the timings and frequency of some committee meetings to support members to scrutinise current information more often. Reviewing timings will also allow maximum attendance at meetings. The Health Board should: a) Review the frequency of Audit Committee meetings to close the gap between the May and September meeting. b) Review independent member's capacity and timings of committee meetings where there is infrequent independent member attendance	Agree this can be achieved an additional meeting will be added in for July which will also coincide with other meetings taking place in July 2020. This is already under review with the change in Chair and Vice Chair. Current proposals include increasing the membership of each Committee to ensure the meetings are quorate.		Director of Corporate Governance Director of Corporate Governance / Interim Chair of the UHB	Dec 19 Dec 19	Audit and Assurance	Complete	over 1 year
2019-20	Nov-19	Structured Assessment	Chief Executive Officer	R2	**Performance Management Framework** R2 We found that performance monitoring at an operational level is sound, but some information received by the Board and its committees need to be improved. When the Health Board restarts its performance framework review it should be extended to include: • Monitoring IMTP delivery on a quarterly basis and reporting the wholescale position to the Strategy and Delivery Committee and Board. We have previously suggested presenting the committee with a summarised version of the IMTP progress reports available at clinical board performance reviews. • Ensuring that the Strategy and Delivery Committee receives, the same or more, detailed performance information than that received by the Board.	Agree to recommendation. The flash report which is used for Performance Reviews will be sent to Strategy and Delivery of a quarterly basis. December 2019 we will start from the beginning of the New Year and send to the S&D Committee in January 2020 Agree to the recommendation. The performance information is currently under review alongside other performance information to the Committees to ensure a consistent approach and that assurance can then be appropriately provided to the Board from each Committee.		Director of Planning Director of Digital and Health Intelligence	January 2020 January 2020	Audit and Assurane	Partially complete	Over 1 year
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R1	**Long-term** Further enhance the profile of primary care by building upon the successes of existing promotional campaigns.	We will continue to build on the Primary Choice campaign to promote Primary Care.		Director of Operations, PCIC	Ongoing	Strategy and Delivery	no action taken	over 6 months
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R2	2 Develop a campaign to educate the public about what types of services will be available at each of the centres and hubs.	We have an active engagement programme for each of the Wellbeing Hubs and Health and Wellbeing Centres, we will continue to evolve our engagement working with local organisations, public health colleagues and community groups to promote the services in each centre.	Director Planning		Dec-21	Strategy and Delivery	no action taken	Over 6 Months
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R3	3 Use examples of successfully moving services from secondary to community and primary care to promote and sustain a shift in resources from other services that could be provided closer to home.	Supporting services to move to community delivery is a core element of the Health Board's Integrated Medium Term plan. Through this process we are celebrating and promoting examples of good practice.	Director Planning		Ongoing	Strategy and Delivery	no action taken	Over 6 Months
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R4	4 Develop a model to monitor and review the impact and benefits of the centres and hubs. Use a blended approach that includes outcome measures, data, exemplar projects and patient stories to show not only cost effectiveness but also the positive impact on patient experience.	The Regional Partnership Board is developing an Outcomes Framework which will provide a tool to support the evaluation of the impact of Health and Wellbeing Centres and Wellbeing Hubs.	Director Planning		Jul-20	Strategy and Delivery	no action taken	Over 6 Months
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R5	**Prevention** 5 Undertake needs assessments on an ongoing basis and continually review services to ensure that centres and hubs remain current and fit for purpose.	Primary Care Clusters are required to produce plans to meet the needs of their populations, this will include considerations of Wellbeing Hub services once established. These plans will take into account evidence from wider needs assessments including future updates to the population assessment required under the Social Services and Wellbeing Act and the Wellbeing Assessment required under the WFG Act		Director of Operations, PCIC	Annually	Strategy and Delivery	no action taken	Over 6 Months
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Planning	R6	6 Develop a clear plan to agree finances prior to centre and hub services commencing to prevent duplication of resources.	This will form part of the operating model of the Wellbeing Hubs.	Director of Planning		Nov-21	Strategy and Delivery	no action taken	Over 6 Months
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R7	**Integration** 7 Undertake a community services mapping exercise for each of the localities to identify services it could signpost patients to if they	We will be undertaking this mapping on a locality and cluster basis in partnership with existing tools and services such as Dewis Cymru.	Director of Planning		Oct-21	Strategy and Delivery	partially complete	Over 6 Months
2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R8	**Collaboration** 8 Develop some overarching principles for the centres and hubs operating model which allow for some local variation based on community need.	We will establish an overarching operating model for the Health and Wellbeing Centre and Wellbeing Hubs focussed on operating as single assets and supporting community ownership.	Director of Planning		Oct-21	Strategy and Delivery	partially complete	Over 6 Months

2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	R9	**Involvement** 9 Explore the best vehicles to engage marginalised citizens both in terms of planning future centres and hubs and in ensuring they are accessible to all when in operation. For example, by finding community leaders to help roll out key messages and engage with these groups on an ongoing basis.	We will ensure this forms part of the engagement plan for each project.	Director of Planning		Oct-21	Strategy and Delivery	no action taken	Over 6 Months