AUDIT COMMITTEE

24 APRIL 2017, 9.00AM

CORPORATE MEETING ROOM
HEADQUARTERS, UHW

AUDIT COMMITTEE
Monday, 24 April 2017 at 9.00am
CORPORATE MEETING ROOM, HQ, UHW
AGENDA

PART 1 - SECTION 1: PRELIMINARIES *(Chair)*		
1.	Welcome and Introductions	*Oral*
2.	Apologies for Absence	*Oral*
3.	Declarations of Interest	*Oral*
4.	Minutes of the Committee meeting held on 28 February 2017	*Chair*
5.	Action Log from the meetings on 28 February 2017	*Chair*
6.	Any Other Urgent Business: To agree any additional items of urgent business that may need to be considered during the meeting.	*Oral*
SECTION 2: PATIENT SAFETY		
7.	Patient Safety • Medicines Cost Reduction • DoLS	*Oral* *C Evans*
SECTION 3: AUDIT AND COUNTER FRAUD		
8.	Internal Audit Position Report including the following finalised audit reports/updates as follows: **Assignment** — **Assurance Rating** 1. Radiology – Treat in Turn — Substantial 2. Core Financial Systems — Substantial 3. Dental – Medicines Management — Reasonable 4. Clinical Audit Follow-up — Reasonable 5. Leavers Management Follow-up — Reasonable 6. Llanishen Stores Follow-up — Reasonable 7. Medical Locums Follow-up — Reasonable 8. Mental Health – CHC & Out of Area — Reasonable **Please see part 2 agenda item 23 for full copies of reports*	*J Johns*
9.	To Approve Internal Audit Annual Plan and Charter	*J Johns*

10.	Wales Audit Office – Audit Committee Update	*WAO*
11.	Wales Audit Office – Review of Radiology Services	*WAO*
12.	To Receive Tracking Report on Audit Recommendations	*P Welsh*
13.	To Note the Management Response to the Wales Audit Office Annual Report and Structured Assessment	*P Welsh*
14.	Post Payment Verification – Receive Annual Report	*S Lavendar*
SECTION 4: POLICIES AND COMPLIANCE REPORTS		
15.	No items to report	*B Chadwick*
SECTION 5: COMMITTEE GOVERNANCE		
16.	Report of Hospital Register & Register of Declarations of Interest	*P Welsh*
17.	To Receive the Corporate Risk and Assurance Framework	*P Welsh*
18.	To Receive Regulatory Bodies & Review Tracking Report	*P Welsh*
19.	To receive and refer items from Board or other Committees as appropriate	*Oral* *P Welsh*
SECTION 6: ANNUAL FINANCIAL AND GOVERNANCE STATEMENTS		
20.	Topical Legal and Regulatory Items	*Oral* *P Welsh*
21.	Audit Enquiries to those Charged with Governance and Management	*R Chadwick*
SECTION 7: ITEMS FOR DECISION		
22.	No items to report	
PART 2 - ITEMS FOR INFORMATION		
23.	Internal Audit reports for information: **Assignment** — **Assurance Rating** 1. Radiology – Treat in Turn — Substantial 2. Core Financial Systems — Substantial 3. Dental – Medicines Management — Reasonable 4. Clinical Audit Follow-up — Reasonable 5. Leavers Management Follow-up — Reasonable 6. Llanishen Stores Follow-up — Reasonable 7. Medical Locums Follow-up — Reasonable 8. Mental Health – CHC & Out of Area — Reasonable	

24.	Post Payment Verification – Approve Annual Plan	*S Lavendar*
FINAL CLOSURE AND FUTURE MEETINGS		
25.	Review of the Meeting	*Oral* *Chair*
26.	To note the date, time and venue of the next meeting of the Committee: • **Tuesday, 23 May Workshop 2017, 9.00am** Corporate Meeting Room, Headquarters, University Hospital of Wales	

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]

UNCONFIRMED MINUTES OF A MEETING OF THE AUDIT COMMITTEE HELD ON 28 FEBURARY 2017 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UHW

4

Present:

Ivar Grey	Independent Member – Finance, Chair
John Antoniazzi	Independent Member - Estates
Stuart Egan	Independent Member – Trades Unions

In Attendance:

Robert Chadwick	Director of Finance
James Johns	Head of Internal Audit
Simon Cookson	Director of Audit and Assurance, NWSSP
John Herniman	Wales Audit Office
Anne Beegan	Wales Audit Office
Craig Greenstock	Counter Fraud Manager
Mark Jones	Wales Audit Office
Carol Evans	Assistant Director of Patient Safety and Quality

Apologies:

Prof Elizabeth Treasure	Independent Member - University
Peter Welsh	Director of Corporate Governance
Nigel Gibbs	Trade Union Representative

Observer:

Kate Febry	Wales Audit Office

Secretariat: Glynis Mulford

AC: 16/087 WELCOME AND INTRODUCTIONS

The Chair welcomed all present to the meeting.

AC: 16/088 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

AC: 16/089 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings. None were declared.

AC: 16/090 UNCONFIRMED MINUTES OF THE MEETING HELD ON 15 NOVEMBER 2016

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 15 November 2016.

AC: 16/091 ACTION LOG FROM MEETING OF 9 FEBRUARY 2016

The Committee **RECEIVED** the Action Log from the meeting of 15 November 2016 and **NOTED** the following:

AC 16/076 – ***Internal Audit Position Report:*** C Evans had discussed with Director of Nursing of Medicine Clinical Board and QSE Lead. Reports set up on Datix and will be meeting again shortly. **COMPLETE**

AC 16/078 – WAO Progress Against Plan: Will be considering the Health Boards discharge planning arrangements to ensure this was being managed and arrangements around repatriation in specialist services. **COMPLETE**

AC 16/080 – Post Payment Verification: C Evans had met with auditors and discussed with Director of Nursing PCIC, who will send out correspondence to community pharmacists. **COMPLETE**

AC 16/017 – Medacs / Locums: This item will be brought to April meeting.

AC 16/17 - DoLS: Was unable to give full assurance around this issue as UHB had around 1500 patients awaiting for DoLs applications to be processed. The majority of these patients lay with the Local Authority but the Health Board still had 75 applications to be assessed and processed to put arrangements in place. This was being monitored by Mental Health and Capacity Legislation Committee.

ACTION: C Evans to check if this is a standing item on MHCLC Committee agenda and if placed on risk register

AC 16/059 – Security at Llandough: Confirmed by Head of Security this action was **COMPLETE.**

AC: 16/092 ANY OTHER URGENT BUSINESS

The Chair explained that due to the acceleration with the sign off of accounts, on completion these will be emailed to the Head of Internal Audit and Independent Members to be reviewed offline. The arrangements and dates for reports and accounts to be submitted to Welsh Government was further explained and discussed.

ACTION: I Grey to discuss with P Welsh to confirm in writing the arrangements and dates for Year End reporting

AC: 16/093 INTERNAL AUDIT POSITION REPORT AND TRACKING REPORT

James John, Head of Internal Audit (HoIA) highlighted the audit assignments which had been finalized with key messages and summaries from reports as follows. The Claims Reimbursement received Substantial Assurance. Nine had received reasonable assurance, which included Safeguarding (Children), Carbon Reduction Commitment and Public Health Targets, with one report receiving Limited Assurance.

The Chair asked why there was no executive attending the meeting to respond to the limited assurance report as this was a long standing policy to ensure that remedial action was taken. It was agreed that in future this would be specifically agreed at the pre-audit agenda setting meeting.

It was reported that a large number of pieces of work had been finalized which will be brought to the April meeting. The Chair was concerned that there were still 21 reports to be received at the next meeting.

James Johns informed the Committee in terms of our overall progress there a number of reviews where additional work and discussions have been required and this has inevitably taken extra time due to the emerging findings.

In addition to this audit, we had been asked by two Clinical Boards to undertake some urgent work to assist with some anomalies with additional payments. Furthermore the Medical Director had written to us for some work to be undertaken to support the improvements of procedures developed with the Medicine Clinical Board.

It was also noted that as a result of the requirement to bring forward the annual reporting timescales, we are going to have to undertake some originally 2017/18 planned work much earlier, as this will need to commence prior to the end of the 2016/17 year.

The impact of the additional work and the need to bring forward the reviews mentioned above will have an impact on the delivery of a small amount of 2016/17 work which I recommend moves back and we pick up as part of the 2017/18 planned work. The reviews suggested for moving back in to 2017/18 were Charitable Funds, R&D, Regulatory Compliance and also Virtulisation.

The Committee **AGREED** to the recommendation of changing the 2016/17 work plan deferring four reports to the 2017/18.

ACTION: J John to liaise with R Chadwick to look at re-arranging dates

The Committee was informed that the issue of too many audit reports being delivered at end of year was an all Wales concern. There was wider discussion on the pressures of submitting reports with the effect of the Annual Report change

of date. The expected dates for completing individual assignments and the timing of meeting and will be reviewed as part of the planning for 2017/18.

Operational Services – Reasonable Assurance: It was highlighted that rotas had been appropriately drawn up to meet the needs of the service and recommendations were made around strengthening some of the manual processes. Assurances were given in relation to there being available resource to use an automating system (Kronis). With regard to a change in the terms of employment to comply with UHB policies, the Union had arranged a meeting with HR and Estates to talk through the terms of employment and was content they would fulfill the requirements.

Estates Follow-up – Reasonable Assurance: Previous reports had highlighted concerns and this follow-up report centred around a number of issues which had progressed and had moved on substantially but further work was needed in wider embedment of systems. It was emphasized that Kronis was part of solution and will help with the process. It was raised whether there were completion dates in the Management Response. Revised dates had been set which will be monitored through the routine follow up.

Dental Medical Advice – Reasonable Assurance: It was stated that policies, processes and procedures in place were well established and widely disseminated and appropriate training to staff had been provided. Improvements to be made around coding had been identified. Although procedures were in place there was a need for enhancements around the monitoring of several aspects.

The Chair raised concerns in regard to maintenance records for devices and whether this was Health Board wide.

ACTION: I Grey to discuss with Chair of PPP Committee

Children and Women Clinical Board Staffing – Reasonable Assurance: Appropriate arrangements were in place around rotas, skill mix and contracted hours and with Bank staff being properly authorized. The management of annual leave processes around nursing staff was good but identified weaknesses around the medical staff side.

Concerns were raised with the reluctance of medical staff returning documents and ESR not being used. This was considered to be a UHW wide issue and the Head of Internal Audit assured the Committee that this area was in the planning discussions for the year ahead. There was discussion on whether a wider review should take place. The Director of Audit and Assurance stated that he met with all the Heads of Internal Audit to see if there were any common themes and would take them forward through to the Health Board and Wales Audit Office (WAO) to identify common issues to feed through study programmes WAO are undertaking.

ACTION: I Grey to write to Medical Director

Surgical Medical Staff Study Leave – Reasonable Assurance: An all Wales policy was in place but local procedures need to be brought up to date. Part of testing identified episodes of late submissions of claims and costs incurred. It was considered that some requirements of study leave should be part of an appraisal process and should be part of the all Wales annual appraisal electronic system (MARS).

ACTION: I Grey to talk to Medical Director

Medicines Cost Reduction – Reasonable Assurance: This report was a follow up on medicine wastage and the Committee was informed that processes had been strengthened since early work. Recommendations had been taken forward with some being addressed in a different way from the original recommendations with new initiatives and improved arrangements.

There was discussion around there being no logging of medicines returned where the response of cost benefit was questioned and whether this was acceptable.

Anne Beegan WAO stated that reference had been made to a national report which was published on prescribing and secondary care medicines management and asked for this to be shared with key officers.

ACTION: Carol Evans to look at concern and bring back to next meeting as part of patient safety update

PCIC Clinical Board – Community Stock – Limited Assurance: The report looked at aspects of stock management within the locality premises and considered a number of clinics across the Health Board. It was identified there was no structured stock management process in place and insufficient procedures of guidance. Stock was held securely, but the layouts of some clinics were not ideal with areas open to the public. There was some risk around water and fire damage in relation to where the stock was held. With the lack of stock process this meant that ordering and stock management processes in those clinics was inefficient and lacked management information around stock. The value of stock held in the localities was not large but key to the services provided. There was a need for the response and actions to be considered in the overall context of the value of stock.

Concern was raised around a number of projects introduced to make various improvements but not followed through. It was stated if a Clinical Board was committed to a project then it was committing that they had identified the resource. If they were unable to complete the action then they should raise it with the Executive responsible.

Concern was raised on how this would impact on external audit and responded that WAO will look at outcomes of various work and consider the issue and how this would impact the year end accounts.

The WAO gave an overview of the stock value, analysis, stock testing and how this informs the risk assessment. If there were error rates in samples considerations are made in terms of the extent and impact on the annual accounts.

ACTION: I Grey to contact Sue Morgan for an update

The Committee:
RECEIVED and **NOTED** the Internal Audit Position Report and Tracking Report

AC: 16/094 WALES AUDIT OFFICE STRUCTURED ASSESSMENT

Ms Anne Beegan, Wales Audit Office, presented the Structured Assessment report. It was explained the report focused on four areas which were the Health Board's financial management and governance arrangements, Board assurance and what the Health Board's arrangements were for developing the three year plan. There was a smaller fourth aspect of recommendations raised by WAO and how well these issued had been progressed. The Structured Assessment will be fed into Board Development Day and once reported to Committee would be placed on the WAO website.

It was discussed and noted:

- In terms of financial management, it was explained this would be the first year where the Health Board would be formally assessed against the requirements to balance over three years, The UHB was not expecting to achieve financial balance resulting in a qualified regulatory opinion on the accounts.

- In response to the impact of the qualification on auditor's report it was explained that two opinions would be given, in the first instance a true and fair view would be presented and secondly, a regulatory report would be put on the HB account to explain position. Also explained were changes with the revised legislation.

- The opinion on the account would raise issues in terms of audit risks. WAO would report back to Welsh Government that the resource limit had been breached. Wider discussions ensued on the plan and financial management of the Health Board.

- In relation to follow-up of previous recommendations, it was stated that these had come to Audit Committee due to the lack of progress in many areas in addressing the recommendations. It was stated the Audit Committees role in ensuring progress of action in response to recommendations had not worked well, as actions were not being tracked and there was a need to rethink how this will take place.

ACTION: I Grey, B Chadwick and P Welsh to meet and discuss

ACTION: Structured assessment action plan had not been completed. A Beegan to liaise with P Welsh

The Committee:

- **NOTED** the Report on Structured Assessment

AC: 16/095 WALES AUDIT OFFICE – CONSULTANT CONTRACT

Ms Anne Beegan, Wales Audit Office, presented the Consultant Contract follow up review on previous work undertaken in 2010. There was also combined follow-up on recommendations made both nationally and locally. It was stated that few of the national recommendations had been implemented fully.

There was variability across Clinical Boards and directorates in regard to training for those who are running job plan. An action plan had been agreed with the Medical Director.

There was further discussion to the management response in relation to original date and completion date which should remain visible.

ACTION: I Grey - report to go to PPP Committee and raise concerns with Chair

ACTION: A Beegan to reissue report with original dates in management response.

The Committee:
NOTED the report on Consultant Contract and Management Response

AC: 16/096 WALES AUDIT OFFICE – DELAYED TRANSFERS OF CARE

Ms Anne Beegan, Wales Audit Office, presented the report which looked at partnership arrangements between the Health Board, Health and Social Care Community Services and both Local Authorities. This was a positive report in terms of how partnerships are working together and what organizations are doing in putting arrangements and processes in place. Work was needed around having a plan B if joint funding arrangement stopped.

The Committee:

- **NOTED** the Report on Delayed Transfers of Care

AC: 16/097 WALES AUDIT OFFICE – REVIEW OF ESTATES

Ms Anne Beegan, Wales Audit Office, presented the report on Review of Estates from two aspects which were operational in terms of how the estates function and strategically where estates were situated.

Wales Audit Office had raised concerns around the estates backlog. Progress had been made and had identified positive steps in improving estates management. Interface between estates and the Clinical Boards had improved and information was better around performance management. But raised concerns around being under resourced. From a strategic aspect there was a clear view of where estates were going but this had not been documented.

There was wider discussion on the lack of completion dates on all the management responses and stated these were not acceptable.

The Committee

- **NOTED** the report on Review of Estates and Management Response

AC: 16/098 WELSH AUDIT OFFICE ANNUAL REPORT 2016/17

Mr John Herniman, Wales Audit Office presented the report where the Committee **CONSIDERED** and **NOTED** the Progress Report Against Plan which summarised the key messages and findings of all the reports issued throughout the year. This report will be presented to the Board meeting in March 2017.

AC: 16/099 WALES AUDIT OFFICE – AUDIT COMMITTEE UPDATES

Mr John Herniman and Ms Anne Beegan, Wales Audit Office, presented the Audit Committee Updates stating there were no significant issues unexpected and was progressing well. In terms of performance, work was still ongoing from previous plan in relation to a Thematic Review on radiology but this had now been completed. Also highlighted was the Emergency Ambulance Commissioning Review which is being finalized with EASC. The report will be taken to EAS Committee at end of March and will be circulated to various committees. Out of Hours PCIC draft report was being finalized and will circulate back out to PCIC for commentary. The Follow-up of Outpatients Progress Update which was not detailed but doing a progress stock take on recommendations made previously. This will be amalgamated with other Health Boards to present an All Wales position.

The Committee was informed that a number of reports and sites to access had been referenced with links incorporated.

The Committee:
NOTED the Wales Audit Office report on Audit Committee Updates

AC: 16/100 WALES AUDIT OFFICE ANNUAL PLAN 2017

Mr John Herniman, Wales Audit Office presented the Annual Plan, stating it ran through WAO responsibilities, setting out work that would be undertaken during the year. It presented the opinion on the Health Board accounts and went through the key risks. Further content of the Annual Plan was explained and relayed to members of the Committee.

It was stated that the Performance Audit work and Structured Assessment, focused on different aspects and looked at areas where there would be comparative work to do, that would add value and challenge the work being undertaken.

This year the Wellbeing and Future Generations Act commences, so will be looking at a baseline assessment of objectives across all bodies the Act applies to and assured guidance and feedback will be provided. Part of work will form part of Year 1 Commentary which will pull together the position across Wales. There will also be thematic reviews around primary care and working with local government partners. In addition to good practice, time will be spent on follow up ensuring there would be movement in response to recommendations being made.

The Committee:

- **NOTED** the WAO Annual Plan 2017

AC: 16/101 TRACKING REPORT ON AUDIT RECOMMENDATIONS

The Committee **RECEIVED** the Tracking Report on Audit Recommendations and it was **NOTED** and **AGREED** from the previous minute AC: 16/094, that more detail was needed on the responses to the recommendations in order to attain better assurance.

ACTION: I Grey and R Chadwick to discuss and liaise with P Welsh

AC: 16/102 CLINICAL AUDIT PROGRAMME

It was stated that the Quality, Safety and Experience Committee received a good report at their last meeting which showed the Clinical Boards were identifying the clinical audit programme much better than in the past although there was weakness in ensuring they were properly logged and monitored. At the next Committee meeting the Chair asked for a report on what would be the proposed Clinical Audit Programme for next year and how it ties in with the internal audit work.

ACTION: Report requested to be submitted to Committee on Clinical Audit Programme

AC: 16/103 BI-ANNUAL REPORT OF HOSPITALITY REGISTER AND REGISTER OF CONFLICTS OF INTEREST

The Committee **RECEIVED** and **NOTED** the report but due to the Board Secretary not being present at the meeting and inaccuracies highlighted on spreadsheet, this would be deferred for a verbal update at the next meeting.

ACTION: P Welsh to verbally update at next meeting

AC: 16/104 CORPORATE RISK ASSURANCE FRAMEWORK

The Committee **REVIEWED** and **NOTED** the risks assigned to the Audit Committee which provided assurance to the Board.

AC: 16/105 LOSSES AND SPECIAL PAYMENTS REPORTS

Mr R Chadwick presented the report, which summarized the meetings of the panel.

The Committee:

- **APPROVED** the write off of the losses and special payments outlined in the assessment section shown below:
- **NOTED** the minutes of the 15 November 2016 meeting of the Losses and Special Payments Panel.

AC: 16/106 INTEMS FOR INFORMATION

The Committee **RECEIVED** and **NOTED** items for information.

AC: 16/107 REVIEW OF MEETING

It was agreed that the following matters should be raised by the Chair:

- To ensure that the arrangements and dates for year-end reporting were relayed in writing to the Committee
- Recording of dental devices – To be raised with PPP Committee Chair
- To raise issue of ESR not being used by medical staff with Medical Director
- To raise with Medical Director concerns around controls relating to study leave

- To contact Head of Operations and Delivery PCIC for an update on community stock
- Ensuring WAO reports are going to relevant committees and actions were appropriate with dates with improved tracking

AC: 16/108 URGENT BUSINESS

There was no urgent business

AC: 16/109 DATE OF NEXT MEETING

The next Audit Committee meeting is scheduled to take place at 9.00am on **Monday, 24 April 2017,** in the Corporate Meeting Room, Headquarters, UHW.

AUDIT COMMITTEE – ACTION LOG FOLLOWING FEBRUARY 2017 MEETING

Minute	Date of Meeting	Subject	Agreed Action	Action to	Status
AC 16/093	28.02.17	Internal Audit Position Report and Tracking Report	To look at re-arranging dates on IA workplan in order to be more streamlined with the Annual Report	J Johns	To liaise with P Welsh
AC 16/093	28.02.17	Internal Audit Position Report and Tracking Report	Dental CB – to discuss with Chair of PPP Committee the omission of record keeping in relation to dental devices	I Grey	Email sent to Chair of PPP Committee
AC 16/093	28.02.17	Internal Audit Position Report and Tracking Report	PCIC Community Stock – To contact Head of Operations and Delivery for an update	I Grey	
AC 16/094	28.02.17	WAO Structured Assessment	To liaise with P Welsh and ensure WAO reports are going to relevant committees and actions are appropriate with date and improved tracking To liaise with P Welsh as action plan not complete	I Grey A Beegan	**COMPLETE** Discussed with P Welsh.
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS					
AC 16/093	28.02.17	Internal Audit Position Report and Tracking Report	Medicines Cost Reduction – to look at the absence of logging medicines returned	C Evans	To report to **April 2017** meeting as part of Patient Safety update
AC 16/102	28.02.17	Clinical Audit Programme	Report requested to be submitted to Committee	Secretariat	To be reported at **September 2017** meeting
AC 16/103	28.02.17	Report of Hospital Register & Register of Conflicts of Interest	For a verbal update at next meeting	P Welsh	To be reported at **April 2017** meeting

5

AC 16/076	15.11.16	WAO Progress Against Plan	Resources in Corporate Governance Team to be raised at Board	I Grey	Resource allocation being reviewed by Management Executive. No action until outcome is known. To be raised at Governance Coordinating Group
AC 16/079	15.11.16	WAO Tracking Report	Ask Medical Director to undertake an audit on orthopaedic revision rates and present to QSE Committee	P Welsh	QSE Committee
AC 16/017	12.04.16 20.09.16	Medacs / Locums	Medacs / Locums – Limited Assurance: An update to be presented in six months' time To raise concerns with limited responses in recommendations 3 of report and recommendation 4 – in relation to compliance of mandatory training	G Shortland P Welsh	Internal Audit update due **April 2017** Following IA meeting with GS, the issues will be covered by the IA follow up which will be undertaken in **Feb/March 2017** and reported back to Committee
AC 16/017	12.04.16	DoLS	DoLS – Limited Assurance: The Medical Director to talk with Chair of MHCLC about risk management in relation to documentation and issues around culture and change in legislation	G Shortland	Action plan progressing however some key action e.g. around culture are taking longer to be delivered. It had been required that the IA will follow-up and be deferred until 17/18 plan to allow these actions to

5

AC 16/073	15.11.16 28.02.17		To check if DoLs is standing item on MHCLC agenda and if issues highlighted had been placed on risk register		be delivered. As some of the actions were delayed, assurance was required that legal requirements were being met and patients were being looked after properly. To report verbal update back at next meeting **April 2017**
AC 15/008	24.02.15 8.12.15	Business Continuity Planning	Provider a follow up report in September 2015	J Johns	The follow up has been put back to the 17/18 plan at the request of the Executive Director
AC 16/077	15.11.16	Internal Audit Theatre Stock	Receive an update report	J Johns	Internal Audit has undertaken the follow up. A draft report has been issued to management indicating reasonable assurance. Whilst some actions still require further implementation this, represents significant improvements from previous reviews.

5

COMPLETED ACTIONS (TO BE REMOVED ONCE REPORTED TO MEETING AS COMPLETE)					
AC 16/092	28.02.17	Any other urgent business	To ensure that the arrangements and dates for Year End reporting is communicated in writing to Board members	P Welsh	**COMPLETE.** Discussed at Governance Coordinating Group
AC 16/093	28.02.17	Internal Audit Position Report and Tracking Report	C&W Staffing – To write to Medical Director on the lack of medical staff not using ESR to record annual leave	I Grey	**COMPLETE**
AC 16/093	28.02.17	Internal Audit Position Report and Tracking Report	Surgical Medical Staff – To discuss with Medical Director medical staff claiming study leave and not attending events.	I Grey	**COMPLETE**
AC 16/095	28.02.17	WAO - Consultant Contract	WAO report to go forward to PPP Committee and to liaise with Chair and discuss concerns with management response.	I Grey	**COMPLETE.** Report to go to PPP Committee
AC 16/096	28.02.17	WAO – Delayed Transfer of Care	Report forwarded to QSE Committee	S Curry	**COMPLETE.** On agenda for next QSE meeting 18 April 2017

5

INTERNAL AUDIT	
Audit Committee	**April 2017**

Executive Lead : Executive Director of Finance & Director of Corporate Governance
Author : Head of Internal Audit, NWSSP Audit & Assurance Service, UHW 42724
Caring for People, Keeping People Well :
Financial impact : n/a
Quality, Safety, Patient Experience impact : n/a
Health and Care Standard Number - ALL **CRAF Reference Number ALL**
Equality Impact Assessment Completed: n/a

8

RECOMMENDATION

The Audit Committee is asked to:

CONSIDER the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports.

APPROVE the Internal Audit Plan including the Strategy and Charter for 2017/18.

SITUATION

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

- Detail relating to outcomes, key findings and conclusions from the finalised internal Audit assignments
- Specific detail relating to progress against the audit plan and any updates that have occurred within the plan.
- The Internal Audit Plan, Strategy and Charter sets out our risk based plan of work for the year 2017/18.

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 the Executive Directors.

The progress report provides the Audit Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee, amendments to the plan and also assignment follow ups.

The progress report highlights the conclusion and assurance ratings for audits finalised in that period. Reports that are given substantial or reasonable assurance are summarised in the progress report with the reports given Limited assurance or below included in full.

ASSESSMENT AND ASSURANCE

The progress report provides the Committee with the level of assurance given to the management of a series of risks covered within the specific audit assignments delivered as part of the Internal Audit Plan, along with information regarding the necessary actions required to address control weakness identified. The report also sets progress with the delivery of the Internal Audit plan.

8

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit Committee April 2017

Private and Confidential

8.1

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

8.1

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, 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 the Cwm Taf University Local Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. INTRODUCTION

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

1.2. The report includes details of the progress made to date against individual assignments, outcomes and findings from the reviews, along with details regarding the delivery of the plan and any required updates.

1.3 The plan for 2016/17 was agreed by the Audit Committee in May 2016 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

8.1

2. OUTCOMES FROM COMPLETED AUDIT REVIEWS

2.1 A number of assignments have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

2.2 A summary of the key points from the assignments with Reasonable and Substantial assurance are reported in Section four.

AUDIT ASSIGNMENT	ASSURANCE RATING	
CD&T Clinical Board – Radiology - Treat in Turn	Substantial	
Core Financial Systems	Substantial	
Dental - Medicines Mgt. (prescribing).	Reasonable	
Clinical Audit Follow up -	Reasonable	
Leavers follow up –	Reasonable	
Llanishen Stores Follow up	Reasonable	
Medical locums follow up	Reasonable	
Mental Health - CHC & Out of Area.	Reasonable	

3. DELIVERY OF INTERNAL AUDIT PLAN

3.1 Considerable progress can be demonstrated with the delivery of the plan with a number of audits finalised and a large number others at draft report.

3.2 The detail of the updated schedule and current progress of the audit work for the year is outlined in the assignment status schedule which is included at Appendix A.

3.3 Included at Appendix B is a summary of 2016/17 audit reports per assurance domain in order to provide information on assignment outcomes that can impact on the potential year end rating for that domain.

3.4 The Head of Internal Audit Annual report and Opinion is currently being developed. It is anticipated that at present a Reasonable Assurance opinion will be given for 2016/17, subject to the reaming audits and the quality review by the Director of Audit and Assurance.

8.1

4. FINAL REPORT SUMMARIES

4.1 CD&T Clinical Board – Radiology -Treat in Turn

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with treat in turn within Radiology is **Substantial Assurance**.

RATING	INDICATOR	DEFINITION
Substantial Assurance		The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

8.1

Radiology have adequate systems in place in order to record and monitor the referral date, receipt date and subsequent appointment date of each patient, and ensure patients are treated in turn.

Each patient is initially classified as urgent or routine and subsequently vetted by a Radiologist to determine the set waiting time and list based on the diagnostic procedure and exam. The waiting lists can be cross-referenced to the RTT (Referral to Treatment) Warehouse to ensure there are no breaches.

Although the RADIS system and referral forms provide the opportunity to be annotated to document justifications of appointments offered, this facility is not always used.

4.2 Core financial Systems

The level of assurance given as to the effectiveness of the system of internal control in place to manage the Core Financial Systems is **Substantial** Assurance.

RATING	INDICATOR	DEFINITION

Substantial		The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

Overall the controls in place to manage the risks associated with the systems and processes tested within the review are of a high standard. Good practice was noted in processes concerning management of cash and the management of the capital asset register.

The audit however did identify a number of issues concerning monthly reconciliations and timeliness of requests for debtors, credit notes and write offs. Improvements are also required around the monitoring of access to the Oracle System and also the PO hierarchy approval structure.

8.1

4.3 Dental Clinical Board Medicines Management (Prescribing)

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Medicines Management within the Dental Clinical Board is **Reasonable Assurance**.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Although there are operational processes in place for medicines management the Clinical Board does not have a formally documented structure or Group in place that oversees and coordinates the approach to Medicines Management, which leaves the process reliant on individuals. Additionally, there is no specific Clinical Board protocol for management of issues arising from medicines mismanagement.

Monthly financial information is submitted to budget holders outlining expenditure and variance analysis on drugs/medicines and any

overspends, wastage or loss are actively managed and where appropriate escalated within the Clinical Board for discussion and action.

Dental Clinical Board has appropriate processes in place for the management and recording of controlled and non-controlled drugs and medicines across all departments/clinics tested. These processes also ensure the regular review of items held to ensure that expiration dates are not breached and items are disposed of in a safe and effective manner.

Testing did identify that a small number of Community Dental Service clinics undertaking regular checks on their emergency drug kits were not signing the checklist off upon completion and there are currently no local procedures for the disposal and replacement of medicines used at any of the departments/clinics visited during the review.

8.1

4.4 Clinical Audit Follow up

The follow up review concluded that based upon discussions with relevant management, review of the evidence provided, along with the results of re-testing where appropriate, that good progress had been made with addressing agreed actions for each of the recommendations. In the case of each recommendation the actions have either been fully or partially implemented, or alternative actions have been taken forward.

As well as the progress with specifics from the recommendations additional actions have been taken forwarded to improve the Clinical Audit process, as well as looking to implement clinical audit software package to further enhance the process.

Therefore based on the findings of the follow up review the level of assurance that we are now able to provide is **REASONABLE** Assurance.

This increased assurance rating represents an improvement from the original review.

4.5 Leavers Management Follow up

The follow up review concluded that based upon discussions with relevant management, review of the evidence provided, ward and department discussions along with the results of re-testing where appropriate, that good progress had been made at a corporate level with the UHB by the Workforce Governance team across each of the recommendations.

However testing at ward and departmental level has still highlight awareness and compliance issues that will require further work to ensure an improved level of compliance with the new guidance is achieved across the organisation.

8.1

Therefore based on the findings of the follow up review the level of assurance that we are now able to provide is **REASONABLE** Assurance. 

This increased assurance rating represents an improvement from the original review.

4.6 Llanishen Store Follow up

The follow up review concluded that based upon discussions with the relevant manager, review of the evidence provided and the results of re-testing where appropriate, that good progress has been made. Management have ensured that action has been taken against the agreed management responses in order to address the original control weaknesses identified.

Since the audit report Cardiff Council have employed a Project Manager who is responsible for ensuring that the recommendations from both UHB audit reports and their own Council audit reports are implemented. The project manager is hoping to outline to both organisations at the Strategic Leadership groups what the service is at present and what it will look like, along with the likely expectations.

Cardiff Council are currently researching a new IT system, and have been given funding for this. At present the system has not been purchased as they are waiting to see how other organisations are

using the system, with the Llanishen Stores Manager hoping to meet with these organisations to ensure that the system is fit for purpose. In addition the store manager intends to meet with RCT to look at the new budget model that they have in place.

On the basis of this follow up, the level of assurance that could be given as to the effectiveness of the system of internal control in place to manage the risks associated with Llanishen Stores has improved to **Reasonable Assurance.**

8.1

4.7 Medical Locums Follow up

The follow up review concluded that based upon discussions with relevant management, review of the evidence provided and the results of re-testing where appropriate, reasonable progress has been. There are a number of agreed management actions that need to be further progressed in order to fully address the original control weaknesses identified.

On the basis of this follow up, the level of assurance that could be given as to the effectiveness of the system of internal control in place to manage the risks associated with (Medacs) Medical Locums has improved to **Reasonable Assurance**.

The Medical Workforce Department, alongside the Medacs Client Relationship Manager, have put processes in place to address a number of the issues highlighted from the original review; including the justification of locum requests, the completion of accruals for non-invoiced sessions and the submission of management information. However, further work is required to produce a policy and an up to date SLA. The issues around confirming authorising staff details, validating the appropriateness of induction training, monitoring locum performance and ensuring prompt payment of invoices also require further work.

4.8 Mental Health CHC & Out of Area

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Continuing Health Care (CHC) & Out of Area (OOA) is **Reasonable Assurance**.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

8.1

Overall the level of assurance given is reasonable. There is guidance in place at an All Wales, UHB and Clinical Board level for the assessment, quality assurance and approval of CHC and Out of Area placements. Testing showed that the processes were working appropriately with patients being appropriately assessed and subject to quality assurance. Whilst there were occasions where the timeliness of the process was not compliant with standards, it was noted that more recent cases show evidence of a better process flow and timeliness.

Patients were also subject to ongoing management / contact with evidence of regular care plan reviews.

Issues were identified with non-compliance with process; with not all patients having a contract on file and a small number of patients not having care plan reviews / contact.

It was also noted that historically there was no consistent process for reviewing provider sites; however the introduction of a new framework contract now provides a mechanism to resolve this.

Assignment Status Schedule Appendix A

ASSIGNMENT 2016/17	STATUS	EXECUTIVE LEAD	DRAFT	FINAL	ASSURANCE	AC DATE
Quality Governance - Dental Clinical Board	FINAL	Nursing	June	July	Reasonable	Sept 16
Quality Governance - CD&T Clinical Board	FINAL	Nursing	June	July	Substantial	Sept 16
Quality Governance - PCIC Clinical Board	FINAL	Nursing	June	July	Substantial	Sept 16
Quality Governance - Mental Health Clinical Board	Final	Nursing	June		Reasonable	Sept 16
Data Quality	FINAL	Public Health	June		n/a	Sept 16
Assurance against Key Risks	FINAL	Governance	July		substantial	Sept 16
Policy Management	FINAL	Governance	Aug.		reasonable	Sept 16
Health & Care Standards (Mid-Year)	Final	Nursing	Sept	Sept	Reasonable	Nov 16
Quality Governance - Specialist CB	Final	Nursing	June	Oct	Reasonable	Nov 16
Quality Governance Children & Women	Final	Nursing	July	Oct	Substantial	Nov 16
Quality Governance - Medicine CB	Final	Nursing	July	Oct	Reasonable	Nov 16
Quality Governance - Surgery CB	Final	Nursing	June	Oct	Reasonable	Nov 16
Annual Quality Statement	Final	Nursing	Sept	Oct	Substantial	Nov 16
Sustainability Reporting	Final	Planning	Sept	Oct	Reasonable	Nov 16

ASSIGNMENT 2016/17	STATUS	EXECUTIVE LEAD	DRAFT	FINAL	ASSURANCE	AC DATE
CDT Additional Payments	Briefing completed	COO	--	---	n/a	Feb 17
Dental - medical device mgt.	FINAL	COO	Dec	Feb	Reasonable	Feb 17
Safeguarding – Children	FINAL	Nursing	Nov	Jan	Reasonable	Feb 17
Estates follow up	FINAL	Planning	Oct	Dec	Reasonable	Feb 17
Operational Services	FINAL	Planning	Oct	Jan	Reasonable	Feb 17
Carbon Reduction Commitment	FINAL	Planning	Nov	Jan	Reasonable	Feb 17
Claims Reimbursement	FINAL	Nursing	Feb	Feb	Substantial	Feb 17
Public Health – Obesity Pathway	FINAL	DPH	Dec	Feb	Reasonable	Feb 17
PCIC Clinical Board – Localities Stock	FINAL	COO	Oct	Feb	Limited	Feb 17
Women and Children CB Staffing	FINAL	COO	Oct	Feb	Reasonable	Feb 17
Surgery - Medical Staff Study Leave	FINAL	COO	Feb	Feb	Reasonable	Feb 17
Medicines - Cost reduction and Waste	FINAL	Medical	--	Feb	Reasonable	Feb 17
Mental Health - CHC & Out of Area.	**FINAL**	***COO***	***March***	***April***	**Reasonable**	**April 2017**
Dental - Medicines Mgt. (prescribing)	**FINAL**	**COO**	**Feb**	***April***	**Reasonable**	**April 2017**
CD&T - Radiology - "Treat in Turn"	**FINAL**	**COO**	**March**	***April***	**Substantial**	**April 2017**
Medical locums follow up	**FINAL**	**Medical**	**April**	***April***	**Reasonable**	**April 2017**
UHB Core Financial Systems	**FINAL**	**Finance**	**March**	***April***	**Substantial**	**April 2017**
Leavers follow up	**FINAL**	**WOD**	**March**	***April***	**Reasonable**	**April 2017**
Clinical Audit Follow up	**FINAL**	**Nursing**	**March**	***March***	**Reasonable**	**April 2017**
IT System - T&O (Bluespier)	***draft***	*Therapies*			*Reasonable*	
Continuing Health Care	*Draft*	*COO*			*Limited?*	
IT system - Neuroscience	*draft*	*COO*			*Limited?*	

8.1

ASSIGNMENT 2016/17	STATUS	EXECUTIVE LEAD	DRAFT	FINAL	ASSURANCE	AC DATE
Theatre Stores Follow up	Draft	COO	April		Reasonable	
IMTP (Workstreams)	draft	Planning	March		Reasonable	
Waiting List Initiative Payments	draft	COO			Limited?	
Community Resource Teams	draft	COO			Substantial	
Medicine CB – Medical Staff Rotas and Sickness	draft	COO			Reasonable	
CD&T CB - Information governance	draft	COO			Substantial	
Mental Health CB - Information governance.	draft	COO			Reasonable	
Specialist CB - PP payments	Draft briefing	COO			n/a	
Specialist Clinical Board - Medical staff study leave	draft	COO			Reasonable	
Medicine Clinical Board - Specialing	wip	COO				
Health & Care Standards	wip	COO				
Patient Access	wip	COO				
Records Management Follow up	wip	Medical				
Capital Scheme - Rookwood Relocation	Wip	Planning				
Capital Estates- Statutory Compliance	wip	Planning				

CARDIFF AND VALE UHB – INTERNAL AUDIT PLAN 201/17 **APPENDIX B**
SUMMARY OF ASSURANCE BY DOMAIN

Assurance domain		Overall rating	Not rated	No assurance	Limited assurance	Reasonable assurance	Substantial assurance
Corporate governance, risk and regulatory compliance						• Policy Management • H&C standards (midyear)	• Assurance Key Risks • Claims
Clinical governance quality and safety						• Dental CB • Medicine CB • Mental health CB • Specialist CB • Surgery CB • Safeguarding Children • Clinical Audit follow up	• PCIC CB • CD&T CB • C&W CB • AQS
Financial governance and management							• Financial Systems
Strategic planning, performance management and reporting						• Public Health Targets IMTP (work streams)	
Information governance and security			• Data Quality			IT System T&O	

8.1

Operational service and functional management			• CDT Additional payments • Specialist Services – PP payments		• PCIC Community Stock • IT System – Neuroscience • CHC • WLI	• Operational Services • Estates Follow up • Children & Women CB – Staffing • Dental; CB – Medical Device Mgt. • Surgery Medical Staff Study • Dental meds Mgt. • MH CHC & OOA •	• Radiology Treat In Turn
Workforce management						• Leavers follow up • Medical Locums Follow up	
Capital and estates management						• Sustainability Reporting • Primary Care Estate • CRC	
TOTAL							

8.1

Cardiff and Vale University Health Board

Audit Committee

8.1

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Audit and Assurance Services
Cardiff and Vale / South Central Team
First Floor, Brecknock House
University Hospital of Wales
Heath Park
Cardiff
CF14 4XW
Contact details: Tel • 02920 742724

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

NHS WALES GIG CYMRU | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Cardiff and Vale University Health Board

Internal Audit Plan 2017/18

April 2017

NHS Wales Shared Services Partnership
Audit and Assurance Services

Contents

9

1. Introduction

This document sets out the Internal Audit Plan for 2017/18 ('the Plan') detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

As a reminder, the Accountable Officer (the Health Board's Chief Executive) is required to certify in the Annual Governance Statement that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards require that "The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities."

Accordingly this document sets out the risk based approach and the Plan for 2017/18. The Plan will be delivered in accordance with the Internal Audit Charter. All internal audit activity will be provided by Audit & Assurance Services, a division of NHS Wales Shared Services Partnership.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Public Sector Internal Audit Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- quantification of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering the:

- organisation's risk assessment and maturity;
- coverage of the audit domains;
- previous years' internal audit activities; and
- audit resources required to provide a balanced and comprehensive view.

Our planning also takes into account the NHS Wales Planning Framework 2017/20 and is also mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the

Integrated Medium Term Plan (IMTP) and/or Annual Plan and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

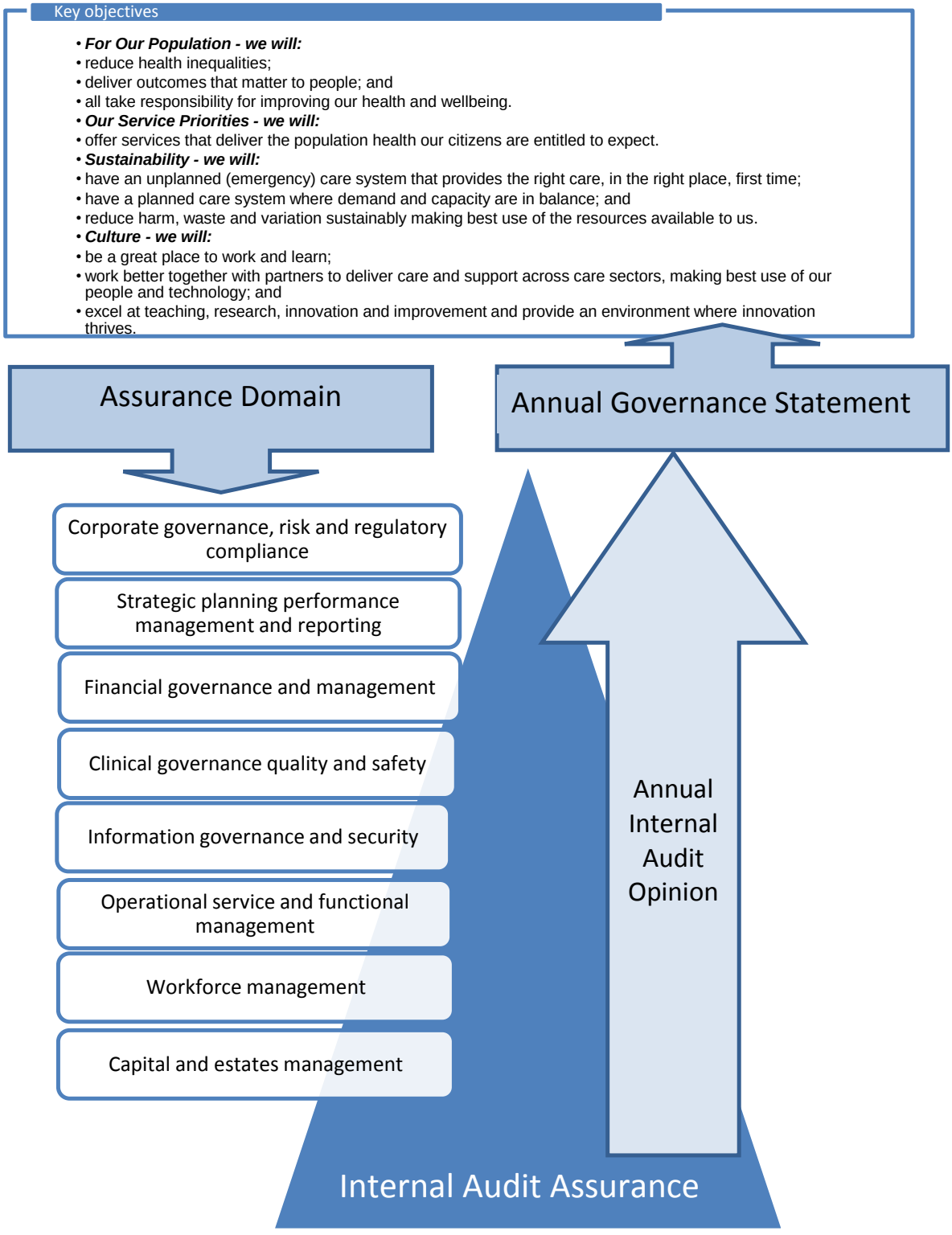
We will ensure that the Plan remains fit for purpose by reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control require annual review, and some work is mandated by Welsh Government, our risk based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe), categorised into eight assurance domains. The risk associated with each domain is assessed and this determines the appropriate frequency for review. As part of this approach we also develop and maintain a 3-year audit strategy to identify when audit areas will be audited.

The eight audit domains are shown in figure 1 which also shows how the cumulative internal audit coverage of them contributes to the Annual Internal Audit Opinion which in turn feeds into the Annual Governance Statement and the achievement of the key objectives for the organisation.

The mapping of the Plan to the eight assurance domains is designed to give balance to the overall annual audit opinion which supports the Annual Governance Statement.

Figure 1 Internal Audit assurance on the domains



2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; thus we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the Corporate Risk Register;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee and Quality & Safety Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- other assurance processes including planned audit coverage of systems and processes now provided through NHS Wales Shared Services Partnership (NWSSP) and, where appropriate, WHSSC, EASC and NWIS;
- work undertaken by other assurance bodies including the Health Board's Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV)
- work undertaken by other review bodies including Wales Audit Office (WAO) and Health Inspection Wales (HIW); and
- coverage necessary to provide reasonable assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met with a number of Health Board Executives and Independent Members to discuss current areas of risk and related assurance needs. Meetings have been held with the following key personnel during the planning process:

- Chief Executive Officer;

- Executive Director of Finance;
- Chief Operating Officer;
- Executive Director of Planning;
- Director of Governance;
- Executive Medical Director;
- Executive Director of Nursing;
- Executive Director of Workforce;
- Director of Capital & Estates

The draft Plan was then discussed with the full Management Executive meeting to ensure that internal audit effort was best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal control). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, potential for fraud and sensitivity.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2017/18

The Plan is set out in Appendix A and identifies the audit assignment, lead executive officer, outline scope, and proposed timing.

Where appropriate the Plan makes cross reference to key strategic risks identified within the corporate risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management and WAO requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

Audit coverage in terms of capital audit and estates assurance will be delivered by our Specialist Services Unit. Given the specialist nature of this work and the assurance link with the all-Wales capital programme we will need to refine with management the scope and coverage on specific schemes. The Plan will then be updated accordingly to integrate this tailored coverage.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above. We will review and update the risk assessment and rolling 3-year audit plan annually giving definition to the upcoming operational year and extending the strategic view outward.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. Hence, the Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. In particular the Plan will need to be periodically reviewed to ensure alignment with the developing systems of assurance.

Consistent with previous years and in accordance with best professional practice an unallocated contingency provision has been retained in the Plan to enable internal audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with the Wales Audit Office as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The Plan indicates an indicative resource requirement of 1250 days to provide balanced assurance reports to the Chief Executive as Accountable Officer in accordance with the Public Sector Internal Audit Standards.

This assessment is based upon an estimate of the audit resource required to review the design and operation of controls in review areas for the purpose of sizing the overall resource needs for the Plan. Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

This total resource allocation covers the servicing of the local audit plan (1250 days) including capital audit and estates assurance coverage less the contribution to the audit of national systems through the NWSSP plan (90 days). These numbers are consistent with previous years.

The top-slice funding passed to NWSSP is sufficient to meet these audit resource needs. The inclusive internal provision through NWSSP Audit & Assurance Services represents best value for NHS Wales in comparison with external commercial rates for the equivalent provision of these professional services.

The Public Sector Internal Audit Standards enable internal audit to provide consulting services to management. The commissioning of these additional services by the Health Board is discretionary and therefore not included in the Plan. Accordingly, any requirements to service management consulting requests would be additional to the Plan and will need to be negotiated separately.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2017/18 and:

- Approve the Internal Audit Plan for 2017/18;
- Approve the Internal Audit Charter; and
- Note the associated internal audit resource requirements and key performance Indicators.

James Johns
Head of Internal Audit (Cardiff and Vale University Health Board)
Audit & Assurance Services
NHS Wales Shared Services Partnership

Cardiff and Vale University Health Board
Internal Audit Plan 2017/18 **Appendix A**

Planned output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Corporate governance, risk and regulatory compliance						
Annual Governance Statement		8.2	To provide an opinion and undertake specific areas of review to underpin the completion of the Statement.	5 days	Corporate Governance	Q4
Governance, Leadership & Accountability Assessment		8.2	To review the process that has been adopted and evidence supporting the self-assessment.	5 days	Corporate Governance	Q4
Risk Management & Assurance and Corporate Risk Assurance Framework Development (CRAF).		8.2	On-going overview of general governance and risk management arrangements. Involvement in the process and groups reviewing and developing the CRAF.	40 days	Corporate Governance	Q1-4
Health and Care Standards		5.1.6		30 days	Director Nursing	Q2-Q4
Claims Reimbursement		8.1	Review compliance with Welsh Risk Pool Standard requirements for claims reimbursement.	5 days	Director Nursing	Q3/4
Board Working		8.2		20 days	Corporate Governance	Q2-3
Corporate governance, risk and				**105 days**		

9

Cardiff and Vale University Health Board
Internal Audit Plan 2017/18 **Appendix A**

Planned output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
regulatory compliance domain sub-total						
Strategic planning performance management and reporting						
Business Continuity Planning Follow up		5.4	Follow up of agreed actions form previous Limited assurance report.	10	Director of Planning	Q4
Research & Development		7.3	Review controls in place to manage key risk areas within the process.	25	Medical Director	Q1-2
Wellbeing Objectives		3	Review process for setting, delivering and monitoring onjcetives.	25	Director of Public Health	Q/4
Strategic Planning/IMTP		3	Review on going delivery and monitoring of the plans.	15	Director of Planning	Q4
Continuing Health Care		2.5.1	Follow up from previous report.	10	COO	Q3
Strategic planning performance management and reporting domain sub-total				**85 days**		
Financial Governance and management 115						
UHB Core Financial Systems		6.7	Review a selection controls in place to	35 days	Director of	Q3/4

9

Cardiff and Vale University Health Board
Internal Audit Plan 2017/18 **Appendix A**

Planned output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
			manage key risk areas across the range of the main financial systems.		Finance	
Charitable Funds		---	Review governance arrangements, including the management of expenditure and donations.	25 days	Director of Finance	Q1-2
Cost Improvement Programmes		6.7	Review the development and delivery of the improvement plans.	30 days	Director of Finance	Q3
Costing		6.7		25 days	Director of Finance	Q3
Financial Governance and management domain sub-total				**115 days**		
Clinical governance quality & safety						
Annual Quality Statement		5	To provide an opinion on the process that has been adopted and the evidence recorded supports the self-assessment.	15 days	Director Nursing	Q1
DOLS		5.5	Follow up of agreed actions form previous Limited assurance report	10	Medical director	Q3-4
Serious Incidents Management		5.6	Review Incident Closures	25	Nursing	Q2/3
Mortality Reviews		5.6.1	Review Process and actions taken.	25	Medical	Q1-2

9

Cardiff and Vale University Health Board
Internal Audit Plan 2017/18 **Appendix A**

Planned output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Q&S Governance		5	Follow up from 16/17 report	25	Nursing	Q1-2
Clinical governance quality & safety domain sub-total				**100 days**		
Information Governance and Security						
IT Strategy		6.8	Strategic MTED deployment	15 days	Director of Therapies	Q2
Virtulisation		6.8	Review the security and resilience of the updated virtualised environment.	15 days	Director of Therapies	Q3
Cyber Security		6.8		15days	Director of Therapies	Q2/3
IT Help Desk or Departmental IT System		6.8	WCP Deployment including Helpdesk or Welsh Patient Referral System	15 days	Director of Therapies	Q3/4
Information Governance and Security domain sub-total				**60 days**		

9

Cardiff and Vale University Health Board
Internal Audit Plan 2017/18 **Appendix A**

Planned output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Operational service and functional management						
Clinical Board 1		6.2-6.2.1	To review a specific serious of risks as agreed with the Clinical Boards. (suggested areas staff management and additional payments)	30	COO	Q1-2
Clinical Board 2		6.2-6.2.1	As above	30	COO	Q1-2
Clinical Board 3		6.2-6.2.1	As above	30	COO	Q1-2
Clinical Board 4		6.2-6.2.1	As above	30	COO	Q2
Accommodation			Review arrangement in place for accommodation.	20		Q1-2
WLI follow up		6.7	Follow up on 16/17 report.	15	COO	Q2-3
Neuroscience IT system follow up		6.8	Follow up on 16/17 report.	10	COO	Q2-3
Stock control in localities follow up			Follow up on 16/17 report.	10	COO	Q1

Cardiff and Vale University Health Board
Internal Audit Plan 2017/18 **Appendix A**

Planned output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
CD&T Additional Payments			Follow up on 16/17 work and briefing	10	COO	Q2
Specialist Services Private Patients			Follow up on 16/17 work and briefing	10	COO	Q2/3
PCIC incident management (rolled forward at request by PCIC)		5.6	Review process for managing incident that cut across other areas.	15	COO	Q3/4
Operational service and functional management domain sub-total				**210 days**		
Workforce management						
Consultant Job Planning(30)		6.2	Review controls in place to manage key risk areas within the process.	30 days	Medical Director.	Q2-3
Nurse Revalidation (30)		6.2	Review controls in place to manage key risk areas within the process.	30 days	Director of Workforce & OD.	Q2-3
Organisational Values (25)		9.1.1	Review controls in place to manage key risk areas within the process.	25 days	Director of Workforce & OD.	Q3/4
Workforce management domain sub-total				**85 days**		
Capital and Estates						

Cardiff and Vale University Health Board
Internal Audit Plan 2017/18 **Appendix A**

Planned output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Sustainability Reporting (10)		6.4	To provide an opinion that the Health Board has robust systems in place to record and report minimum sustainability requirements as required by the Welsh Government.	10 days	Director of Planning	Q1-2
Model Ward		6.4	Review arrangements following trial three month period	20 days	COO	Q1-2
Cleaning Standards		6.4.8	Review current Service Provision.	20 days	Director of Planning	Q1-2
Commercial Outlets			Review arrangements for commercial outlets (inc. Aroma and spar UHL)	20 days	Director of Planning	Q1-2
Carbon Reduction Commitment		6.4	To ensure the Health Board complies with the requirements of the Order and that the information held is accurate, complete and the purchase of the credits is based upon actual usage or informed estimates.	10 days	Director of Planning	Q2/3
Neo Natal		6.4	To review key aspects of the schemes	25 days	Director of Planning	Q2/3
Rookwood Relocation		6.4	To review key aspects of the schemes	25 days	Director of Planning	Q2/3
Shaping Future Wellbeing Schemes		6.4	To review key aspects of the early part of a scheme.	20 days	Director of Planning	Q2/3

9

Cardiff and Vale University Health Board
Internal Audit Plan 2017/18 **Appendix A**

Planned output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Capital and Estates domain sub-total				**150 days**		
Contribution to NWSSP Audits				**90 days**		
Audit Contingency						
Audit Management and Reporting				**250 days**		
Audit planning reporting and management			Ongoing work.			
Liaison with WAO and HIW			Ongoing work.			
Follow up of previous audit reports			Follow up of previous audits that received limited or no assurance and an assessment of progress with the Audit Recommendations Tracker.			
Audit Committee preparation and attendance			Incorporating preparation and attendance at Audit Committee. We also attend other key Board and Committee meetings.			

9

Cardiff and Vale University Health Board
Internal Audit Plan 2017/18 **Appendix A**

Planned output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
Head of Internal Audit Annual Report			Mandatory requirement to comply with the Public Sector Internal Audit Standards for the NHS in Wales and the Annual Governance Statement.			
Total audit management and reporting				**250 days**		
			Indicative Total Days 2016/17	**1250 days**		

9

Cardiff and Vale University Health Board **Appendix B**
Key Performance Indicators

The KPIs reported monthly for Internal Audit are:

KPI	SLA required	Target 2017/18
Audit plan 2017/18 agreed/in draft by 30 April	✓	100%
Audit opinion 2016/17 delivered by 31 May	✓	100%
Audits reported vs. total planned audits	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [15 days]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

9

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

NHS WALES GIG CYMRU
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Cardiff and Vale University Health Board

INTERNAL AUDIT CHARTER

March 2017

9

Cardiff and Vale University Health Board **Appendix C**
Internal Audit Charter

Contents

9

Cardiff and Vale University Health Board **Appendix C**
Internal Audit Charter

1 Introduction

1.1 This Charter is produced and updated regularly to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Cardiff and Vale University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Cardiff and Vale University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Director of Corporate Governance with liaison with the Executive Director of Finance.

9

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Cardiff and Vale University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

Audit work designed to deliver an audit opinion on the risk management, control, and governance arrangements is referred to in this Internal Audit Charter as Assurance Work because management use the audit opinion to derive assurance about the effectiveness of their controls

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective advisory service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such advisory work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards is the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit budget and resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

3.3 Whilst maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Public Sector Internal Audit Standards that apply to non-audit activities.

9

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly the Head of Internal Audit has a direct right of access to the

Accountable Officer the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance e.g. Quality & Patient Safety Committee, and the Information Governance Committee.

5 Relationships

- 5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance with Liaison with the Executive Director of Finance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.
- 5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance with Liaison with the Executive Director of Finance in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, internal audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

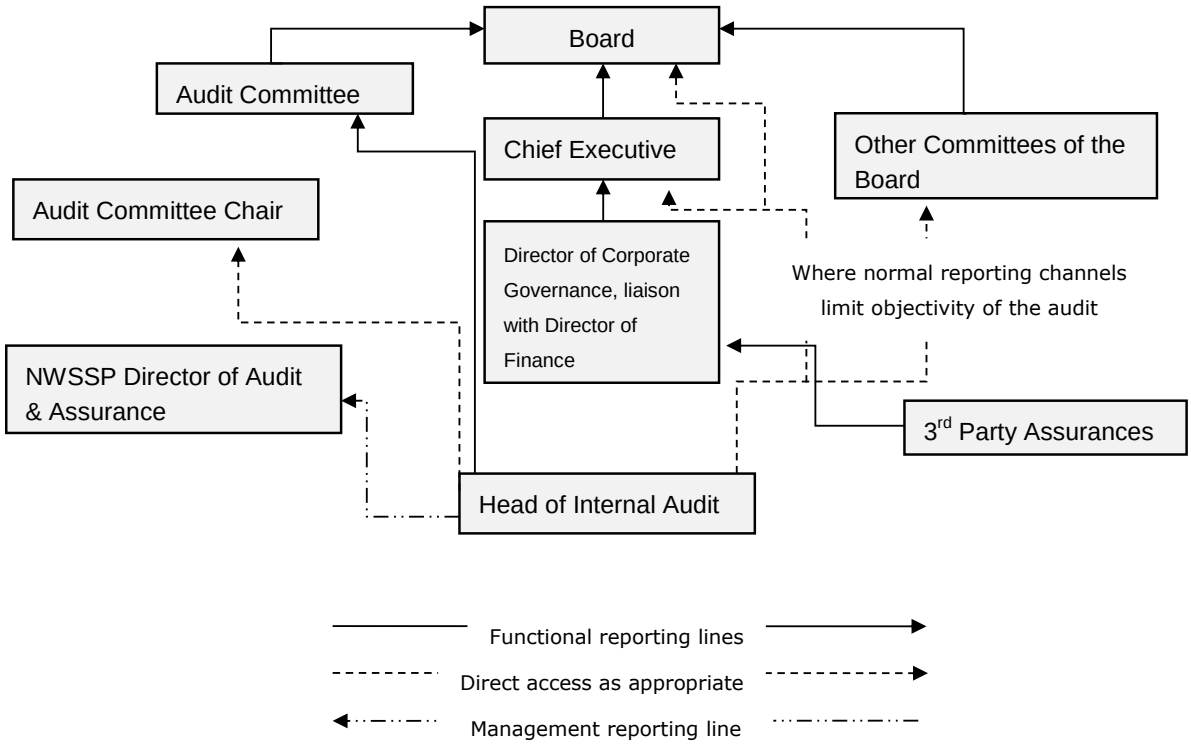
5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, e.g. the NHS Wales Shared Services Partnership, WHCCS, EASC and NWIS.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will

obtain an understanding of the organisation and its activities, encourage two way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The key organisational reporting lines for Internal Audit are summarised in Figure 1 overleaf. As part of this, the Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all reports.

Figure 1 Audit reporting lines



6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2016) and associated performance standards

agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- reviewing arrangements for demonstrating compliance with the Health and Care Standards.
- ensuring effective co-ordination, as appropriate, with external auditors; and

- reviewing the Governance and Accountability modular assessment and the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit, or prejudice the ability of internal audit to deliver a services consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

7.4 The scope of the audit coverage will take into account and include any hosted body.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 2 overleaf

Figure 2 Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales to meet
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Public sector Internal Audit Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisations objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which "are appropriate, sufficient and effectively deployed to achieve the approved plan";
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information, and outlining the scope and timing of audit assignments to be completed during the year ahead.

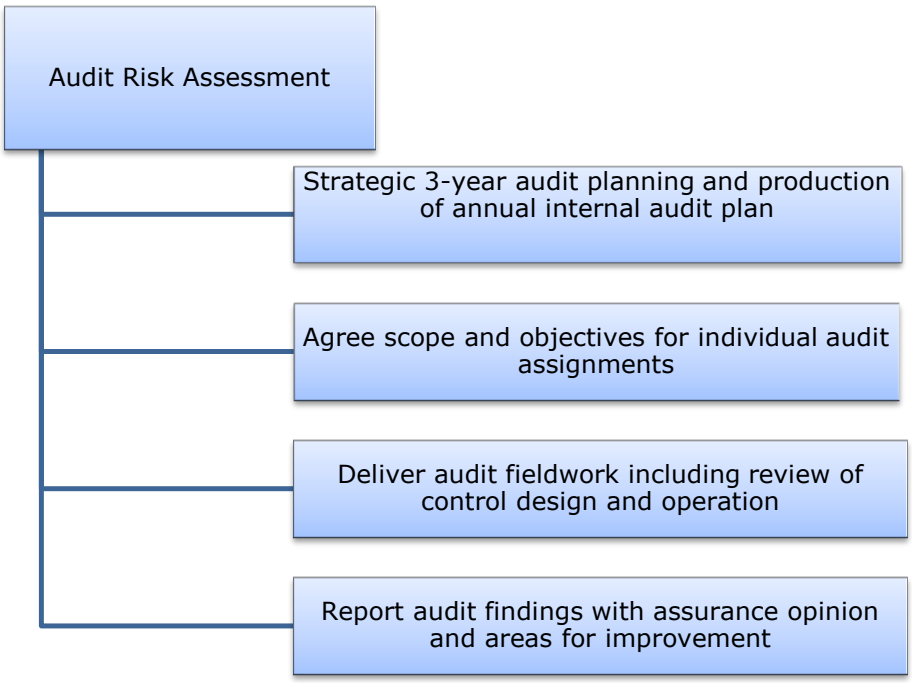
8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead, and will also be copied to the Director of Corporate Governance. The key stages in this risk based audit approach are illustrated in figure 3 below.

Figure 3 Risk based audit approach



9

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement. The process for arriving at the appropriate assurance level for each Head of Internal Audit opinion was subject to a review process during 2013/14, which led to the creation of a set of criteria for forming the judgement that was adopted and used for 2013/14 opinions onwards;

- The Head of Internal Audit opinion will:

a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes, with reference to compliance with the Health and Care Standards;
b) Disclose any qualification to that opinion, together with the reasons for the qualification;

c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and

- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below and presented in flowchart format in Appendix A:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage;
- Operational management will receive draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B. The draft report will also indicate priority ratings for individual report findings and recommendations;
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, stating their agreement or otherwise to the content of the report, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;

- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Director of Corporate Governance and Executive Director of Finance. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately;
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance and Executive Director of Finance. The Head of Internal Audit may present the draft report to the Audit Committee where no management response is forthcoming;
- Final reports inclusive of management comments will be issued by Internal Audit to the relevant Executive Director within 10 working days of management responses being received; and
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and Executive Director of Finance and placed on the agenda for the next available Audit Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then

permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

9

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

9

Simon Cookson
Director of Audit & Assurance - NHS Wales Shared Services Partnership
February 2017

Appendix A Audit Reporting Process

Audit fieldwork completed and debrief with management.	Following closure of audit fieldwork and management review audit findings are shared with operational management to check accuracy of understanding and help shape recommendations for improvement to address any control deficiencies identified.
A draft report is issued within 10 working days of fieldwork completion and the resolution of any queries.	Draft reports are issued with an assurance opinion and recommendations within 10 days of fieldwork completion to Operational Management Leads, and copied to the relevant Executive Leads.
Management responses are provided on behalf of the Executive Lead within 15 working days of receipt of the draft report.	A report clearance meeting may prove helpful in finalising the report between management and auditors. A response, including a fully populated action plan, with assigned management responsibility and timeframe is required within 15 days of receipt of the Draft report.
Outstanding responses are chased for 5 further days.	Where management responses are still awaited after the 15 day deadline, a reminder will be sent. Continued non-compliance will be escalated to Executive management after 5 further days.
Report finalised by Internal Audit within 10 days of management response.	Internal Audit issues a Final report to Executive Director, within 10 working days of receipt of complete management response. All Final reports are copied to the Chief Executive.
Individual audit reports received by Audit Committee.	Final reports are received by the Audit Committee at next available meeting and discussed if applicable. For reports with "green/ yellow" assurance ratings, Executive Summaries are received for noting. For those with "red/ amber" ratings, the full reports are received for discussion. The Audit Committee identifies their priority areas for Internal Audit to follow up.

9

Appendix B Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	 - + Green	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
Reasonable assurance	 - + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited assurance	 - + Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
No assurance	 - + Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

9

9

Office details:

Audit and Assurance Services,
1st Floor Brecknock House,
University Hospital of Wales, Heath Park,
Cardiff,
CF14 7XW

Contact details

James Johns (Head of Internal Audit) – 02920742724

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

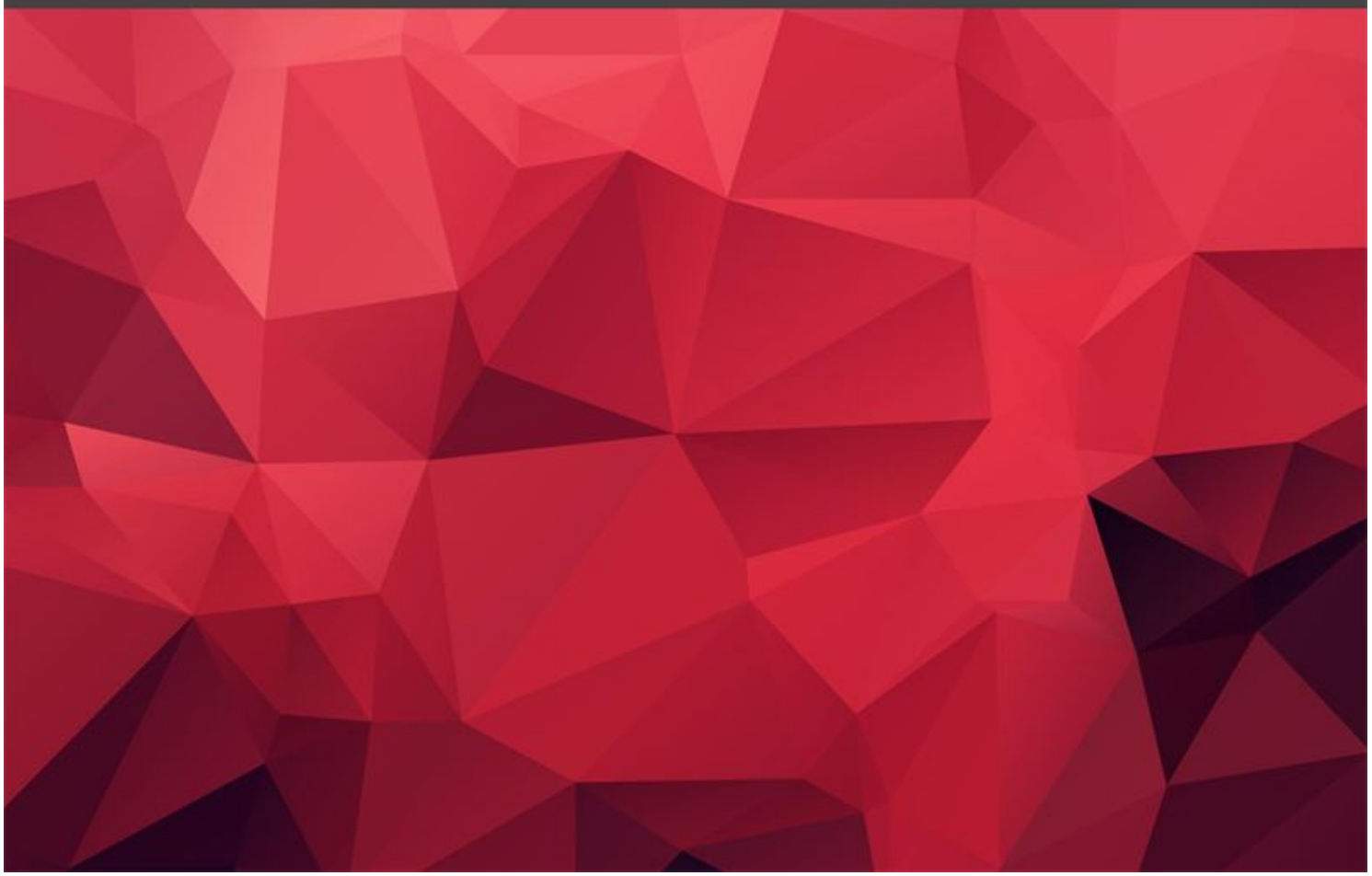
Archwilydd Cyffredinol Cymru
Auditor General for Wales

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

Date issued: April 2017

Document reference: CVACU2017

10



Contents

10

Summary report

About this document

1 This document provides the Audit Committee of Cardiff and Vale University Health Board (the Health Board) with an update on current and planned Wales Audit Office work. Financial and performance audit work is considered and information is also provided on the Auditor General's programme of national value-for-money examinations.

Financial audit update

Exhibit 1: Financial audit update

Work area	Progress	Conclusions
2016-17 Accounts, Annual Report, and Whole of Government Accounts (WGA) return		
The financial audit work relating to the 2016-17 Accounts and the WGA return is progressing in accordance with the planned timescales. We have discussed the preparation of the 2016-17 Annual Report with officers and we are due to receive a final draft version by the end of June 2017. This year the deadline for the publication of the Annual Report is 31 July, being two months earlier than the previous year. We are also discussing with officers the implications of the Social Services and Well Being (Wales) Act 2014 (Statutory Guidance on Partnership Arrangements). In particular we are discussing the requirement in 2016-17 to produce Pooled Budget Memorandum Accounts in relation to Integrated Family Support Services, and funding from the Welsh Government such as the Intermediate Care Fund.		

10

Performance audit update

Work completed since the last Audit Committee update

Exhibit 2: Work completed since last Audit Committee update

Topic (year of Audit Plan)	Conclusions	Status	Executive lead	Considered by Audit Committee	Management response status
Thematic review - radiology (2015)	Whilst operationally the service is well managed, there are risks to the current and future service delivery because of a lack of strategic and business planning, increasing demand, reporting backlogs, aging equipment, and recruitment and retention issues • Generally, patients have good and timely access to the service, however, reporting backlogs and environmental issues need to be addressed. • Waiting lists and referrals are well managed, however rising demand and staffing challenges increase service pressures, and whilst there is potential to increase weekend equipment usage this may cost the service more • Poor strategic planning and lack of equipment replacement programme presents a significant risk, however management structures are clear and there is good Board and corporate oversight of the service	Final Report presented to Audit Committee 24th April 2017	Alice Casey / Steve Curry	April 2017	Being developed

Work currently underway

Exhibit 3: Work currently underway

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
Thematic reviews – patient flow (2016)	**Emergency ambulance service commissioning:** • this work will review the effectiveness of the new collaborative commissioning arrangements for emergency ambulances in Wales, including the implementation of the CAREMORE model and the five-step care pathway.	Report to be finalised in April 2017, and considered at EASC audit committee on 15 May 2017.	Sharon Hopkins	June 2017, after consideration by the EASC audit committee on 15 May 2017
	Out-of-hours primary care: • this work will review issues relating to staffing levels, service performance and governance, and take a view on the extent to which the all-Wales standards for the quality and monitoring of out-of-hours services are being delivered in practice.	Draft report currently in clearance.	Steve Curry	June 2017
	Discharge planning: • this work will review how health bodies are responding to previous external reviews of discharge planning arrangements, and examine whether improvements in discharge planning are being made.	Report currently being drafted.	Ruth Walker	September 2017
Local project (2016)	**Follow-up outpatients progress update** • this work will track progress made by the Health Board in response to the follow-up outpatient appointments review published in 2015	Fieldwork.	Steve Curry	July 2017

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
Thematic review – primary care (2017)	The focus of this work is yet to be determined. Scoping work will be undertaken during the early part of 2017 to help identify the most appropriate area for the work to focus on. Scoping work will include consideration of the commitments set out within the 2014 Plan for Primary Care Services for Wales and other relevant national delivery plans, together with key enablers of change such as the development of primary care clusters and mechanisms to increase capacity and capability within primary care services.	Early scoping.	TBC	April 2018
Thematic review – intermediate care fund (2017)	This work will focus on a service area which impacts on both health and local authority organisations. The area for consideration is likely to be the governance arrangements to support the use of the intermediate care fund. The exact focus is yet to be determined.	Early scoping.	TBC	April 2018
Structured Assessment (2017)	This work will continue to assess the robustness of NHS bodies' arrangements for corporate governance and financial management, and the progress that is being made in addressing issues and concerns identified in previous years' structured assessments. The work will also include a comparative assessment of aspects of governance which have presented challenges to most NHS bodies. The area of comparative analysis is currently being considered. This work will also be used to start to build up a picture of how NHS bodies are responding to their statutory requirements under the Well-being of Future Generations (Wales) Act 2015. This work will inform a national 'year-one commentary' across all relevant public sector bodies.	Early scoping.	Peter Welsh	December 2017

Topic (year of Outline Plan)	Focus of the work	Status	Executive Lead	For Audit Committee
Local project (2017)	The precise focus of this work will be agreed with executive officers and the Audit Committee, and will be reflected in the regular updates that are produced for the audit committee.	Early scoping.	TBC	TBC

Other Auditor General studies

Since the last Audit Committee there have been no reports published of relevance to the NHS, however the Audit Committee may be interested in the following studies/planned outputs.

Exhibit 4: Other Auditor General Studies planned

Planned future publications	
Topic	**Update**
NHS Wales informatics services	In broad terms, the work will be considering the arrangements for delivering investment in updated clinical ICT services. The work will encompass both the respective roles of NWIS, the Welsh Government and individual NHS bodies and will include some more detailed audit work on a number of specific systems. It will also draw on evidence from our local audit work on radiology services and other audit intelligence. Publication in 2017.
NHS integrated medium-term planning (implementation of the NHS Finance Wales Act 2014)	In broad terms, the work will be considering the arrangements that the Welsh Government has put in place, working with NHS bodies, to implement the NHS Finance Wales Act 2014. The work will draw, in part, on evidence from our 2016 structured assessment work in 2016.
Procurement landscape review	The study will cover the procurement of goods and services across central and local government, the NHS, fire and rescue, further education, higher education and the police. The study will examine whether current procurement arrangements in Wales are helping to deliver value for money in public spending and are fit for the future. Currently the plan is to report in early 2017. Subject to the findings, further work on specific issues or within specific sectors may take place in subsequent years.
Improving well-being through housing adaptions	This study forms part of the Auditor General's programme of local government thematic reviews. It will examine housing adaptation services provided by both local authorities and registered social landlords. The study will also involve some work in NHS bodies by examining whether housing adaptations are facilitating timely discharge from hospital. Fieldwork on this study will therefore be closely co-ordinated with local audit work on NHS discharge planning.

10

Good Practice Exchange

The Good Practice Exchange (GPX) helps public services improve by sharing knowledge and practices that work. We run events where people can exchange knowledge face to face and share resources online.

Details of past and forthcoming events, shared learning seminars and webinars can be found on the GPX page on the Wales Audit Office's website. The table below lists recent and forthcoming events.

Exhibit 5: Good Practice Exchange

Recent and forthcoming events
Recent events
Integrating Information Technology through Open Standards – 5 April 2017 (past) Access the material from our recent webinar aimed at sharing how Open Standards can enable better integration of public services
Making Services more accessible to people who do not speak English or Welsh – 16 March 2017 (past) Access the material from our recent seminar which looked to develop an awareness of the requirements upon public bodies to enable people who don't speak English or Welsh to access public services on an equal basis, and to understand the policies and practice that need to be in place.
Forthcoming events
Governance: Supporting improvement across complex public service delivery – 26 April 2017
Improving digital leadership and ownership – 13 June 2017

Diary markers and details of new events are circulated in advance to the Health Board, together with information on booking delegate places. Further information on any of our past or planned GPX events can be obtained by contacting the local audit team or emailing good.practice@audit.wales.

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

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

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

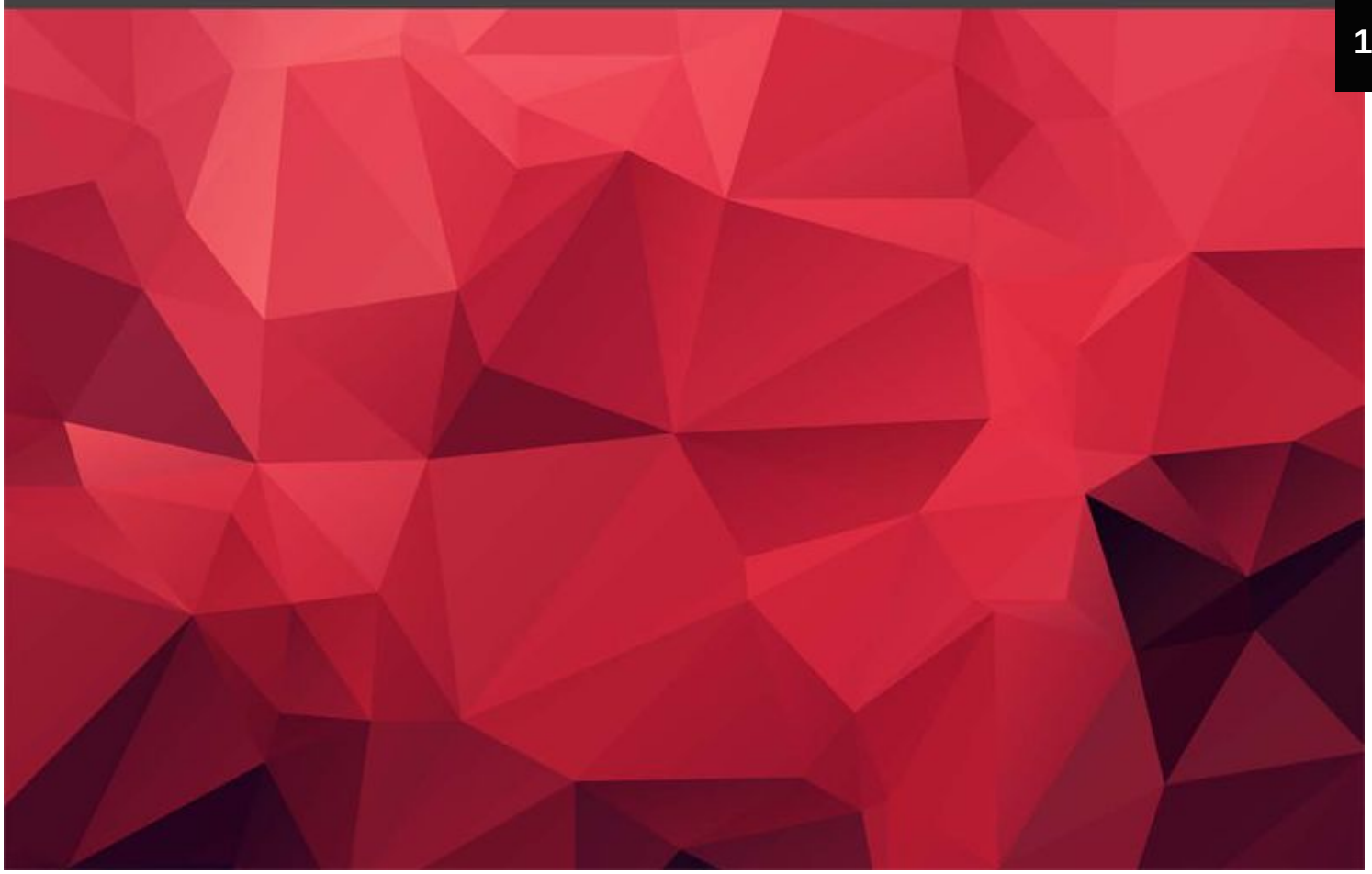
Archwilydd Cyffredinol Cymru
Auditor General for Wales

Radiology Service – **Cardiff and Vale University Health Board**

Audit year: 2016

Date issued: February 2017

Document reference: 184A2-17



11

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at info.officer@audit.wales.

The team who delivered the work comprised Tracey Davies, Katrina Febry, Philip Jones and Urvisha Perez

Contents

Whilst operationally the service is well managed, there are risks to the current and future service delivery because of a lack of strategic and business planning, increasing demand, reporting backlogs, aging equipment, and recruitment and retention issues.

11

Summary report

Background

1 Radiology is a key diagnostic and interventional service for the NHS and supports the full range of specialties in acute hospitals primary care and community services. Hospital-based clinicians, including consultants, other doctors, and in agreed circumstances, non-medical practitioners, often refer patients for radiology imaging, as do general practitioners.

2 Diagnostic radiologists employ a range of different imaging techniques and sophisticated equipment to produce a wide range of high-quality images of patients. Images include plain x-ray, non-obstetric ultrasound (US) and computed tomography (CT) as well as sophisticated techniques such as magnetic resonance imaging (MRI).

3 Clinical radiologists[1] are doctors who use images to help diagnose, treat and manage medical conditions and diseases. They have a key role in the clinical management of a patient's condition, selecting the best imaging technique to enable diagnosis and minimise radiation exposure. Interventional radiologists have a more direct role in treating patients. They use radiological imagery to enable minimally invasive procedures, such as stopping life-threatening haemorrhages, and day-case procedures such as oesophageal stenting and angioplasty. All radiologists work as part of the multidisciplinary teams which manage patient care.

4 Rapid advances in technology and understanding about how the features of disease present themselves on diagnostic images have allowed imaging to be used at earlier stages of the diagnostic process. Similarly, changes in the characteristics of disease with treatment can be better detected, and imaging is frequently used to monitor progress. From the patient's point of view, early radiological detection can improve the outcome of treatment and prevent unnecessary pain and suffering. It can also reduce the scale and cost of treatment.

11

[1] In this report, where reference to radiologists is made, this includes consultant radiologists, middle-grade doctors, specialist registrars and junior doctors. Where there is any variation from this, the report content will specify that, eg consultant radiologists.

5 Demand for radiology services continues to increase year on year. The increase is driven by a number of factors, including demographic changes, new clinical guidelines, lower thresholds for scanning and referral, surveillance work for surviving patients, a growth in screening, and increasing image complexity.

6 **The Future Delivery of Diagnostic Imaging Services in Wales** (2009)[2] showed that demand for some types of imaging had been increasing by 10% to 15% per year. Recent reports by the Auditor General on **NHS Waiting Times for Elective Care in Wales** (January 2015)[3], and **Orthopaedic Services** (June 2015)[4] showed that the increasing demand for radiology services is resulting in long waits for radiological diagnostic procedures and that sustainable solutions were needed to address this.

7 The Welsh Government has introduced delivery plans to improve the treatment of major health conditions such as stroke[5], cancer[6] and heart disease.[7] The plans all highlight the importance of efficient and effective radiological services. The associated care pathways emphasise the need for rapid referral processes, rapid diagnostic testing at particular stages in the pathway, the right equipment and staff who are appropriately skilled.

8 While there is a need to deliver long-term solutions to manage and meet increasing demand for radiology services, there is general recognition that the UK consultant radiologist workforce is under significant pressure. In 2015, 9% of consultant radiologists posts in the UK were unfilled, with 7%[8] of Welsh consultant radiologist posts unfilled. For the period 2015 to 2020, consultant workforce attrition due to retirement is likely to be higher in Wales than in any other part of the UK. Around 30% of consultants in Wales are expected to retire if the retirement age is 60, compared to 20% for the UK as a whole[9].

[2] Welsh Assembly Government, **The Future of Diagnostic Imaging Services in Wales**, 2009

[3] Wales Audit Office, **Elective Care in Wales**, January 2015

[4] Wales Audit Office, **Orthopaedic Services**, June 2015

[5] Welsh Government, **Together for Health**, **Stroke Delivery Plan**, 2012

[6] Welsh Government, **Together for Health**, **Cancer Delivery Plan**, 2012

[7] Welsh Government, **Together for Health**, **A Heart Disease Delivery Plan**, 2013

[8] The Royal College of Radiologists, **Clinical radiology UK workforce census 2015 report**, 2016

[9] The Royal College of Radiologists, **Clinical radiology UK workforce census 2015 report**, 2016

9 The use of interventional radiology (IR) is growing. Such techniques rely on the use of radiological images to precisely target therapy. IR techniques can be used for both diagnostic and treatment purposes. The demand for these techniques is increasing and this places further pressure on already stretched radiology services' staffing resources. It is widely accepted by radiology professions that the numbers of interventional radiologists across Wales, similar to other parts of the UK, are too low. Within Wales, the National Imaging Programme Board (NIPB) has a programme of work which is considering interventional radiologist capacity and how it can be addressed.

10 The NIPB is the primary source of advice, knowledge and expertise for the planning of imaging services in Wales. It is made up of clinical and management representatives from organisations involved in the delivery of imaging services in Wales. In 2010 the NIPB was given delegated authority for developing and implementing a programme of strategic work for radiology through to 2016, and for adopting all-Wales standards and protocols for imaging services in NHS Wales. Although progress is being made at national level, a number of significant challenges are yet to be fully addressed. For example, there are ongoing difficulties in recruiting general and specialist radiology staff and concerns about the information systems that support radiology services.

11 Given the challenges set out above, the Auditor General decided that it was timely to undertake a review of radiology services across all health boards in Wales. The work examined the actions health boards are taking to address the growing demand for radiology services, and the extent to which these actions are providing sustainable and cost-effective solutions to the various challenges that exist. The review also examined key radiology imaging techniques, or modalities, as well as interventional radiology in acute settings. It excluded therapeutic radiology.

12 We undertook the fieldwork at the Cardiff and Vale University Health Board (the Health Board) between August and September 2016. Appendix 1 provides more details of the audit approach and methodology.

13 In addition to this local audit work at the Health Board, the Auditor General for Wales is conducting a value-for-money examination of the NHS Wales Informatics Service, which will, amongst other things, look at the implementation of RADIS[10] and PACS[11] across Wales. The findings from that work are due to be published in late spring 2017.

Contextual information

14 The Health Board's radiology service (the service) provides a range of imaging and interventional procedures across several sites, the main departments are based at University Hospital Wales (UHW) and University Hospital Llandough (UHL). The

[10] RADIS – Wales Radiology Information System

[11] PACS – Picture Archiving and Communications System

radiology service is based within the Radiology, Medical Physics and Clinical Engineering (RMPCE) directorate and sits under the Clinical Diagnostics and Therapeutics Clinical Board (the Clinical Board). As University Hospital Wales is a specialist hospital it provides some Wales wide services, which means that demand for certain specialisms is greater.

Our main findings

15 Overall, we concluded that whilst operationally the service is well managed, there are risks to the current and future service delivery because of a lack of strategic and business planning, increasing demand, reporting backlogs, aging equipment, and recruitment and retention issues.

Exhibit 1: our main findings

Table detailing our main findings.

Our main findings
Generally, patients have good and timely access to the service, however, reporting backlogs and environmental issues need to be addressed: • patients have good access to in and out of hours radiology services, and there is a robust system to ensure referrals are correctly prioritised; • while the time patients have to wait for their radiological examination has fallen waiting time targets are still not being met consistently; • despite a backlog, reporting is not outsourced and radiographers are underutilised; • clinical performance is regularly audited, discussed and fed back to staff, however, there are concerns about staff participation because of capacity issues; • processes are in place to monitor and learn from complaints and incidents, however patient and staff feedback highlights long standing environmental concerns which are not being addressed.
Waiting lists and referrals are well managed, however rising demand and staffing challenges increase service pressures, and whilst there is potential to increase weekend equipment usage this may cost the service more: • steps are being taken to try and reduce service pressures, but clinical advances and external factors, such as demand from other health board areas and public health campaigns, continue to increase demand; • whilst clear referral guidance is in place, referring clinicians are unaware of it, and although the service is taking positive steps to reduce inappropriate referrals the lack of an e-referral system is a risk; • the service has a good system to manage waiting lists and appointment slots; • radiology staffing levels have grown at a slower rate than the rest of Wales and this is complicated by significant local and national recruitment and retention challenges; • the radiology workforce profile generally compares favourably with the rest of Wales, although there are limitations on the staffing comparisons due to the tertiary nature of the service and difficulties accounting for complexity.

Our main findings
• staffing constraints hinder training opportunities and compliance with statutory and mandatory training is poor; and • compared to Wales, there is an above average number of scanners, with longer operating hours, and whilst there is potential to further optimise weekend usage this may cost the service more.
Poor strategic planning and lack of equipment replacement programme presents a significant risk, however management structures are clear and there is good Board and corporate oversight of the service: • the Health Board does not have a radiology strategy nor detailed operational and workforce plans, however, the service is taking steps to address this; • the management structure and lines of accountability are clear, however management meetings require a greater strategic focus; • the service is well represented on Board committees and sub-committees; • in recent years, the service overspent against its budget and missed its savings target and whilst finance performance reports are clear, remedial actions are not included; • despite equipment at or reaching the end of life expectancy, and frequent breakdowns, there is no equipment replacement programme in place; • generally, radiology ICT systems do not serve the Health Board's needs; and • radiology performance is regularly reviewed at corporate and management level, however the performance dashboard needs to be strengthened and used to its full potential.

Recommendations

16 As a result of this work, we have made a number of recommendations which are set out in Exhibit 2.

Exhibit 2: recommendations

Table outlining our recommendations to the Health Board.

Factors affecting patient experience
R1 Develop an action plan detailing how reporting backlogs will be managed sustainably. For example by: – making short-term use of outsourcing, whilst workforce and training plans are developed, – ensuring that radiographers already trained to report are fully utilised, and – establishing whether more radiographers need to be trained and how this will be achieved.
R2 Over the next year, increase appraisal rates for non-clinical radiology staff to at least the level of all other radiology staff.

Factors affecting patient experience
R3 Over the next year, increase mandatory training rates for all radiology staff to at least the Health Board target of 85%.
Demand and capacity issues affecting service performance
R4 Liaise with referring clinicians when developing and reviewing referral guidance. Ensure all referring clinicians know where to access up to date versions of guidance.
Extent to which radiology services are well managed
R5 Over the next 12 months develop a radiology strategy which sets out: – where the service is now in terms of its demand, capacity and available resources; – where the service needs to be; and – how the service will achieve its aims.
R6 Develop a workforce plan alongside the radiology strategy, which identifies the baseline capacity needed to sustainably meet radiology demand in a timely and safe way.
R7 By mid-2017, develop an equipment replacement plan. The plan should include: – equipment priorities, requirements, and associated costs, and – outline the risks to the service/patients of not achieving the plan within the required timescales.
R8 Strengthen directorate performance management by: – setting clear business and service objectives; and – widening the range of performance measures aligned to the business and service objectives to include: equipment downtime, vacancy levels, the number of unreported images, performance against internal referral and reporting times.

Detailed report

Generally, patients have good and timely access to the service, however, reporting backlogs, training, and environmental issues need to be addressed

Patients have good access to in and out of hours radiology services, and there is a robust system to ensure referrals are correctly prioritised

17 Open-access services[12] are widely recognised as a means to reduce the time it takes for patients to access imaging. However, the approach can lead to demand management challenges, particularly when used for more complex imaging. It also has the potential to raise patient expectations and encourage over testing. For example, if a patient with lower back pain has an x-ray, it will not improve their condition. They may insist that the GP refers them for an x-ray because they feel as though something is being done for them. The decision to refer may not be supported when the radiology department or other referral screening service reviews the request. This can lead to a tension between patient expectations and the correct professional response.

18 While most radiology departments offer some form of open access to services, the extent of access varies. Typically, it is limited to plain x-ray only, such as a chest x-ray. If the referring medical professional has determined that a plain film x-ray is necessary, they complete a request form which the patient takes to the radiology department during opening times to receive, if appropriate, the requested x-ray. The Health Board has an effective access system for diagnostic requests from GP's. Patients are given a request form by their GPs, the patient can then either visit or call the radiology department for an appointment.

19 Where open access is not available, for example for more complex imaging, the referral should specify the degree of urgency. Typically, referrals are classed as urgent (outpatient) or routine priority (outpatient). This ensures that the patients with the most critical needs are seen first. Urgent referrals will be seen as soon as they can be accommodated. For all other referrals, the patient will be added to the waiting list, with urgent referrals prioritised. The Health Board uses four referral categories, these being, emergency, urgent, urgent suspected cancer and routine. The Health Board operates a system where radiologists, not referrers, determine the degree of urgency. Radiologists vet (review) forms using the clinical information provided by referrers. This system protects against mis-prioritisation and ensures waiting lists are based on clinical priority.

[12] Where an open-access service is provided, a GP can refer a patient to be seen that day by the relevant x-ray department.

20 Patients with emergency health needs may need access to prompt radiology diagnostics and care outside standard radiology working hours. The Health Board provides a full range of emergency radiology services, which run jointly between UHW and UHL. The following cover is available during the out of hours service:

- CT scans – a radiologist and radiographer are on site at UHW and at UHL a radiographer is on call and discusses cases with a radiologist before accepting;
- MRI scans – there is a radiologist and radiographer on-call and all emergency MRIs are transferred to UHW;
- US scans – a radiologist on site at UHW covers both UHW and UHL;
- interventional radiology – cover at both UHW and UHL; and
- vascular radiology – the out of hour's service only runs from UHW.

21 A review of the service's risk register shows that there are some concerns about excessive numbers of CT scans undertaken during the out of hours service, which over burdens the single on-site radiographer. To mitigate this risk, in October 2015 the service introduced a shift system for out of hours CT cover.

While the time patients have to wait for their radiological examination has fallen waiting time targets are still not being met consistently

22 All NHS bodies in Wales are required to comply with the Welsh Government diagnostic waiting times target which states that no patients should wait more than eight weeks to receive their diagnostic test. The diagnostic waiting time target applies to all radiological interventions including magnetic resonance imaging (MRI), computed tomography (CT), and non-obstetric ultrasound (US), fluoroscopy, barium enema, and nuclear medicine. The Welsh Government target does not apply to plain film x-rays.

23 Since 2009 waiting times for radiological tests have also formed part of the referral to treatment target[13]. Health boards in Wales are required to ensure that 95% of all patients waiting for elective treatment, receive their treatment within 26 weeks from the point at which the referral was received. For many of these patients, diagnostic tests help decide which treatment is the best option.

24 The all-Wales radiology waiting times[14] for consultant and GP referrals shows that for August 2016 there were 6,705 patients waiting for radiology diagnostic imaging at the Health Board: 43% for MRI; 38% for US; 16% for CT; and 3% for nuclear medicine.

25 The Health Board operates a single waiting list for scans that can be undertaken at both UHW and UHL. However, some patient groups, for example cardiac or paediatric, can only be accommodate at either UHW or UHL. This explains the variation in waiting times between the two hospital sites shown in exhibits 3, 5 and 7.

26 Our audit work found consistent waiting times for examinations types which are undertaken at both sites, however there is apparent variation in radiology waiting times across two sites, see exhibits 3, 5 and 7 below. This is as a result of some examinations not being able to accommodate specific patient groups. e.g cardiac patients/paediatric patients.

27 In August 2016, 2,854 patients were waiting for an MRI scan at the Health Board, of which 343 (12%) were waiting over eight weeks (Exhibit 3). Further analysis shows that 22% of the total number of patients waiting for an MRI scan across Wales can be attributed to the Health Board.

[13] Welsh Health Circular (2007) 014 – **Access 2009 – Referral to Treatment Time Measurement**, Welsh Health Circular (2007) 051 – **2009 Access – Delivering a 26 Week Patient Pathway – Integrated Delivery and Implementation Plan** and Welsh Health Circular (2007) 075 – **2009 Access Project – Supplementary Guidance for Implementing 26-Week Patient Pathways**

[14] **NWIS Diagnostic and Therapy Services Waiting Times** – NHS Wales Informatics Services (accessed via StatsWales on 30 October 2016)

Exhibit 3: MRI waiting times for August 2016

Table showing that the Health Board has a higher percentage of patients waiting over eight weeks for an MRI scan compared to the all-Wales figures.

	Total number of patients waiting for an MRI scan					Percentage of patients waiting more than 8 weeks
	Up to 8 weeks	Over 8 weeks and up to 14 weeks	Over 14 weeks and up to 24 weeks	Over 24 weeks	Total waiting	
University Hospital Llandough	792	31	1	3	827	4%
University Hospital of Wales	1,719	89	59	160	2,027	15%
Health Board	**2,511**	**120**	**60**	**163**	**2,854**	**12%**
All Wales[1]	**11,662**	**913**	**66**	**163**	**12,804**	**9%**

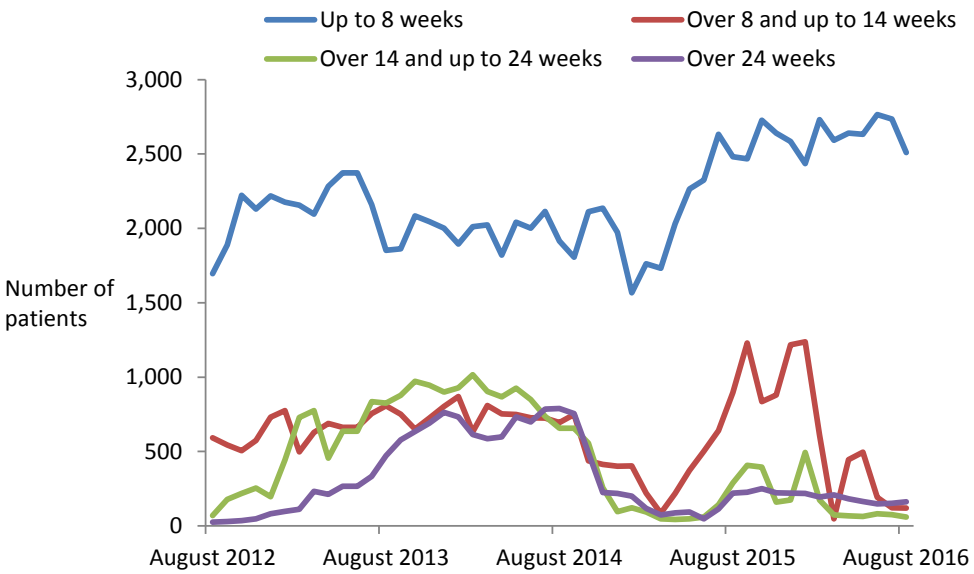
[1] All-Wales figures include all health boards in Wales, except for Powys Teaching Health Board, which has no MRI scanners.

Source: **Diagnostic and Therapy Services Waiting Times**, NHS Wales Informatics Services (accessed StatsWales, hlth0019, 30 October 2016)

28 The total number of patients on the waiting list for an MRI scan at the Health Board increased by 16% between August 2012 and August 2016, but the percentage waiting more than eight weeks decreased from 29% to 12% in the same period (Exhibit 4).

Exhibit 4: MRI waiting times trend from August 2012 to August 2016

Graph showing fluctuating MRI waiting times over the last five years, and growth in the number of patients. However, in the six months between February 2016 and August 2016 the majority of patients received their scan within the eight weeks target.



Source: **Diagnostic and Therapy Services Waiting Times**, NHS Wales Informatics Services (accessed via StatsWales, 30 October 2016).

29 In August 2016, 1,100 patients were waiting for a CT scan at the Health Board, of which just 16 (1%) were waiting over eight weeks (Exhibit 5). Further analysis shows that 15% of the total number of patients waiting for a CT scan across Wales can be attributed to the Health Board.

11

Exhibit 5: CT waiting times for August 2016

Table showing that the Health Board has a lower percentage of patients waiting over eight weeks for a CT scan compared to the all-Wales figures.

	Total number of patients waiting for a CT scan					
	Up to 8 weeks	Over 8 weeks and up to 14 weeks	Over 14 weeks and up to 24 weeks	Over 24 weeks	Total waiting	Percentage of patients waiting more than 8 weeks
University Hospital Llandough	368	2	0	0	370	1%
University Hospital of Wales	716	9	5	0	730	2%
Health Board	**1,084**	**11**	**5**	**0**	**1,100**	**1%**
All Wales[1]	**7,293**	**63**	**51**	**11**	**7,418**	**2%**

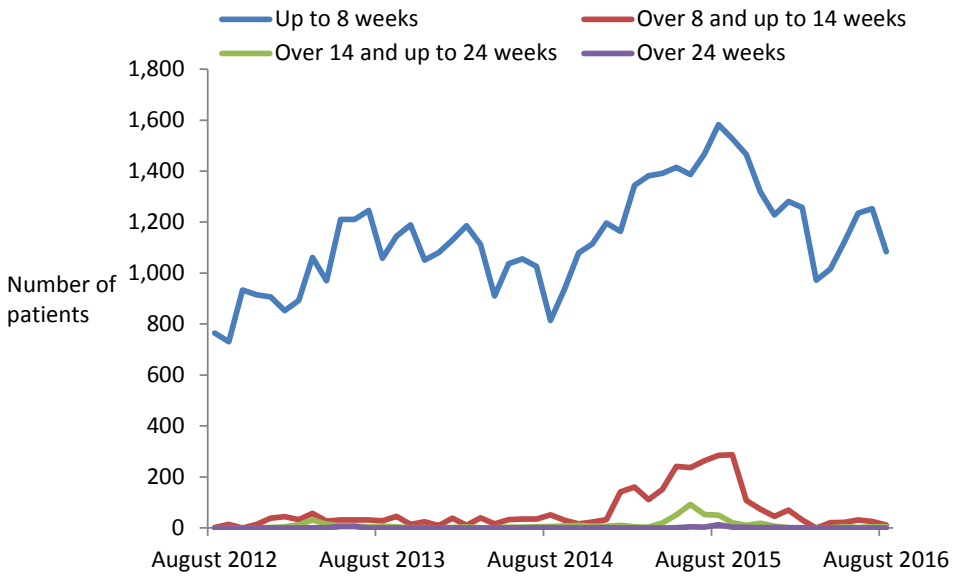
[1] All-Wales figures include all health boards in Wales, except for Powys Teaching Health Board, which has no CT scanners.

Source: **Diagnostic and Therapy Services Waiting Times**, NHS Wales Informatics Services (accessed via StatsWales, on 30 October 2016)

30 The total number of patients on the waiting list for a CT scan at the Health Board increased by 30% between August 2012 and August 2016, but the percentage of patients waiting more than eight weeks increased from 0% to 1% in the same period (Exhibit 6).

Exhibit 6: CT waiting times trend from August 2012 to August 2016

Graph showing a growth in the numbers of patients waiting for a CT scan. In general, other than a period during 2015, the service has consistently met the eight week waiting times target.



Source: **Diagnostic and Therapy Services Waiting Times**, NHS Wales Informatics Services (accessed via StatsWales, 30 October 2016)

31 In August 2016, 2,559 patients were waiting for a non-obstetric US scan at the Health Board, of which 130 (5%) were waiting over eight weeks (Exhibit 7). Further analysis shows that 12% of the total number of patients waiting for a US scan across Wales can be attributed to the Health Board.

11

Exhibit 7: non-obstetric US scan waiting times for August 2016

Table showing that the Health Board has a lower percentage of patients waiting over eight weeks for non-obstetric US scans compared to the all-Wales figures.

	Total number of patients waiting for a non-obstetric US scan					
	Up to 8 weeks	Over 8 weeks and up to 14 weeks	Over 14 weeks and up to 24 weeks	Over 24 weeks	Total waiting	Percentage of patients waiting more than 8 weeks
University Hospital Llandough	700	27	5	0	732	4%
University Hospital of Wales	1,729	95	3	0	1,827	5%
Health Board	**2,429**	**122**	**8**	**0**	**2,559**	**5%**
All Wales[1]	**18,944**	**1,999**	**626**	**133**	**21,702**	**13%**

[1] All-Wales figures include all health boards in Wales, except for Powys Teaching Health Board, which has no US scanners.

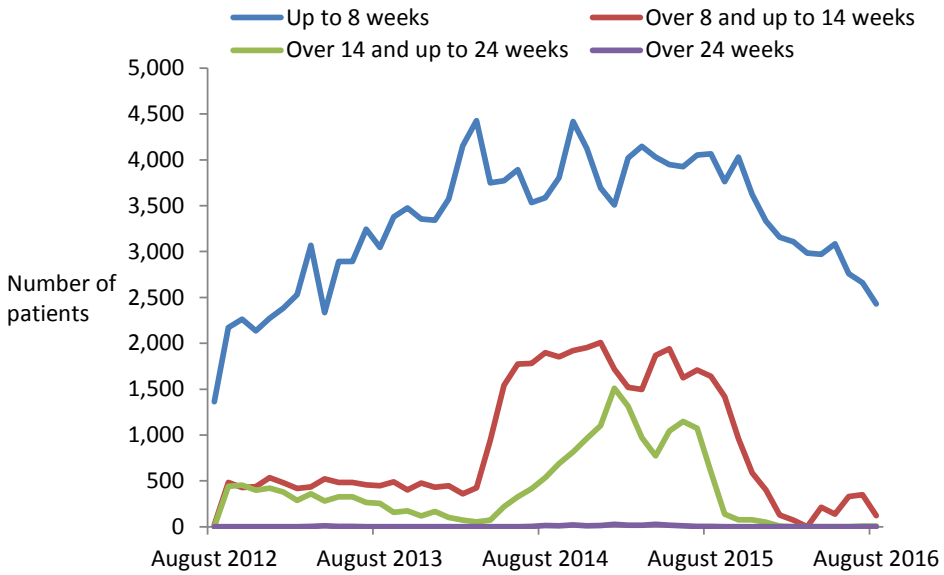
Source: **Diagnostic and Therapy Services Waiting Times**, NHS Wales Informatics Services (accessed StatsWales, 30 October 2016)

32 The total number of patients on the waiting list for a non-obstetric US scan at the Health Board increased by 46% between August 2012 and August 2016, and the percentage of patients waiting more than eight weeks decreased from 35% to 5% (Exhibit 8).

11

Exhibit 8: non-obstetric US scan waiting times trend from August 2012 to August 2016

Graph showing a sharp increase in the number of patients waiting for US scan between 2012 and 2015, and sharp decrease between 2015 and 2016. The rise in patients waiting more than eight weeks for their scan mirrors the increase in demand. However, between February 2016 and August 2016 waiting times performance improved.



Source: **Diagnostic and Therapy Services Waiting Times**, NHS Wales Informatics Services (accessed StatsWales, 30 October 2016)

Despite a backlog, reporting is not outsourced and radiographers are underutilised

33 Effective management of patient care requires timely reporting of radiology images, by a qualified authorised practitioner, generally a radiologist. The report is a record of the interpretation of the scan, used to make further decisions on the care of the patient. Any delays in reporting can adversely affect patient outcomes.

34 All images must be reported and provided to the referring clinician in appropriate time in accordance with the patient's needs and clinical condition. The Welsh Reporting Standards for Radiology Services 2011 (the Standards) were produced in order to clarify previous guidance and regulations. The Standards set out that radiology should aim to provide reporting turnaround times as follows:

- urgent – immediately/same working day;
- inpatient – within one working day;
- A&E – within one working day;

- GP – within three working days; and
- outpatient – within ten working days.

35 The reporting times set out in the Health Board's radiology service internal professional standards are as follows:

- referrals from the emergency unit, medical or surgical assessment unit, short stay wards at UHW, medical emergency assessment unit at UHL and other in patient ward areas will be reported within 24 hours;
- urgent/emergency imaging will be reported within 1 hour of the scan being completed; and
- referrals with planned date of discharge on the same day or following morning will be fast-tracked for same day reporting.

36 The Health Board reported that in order to highlight reporting backlogs, a list of unreported images is run from RADIS, which is then sent to the site superintendents who speak to the radiologist concerned. However, when we asked the Health Board to provide us with the average and longest report turnaround time for CT, MRI, US and x-ray scans during 1 April 2015 to 31 March 2016; the Health Board told us they were unable to provide this data. The Health Board was also unable to tell us the number of unreported examinations as at 31 March 2016 at UHL and UHW. Although they do monitor the number of images not reported within 10 days, the target for which is zero, as part of the directorate performance dashboard. A review of the 2015-16 performance dashboard shows the target is consistently unmet across all modalities, with higher levels of reporting backlogs for CT, MRI and x-ray images. The data for March 2016 shows: 1,585 x-ray, 524 MRI, 177 CT and 99 ultrasound images waiting in excess of 10 days to be reported. In 2015/16, on average, there were 1,339 x-ray, 288 MRI, 96 CT and 63 US images waiting over 10 days to be reported each month.

37 Service leads that we interviewed raised concerns that the radiological diagnostic national targets only included the time from referral to the time the diagnostic test is completed. In their view, the waiting time target should also include the time it takes to report, as until this is completed it may not be possible to determine definitive treatment for the patient. Positively, the target focus has meant that waiting times have improved greatly. However, as demonstrated above, reporting backlogs is still an issue, potentially meaning delays in the patient's care journey.

38 Clinicians making referrals to the service had mixed views about the timeliness of reporting. The target for plain film x-rays in the emergency department is 24 hours but a consultant told us, at times, this target is not being met, especially on weekends when an x-ray taken on a Friday would not be reported until Monday. And CT reporting is supposed to be reported within an hour but there are instances where this target is not met. For GPs, whilst inpatient scans are reported on the same day, outpatients' reports can take 2-3 week to be returned. Referrers' also experienced different reporting turnaround times for different modalities for example MRI scans could take 4-6 weeks but for pelvic and abdominal ultrasound turnaround times are becoming faster. The referring clinicians that we interviewed

were aware of the reporting backlog. On receiving imaging reports referring clinicians generally felt they were able to get advice or clarification from a radiologist if needed, although the availability of radiologists is sometimes an issue.

39 Extended practice radiographers receive extra training to interpret and report some types of images, typically less-complex scans, such as plain x-rays. For patients attending the emergency department and receiving a plain x-ray in normal hospital hours, the use of extended practice radiographers increases the likelihood that a report will be produced whilst the patient is still in the department. Where x-rays are reported by radiologists only, the formal report may not be produced until hours, and sometimes days, after the patient has left the hospital. In these instances, x-rays will be initially assessed by a clinician with no formal radiology training. The use of extended practice radiographers can help to reduce the number of patient recalls caused by initial incorrect x-ray interpretation.

40 Our review found that across the service, a limited number of radiographers are trained and regularly report on images with the highest proportion reporting on ultrasound examinations. There are more reporting radiographers based at UHW than at UHL. However, the Health Board reported that radiographers are one team, and are rotated between sites to expose them to different specialism, which also ensures the service remains resilient. The breakdown is as follows:

- US scans – 15 radiographers at UHW and 5 radiographers at UHL, trained and regularly reporting;
- plain x-ray – 5 radiographers at UHW and no radiographers at UHL, trained and regularly reporting;
- nuclear medicine – 3 radiographers at UHW and 1 radiographer at UHL, have the qualifications to report, but only radiologist provide reporting; and
- upper gastrointestinal tract (GI) imaging – 3 radiographers at UHW and no radiographers at UHL, provide the first stage reports, these are then double reported by radiologist.

41 Exhibit 9 shows that shows that between April 2015 and March 2016 radiologists reported on the majority of CT scans and all MRI scans. This is similar to the all Wales reporting figures, which show that very few if any radiographers report on these two modalities. For US scans there is an equal split between the percentage of scans reported by radiologists and radiographers. However, compared to the all-Wales figures, the Health Board has significantly fewer US scans reported by radiographers, approximately 20% less. The all-Wales figures show that across Wales just under 25% of radiographers report on plain x-ray, at the Health Board the figure is only 5%.

Exhibit 9: percentage of scans reported by radiologists, radiographers and other staff between 1 April 2015 and 31 March 2016

Table showing that between April 2015 and March 2016 the majority of CT and MRI scans were reported by radiologists. Half of radiographers report on US scans and 5% on plain x-ray but figures are low compared to all-Wales percentages.

		% of scans reported by		
		Radiologist	Radiographer[1]	Others[2]
CT	University Hospital Llandough	100%	0%	0%
	University Hospital of Wales	91%	0%	9%
	Health Board[1]	**93%**	**0%**	**7%**
	Wales	**98%**	**0%**	**2%**
MRI	University Hospital Llandough	100%	0%	0%
	University Hospital of Wales	100%	0%	0%
	Health Board[1]	**100%**	**0%**	**0%**
	Wales	**98%**	**1%**	**1%**
US	University Hospital Llandough	45%	55%	0%
	University Hospital of Wales	54%	45%	0%
	Health Board	**51%**	**49%**	**0%**
	Wales	**26%**	**71%**	**3%**
Plain x-ray	University Hospital Llandough	78%	0%	21%
	University Hospital of Wales	87%	6%	7%
	Health Board[1]	**85%**	**5%**	**10%**
	Wales	**63%**	**23%**	**14%**

[1] Radiographers includes ultrasonographers and medical physics technicians.

[2] Others category also includes auto-reported and non-reported images. (Auto-reporting is performed by the referring clinician rather than the radiology team.)

Source: Wales Audit Office, **Health Board Survey**

11

42 The Health Board is investing in extended radiographer roles, for example by creating consultant radiographer posts and training radiographers to report on imaging. However, radiographers felt that the opportunities for training and using new skills were limited. They raised a number of issues, such as:

- lack of budget for higher education and to extend roles/increase pay bands;
- radiographers self-funding their higher education but not having the opportunity to use their skills;
- reporting radiographers underused, for example some radiographers only report for one session per week;
- time for reporting not factored in, some reporting radiographers are expected to fit reporting in around imaging duties;
- extending roles is dependent on radiologists' capacity, for example to train; mentor and quality check radiographers' work, time which is not always available;
- extending roles requiring a degree of culture change because radiographers will be doing roles that are traditionally done by radiologists; and
- not having a training programme in place, radiographers felt that a plan needs to be in place to ascertain when the next cohort of radiographers needed to be trained.

43 Constraints on the availability of radiologists led to the introduction of a national contract to provide extra, outsourced radiology in November 2014. The contract, awarded to Radiology Reporting Online Limited, was to provide outsourced reporting capacity across Wales, initially for two years, with an option to extend the contract for an additional year. The contract value across Wales was for £1.5 million (excluding VAT) for both years. But, increasing demand, particularly in CT and MRI reporting, meant that usage has been significantly in excess of the predicted levels. The NIPB has estimated that the actual spend will be almost double the original contract value.

44 The last time the Health Board outsourced reporting was for a short period in early 2015, this was to alleviate pressure on out of hours CT reporting particularly at UHW. The Health Board reported that the RROL contract was not value for money and some questioned the quality of reporting. However, because of the reporting backlog some felt that the Health Board should outsource reporting more, or extend more radiographers roles.

45 To assess reporting quality the service monitors discrepancy rates, clinical incidences and complaints. The decision to stop outsourcing reporting was based purely on value for money because on review; outsourced and in-house reports had the same discrepancy rate (the discrepancies were mainly around levels of detail included within reports), there was only one clinical incident that did not lead to any harm, and few complaints received.

Clinical performance is regularly audited, discussed and fed back to staff, however, there are concerns about staff participation because of capacity issues

46 Radiology services must ensure that clinical performance always meets the appropriate standards for patient treatment and care. They need to comply with the National Diagnostic Imaging Framework (NDIF). The NDIF draws together a wide range of standards that apply and have relevance to radiology, such as waiting times targets, Healthcare Standards for Wales, and national delivery plans for specific conditions.

47 Radiology departments need to monitor clinical performance to ensure compliance with standards and maintain a clear programme of clinical audit. The Royal College of Radiologists' Good Practice Guide for Clinical Radiologists sets out good practice in relation to the design and delivery of clinical audit. This includes AuditLive, a tool which sets out a collection of audit templates, providing a framework identifying best practice in key stages of the audit cycle, covering over 100 radiology topics.

48 Since April 2015, the Health Board has undertaken a number of clinical audits:

- appropriateness of referrals;
- demand levels by GP and hospital staff;
- accuracy of reporting; and
- reporting turnaround times.

49 The department also regularly reviews the quality of written reports, demand levels by time and undertakes a monthly patient ID check audit. However, appropriateness of urgent and out of hour's referrals, and lost and late reports are not regularly reviewed or audited.

50 The Clinical Diagnostics and Therapeutics Clinical Board has a clinical audit framework (2016-17). The framework sets out who the clinical audit leads are for each department. The leads are responsible for co-coordination and compliance of clinical audits. For example, ensuring compliance with national audits, making sure all audits are registered with the Health Boards clinical audit department and working with senior management to develop an audit programme. The framework also includes audit reporting mechanisms and the clinical audit plan. There are a number of radiology led clinical audits detailed in the plan and these include:

- lumbar spine radiography for low back pain;
- audit of patient pathway from referral to interventional radiology procedure; and
- comparison of carotid artery stenosis grading by ultrasound versus computerised tomography angiography.

51 The Health Board reported that senior radiologists lead clinical audits and that all clinical groups are involved. Although directorate management team minutes show concerns about releasing staff for audit at UHL because of the small pool of staff. On reviewing a selection of minutes, it is clear there is regular discussions about clinical audit at directorate management team meetings and through quality and safety, and radiation protection forums. Radiographers also told us they received feedback after audits had taken place. The minutes show feedback from external audits and plans for forthcoming audits.

Processes are in place to monitor and learn from complaints and incidents, however patient and staff feedback highlights long standing environmental concerns which are not being addressed

52 Radiology services must ensure that their practices are safe. For example, patients should always be offered appropriate radiological techniques which balance any inherent risks with the potential benefits from diagnosis and treatment. The service should ensure that patients receive the correct radiation dose, and staff should be monitored and protected so that they are not exposed to dangerous doses of radiation in the course of their work. Where errors or incidents are identified, health boards should act decisively and openly to learn lessons and prevent such incidents reoccurring.

53 The Health Board has processes in place at both corporate and operational levels to learn from incidents and errors, which are reported through a system called e-Datix. The Clinical Board and Directorate have health and safety sub-groups where incidents and errors are considered. Each of the teams within the directorate, including radiology, have their own health and safety groups that feed up to the directorate health and safety meeting. There is also a Radiation protection group which is attended by the senior leads from each of the divisional teams.

54 The Directorate level health and safety (H&S) group receives a summary of concerns and compliments, and discusses audit results. The Clinical Board H&S group receives reports of serious incidents and governance issues, plus remedial action plans are monitored to closure. The Clinical Board reviews themes emerging from complaints/compliments and the directorate performance dashboard is reviewed which includes quality and safety measures (e-Datix and serious incidents). Radiographers told us that monthly staff meetings take place after audit where incidents and errors are covered, also that they are encouraged to be self-reflecting on incidents and errors as part of their CPD.

55 In 2015, there were 168 reported incidents in radiology departments across the Health Board. Of which 12 were classed as moderate severity, and the rest classed as either low severity or causing no harm. The Health Board told us that there were no incidents reported in 2015-2016 as a result of delays or non-reported examinations.

56 Radiology staff must ensure they protect patients and staff members from the risks of radiation. The Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER), and subsequent amendment regulations in 2006 and 2011, provides a set of regulations for medical staff referring patients to radiology, those justifying the examination and those operating the equipment. Healthcare Inspectorate Wales (HIW) is responsible for monitoring compliance against IRMER. HIW recently conducted an inspection of the nuclear medicine service at UHW. The inspection, undertaken in October 2016, found that the nuclear medicine service is safe and well managed with strong leadership in place. However, the inspection resulted in the Health Board having to complete an action plan to address the issues identified, such as maintaining patient dignity and privacy and updating and reviewing IRMER policies and procedures. Furthermore, the inspection found the service was not compliant with one of the regulations; this resulted in the issue of a compliance notice. The Health Board has since addressed most of the actions within their action plan, with the last to be completed by March 2017.

57 Feedback from patients is a vital source of information for radiology services to understand and improve patient experience. The service gets patient experience feedback through a number of mechanisms that include:

- the national survey of patients (runs every two years) for which the results and remedial actions are challenged through the Board's Quality, Safety and Experience committee; and
- patient focus groups on particular issues, for example, the service is currently working with the Royal National Institute of Blind People (RNIB) to redesign the radiology reception at UHW.

58 The director responsible for patient experience said the service historically has struggled to get good levels of patient engagement. To increase participation the service is looking to use volunteers to conduct the Health Boards 'two minutes of your time' survey face to face.

59 In addition, the National Radiology Board is planning a Wales wide radiology survey, which at the time of this review was being approved by stakeholders.

60 The two professional lead radiographers have responsibility for managing complaints and compliments. They told us that the team often gets compliments about the staff. Complaints tend to focus on the facilities and waiting rooms. Each year the Community Health Council audits the facilities and raises issues around poor accessibility. Radiographers generally felt that radiology facilities are not patient focused. They accepted that buildings are old and there is little room or funding to update facilities, and service managers confirmed this.

61 At UHW, radiographers raised various issues that have an impact on patient experience, which included:

- no air conditioning in waiting rooms;

- waiting room chairs inadequate for larger patients and those with back problems;
- inadequate disabled access;
- limited supply of linen;
- hospital gowns supplied with security tags which pose a risk to patients if put through MRI scanners (the tags are cut out); and
- lack of patient privacy, for example, one room contains three gamma cameras side by side, separated by a curtain meaning personal questions can be over heard.

62 Similarly, radiographers at UHL raised several issues that impact on patient experience, which included:

- small changing rooms which only have one-way access. This means that access for disabled and larger patients is poor. Also, in an emergency, for example, if a patient collapses they could block the only door into the changing room, which in turn may delay any help they need;
- small waiting room with no privacy because everyone waiting can hear patients speaking to reception;
- corridors are often blocked with inpatients waiting on beds;
- the new mental health unit at UHL has bigger beds that are difficult to manoeuvre along the narrow corridors; and
- in general, disabled access is poor.

63 The Imaging Services Accreditation Scheme (ISAS) is a patient-focused accreditation scheme that helps imaging services to manage the quality of their services and make continuous improvements. In Wales, the introduction of ISAS is being overseen by the NIPB. However, there is recognition that progress at individual health bodies has been limited by a lack of staff resources to enable coordination of the work associated with the accreditation process. For Cardiff and Vale, the Clinical Board is supportive of getting accreditation but there are no available resources to take it forward. The directorate is looking to resource this as part of next year's plan.

Waiting lists and referrals are well managed, however rising demand and staffing challenges increase service pressures, and whilst there is potential to increase weekend equipment usage this may cost the service more

Steps are being taken to try and reduce service pressures, but clinical advances and external factors, such as demand from other health board areas and public health campaigns, continue to increase demand

64 The increasing role of radiology in clinical care has led to growing demand for radiological examinations, in particular for CT and MRI scans. Whilst figures are not available for Wales, the most recent data available for England shows that there was a 42% increase in the number of radiology examinations undertaken per year between 2003 (28.8 million scans) and 2014 (40.9 million scans)[15]. The Royal College of Radiologists has predicted that by 2022 the number of radiological examinations carried out in England will be around 62 million[16] per year driven by further innovation and demographic growth.

65 As well as the number of scans undertaken annually increasing, scans are also becoming more complex. The biggest percentage rise in volume for radiological examinations has been for CT and MRI scans as they play an increasing role in the early diagnosis of many diseases. The Royal College of Radiologists predicts that the biggest percentage increase in examinations up to 2022 is expected to be for MRI scans (from 2.7 million scans per year in 2014 to 7.8 million in 2022) and CT scans (5.2 million scans per year in 2014 to 12.3 million in 2022)[17]. MRI and CT scans are complex data examinations, which generally include multiple images, and therefore, per patient examination, are more labour-intensive for radiologists interpreting images than less-complex scan types, such as plain x-ray.

66 Those we spoke to at the Health Board highlighted a number of factors contributing to an increase in demand and the knock-on effects, for example:

- public health campaigns – the recent ‘lung cancer detection’ campaign caused an increase in chest x-ray demand for the service (by approximately 25%).

[15] **Annual Imaging and Radiodiagnostics Data**, NHS England, 2014

[16] Royal College of Radiologists, **Information submitted to Health Education England workforce planning and education commission round 2015-16**

[17] Royal College of Radiologists, **Information submitted to Health Education England workforce planning and education commission round 2015-16**

- clinical trials and advances in interventional radiology – whilst positive, both add pressure to an already stretched service. Growth in these areas have a knock on effect on scheduling diagnostic patients and waiting lists.
- litigation and patient expectation – a culture of GPs 'making sure' and higher patient expectation has led to an increase in demand.
- external demand – as a tertiary and specialist centre patients from other Welsh health boards are legitimately referred to the Health Board. However, patients from other health boards are being sent to Cardiff and Vale for diagnostic scans, which could been done at their local hospital, this further increases demand.

67 In order to reduce demand the Health Board is reviewing some patient pathways, where imaging would not improve a patient's outcome. Such as for lower back and shoulder pain for which physiotherapy is more effective, imaging would be better used for cases where physiotherapy does not improve symptoms. Business case sign-off has also been updated to ensure any service changes consider radiology. However, in general, the service feels it has little control over rising demand levels.

68 The Clinical Director said the Clinical Board and Health Board executives are aware of the capacity and demand issues facing the service.

Whilst clear referral guidance is in place, referring clinicians are unaware of it and although the service is taking positive steps to reduce inappropriate referrals the lack of an e-referral system is a risk

69 GPs and consultants refer patients to radiology. Ensuring that patients are referred for the most appropriate diagnostic investigation depends on clear guidance and standards. Guidance should be based on the Royal College of Radiologists' iRefer [18] tool and support medical professionals referring patients to the service to select the most appropriate imaging investigation(s) or intervention for a given diagnostic or imaging problem. Each inappropriate investigative image performed is, in effect, an appointment slot wasted which adversely affects the service's ability to meet NHS waiting times targets and patient need in a timely way.

70 The Health Boards 'guidance for new referrers' is made available to hospital consultants and GP referrers. The guide clearly outlines referrer's responsibilities and how to complete a radiology referral form. It includes a table that sets out what patient information must be included, an annotated copy of the referral form and the consequences of an incorrect or incomplete form. The guide is reviewed every 12 months. Clinicians are also referred to the iRefer website for further guidance. In addition, the British Medical Ultrasound association (BMUS) recently produced a

[18] iRefer is a radiological investigation guidelines tool from The Royal College of Radiologists.

good practice guide for pelvic ultrasound referrals, which list a number of symptoms and explains whether or not ultrasounds are the best way forward. However, the clinicians we spoke to were not aware of any physical guidance produced by the radiology department and the radiology department did not involve them in producing the local guide.

71 The Heath Board does not have an electronic referral system, so all referrals are paper based. Those interviewed felt that the paper based system was flawed because of the following reasons:

- risk of mismatching sticker with patient details with correct request form;
- creating more administration because all referral forms have to be scanned;
- difficulty in reading handwriting; and
- a potential risk that patients may tamper with forms they have to hand in to the department.

72 There was general consensus that an e-referral system would help mitigate the risks identified above. An electronic referral system would also provide a clear audit trail of each referral, which would make audit of referral patterns and information easier.

73 Once a referral is made a radiologist or appropriately trained radiographer will justify (review) the referral for its appropriateness and to determine whether there is a sufficient benefit to the patient. Referrals may be declined or a more appropriate alternative investigation suggested. The process of justification helps to ensure that patients do not receive unnecessary exposure to radiation and that appointment slots are not wasted.

74 At the Health Board, radiologists vet all referrals to check appropriateness and assign patient urgency. Currently, there are different vetting protocols for each modality and sub-speciality. Radiographers whose roles have been extended vet some plain x-ray, US and CT scans. A review of directorate management team minutes show that the Health Board is trialling electronic vetting and looking to standardise vetting protocols. The minutes identify difficulties with vetting referrals at UHL because there is a smaller pool of staff. Solutions such as ensuring vetting is on consultant job plans and/or delegating work to radiographers were outlined in the minutes.

75 To ensure they are not performing unnecessary examinations, the radiology department regularly reviews the appropriateness of referrals. For inappropriate x-ray referrals, the team completes a feedback form, which is sent to GPs explaining why their patients x-ray was refused. The department keeps a copy of the feedback form so ‘frequent offenders’ can be highlighted. For other modalities, for example CT, MRI or US scans, radiologists have a conversation with GPs. Service leads said that some inappropriate referrals are as a result of GPs not understanding new guidance, patient expectation and clinicians being cautious. A working group has been set up to look at how to reduce demand on imaging. The directorate manager, GP cluster lead and radiologists are members of this

group. Moving forward radiologists will attend GP cluster meetings and/or monthly education sessions to update on patient pathways and guidance.

The service has a good system to manage waiting lists and appointment slots

76 Health boards should ensure that all appointment slots are made use of by keeping patient did not attend rates (DNAs) to a minimum. Some health boards operate partial booking systems. This means that when the patient nears the top of the waiting list, rather than allocating the patient with a set appointment time, the patient is asked to contact the health board to choose a time and (if possible) a place to suit the patient. Services offering partial-booked appointments typically see lower DNAs.

77 Appointment slots at the Health Board are aligned with consultant radiologists job plans, which coupled with high levels of demand means the service does not offer patients flexible appointments and does not operate a partial booking system. Patients will be offered an appointment at either UHW or UHL, which is determined by the patient's address or referring GP practice. If available, urgent appointments and cancellations are offered to patients. However, positively the service has low and reducing levels of 'did not attend' rates (DNA):

- in 2014-15, the DNA rate was 3.1%,
- in 2015/16 it reduced to 2.9%; and
- so far rates for 2016-17 have reduced further to 2.8% (up until October 2016).

78 To help with imaging backlogs the service sent some patients to the Royal Glamorgan hospital for MRI scans, however many patients felt the hospital was too far way and did not turn up for appointments.

79 Health boards must build in flexibility to the appointment timetable to ensure that emergency referrals for scans can be accommodated. Some modalities, such as MRI scans, take 30 to 40 minutes; therefore, health boards need to be able to accommodate any emergency referrals, but without leaving so many free appointment slots that it impacts negatively on the capacity to see routine referrals. The Health Board carves out time in the rota for emergency and inpatient referrals. Time allowed is based on forecast and trends, but demand is unpredictable which means, sometimes, too much or too little time is allowed in the rota. There is also a designated emergency unit superintendent to manage emergency referrals. However, the Directorate Manager told us that if there is a need for a radiologist in the emergency unit, planned appointments suffered because there is a limited pool of radiologists who cover both emergency and planned interventions.

80 Health boards should reduce unnecessary ring fencing of appointments, other than to ensure that emergency and urgent referrals can be accommodated.
Ring fencing of appointments is where some or all appointments are reserved for specific sub-groups of patients (for example where referrals are grouped by the

type of scan, such as gynaecological scans, breast scans etc). This leads to the waiting list being split into sub-lists which increases the likelihood that some patients will wait longer, as sub-lists will differ in length. Similarly, using a single central booking office for the whole health board (rather than for individual hospitals), can help patients to be allocated to the next available appointment rather than potentially waiting longer for a slot to become available at a particular hospital.

81 There is a central radiology waiting list for the Health Board. The waiting list is managed by modality and based on treatment in turn, only clinical prioritisation overrides this system. Each week the two lead radiographers meet with heads of staff, there is one for each modality, to plan how to accommodate the waiting list and prioritise appointments. The modality leads at each site (UHW and UHL) work together to manage the waiting lists appropriately for example by making sure where possible that one site is not overburdened.

82 Booking clerks work to a modality/specialism because there are different protocols. To allow the service to have a central pool of booking clerks, the service is in the early stages of standardising protocols. However, the Service Manager said this is a difficult exercise because there are a number of protocols, which differ greatly.

Radiology staffing levels have grown at a slower rate than the rest of Wales and this is complicated by significant local and national recruitment and retention challenges

83 Radiologists, radiographers, nurses, technical and administrative staff work together to deliver radiology services. It is important to have the right number and skill mix of staff to deliver radiology services.

84 Our review found that the full-time equivalent (FTE) establishment[19] staffing level of radiologists at the Health Board increased by 3.8% between 2012 and 2016, compared with 5.9% across Wales[20] (Exhibit 10). Similarly, the FTE establishment staffing level of radiographers at the Health Board has increased by 5.6% in the same period, compared with 10.2% across Wales.

Exhibit 10: FTE establishment of radiology staff trend 2012–2016 at the Health Board

[19] The staffing establishment is the level of staff that the Health Board has determined it needs to provide services and for which funding has been made available.

[20] The Welsh percentage increase figures for radiologists and radiographers/ ultrasonographers are based on Abertawe Bro Morgannwg, Betsi Cadwaladr, Cardiff and Vale, and Hwyel Dda University health boards only, as these were the only health boards that could provide data for each year between 2012 and 2016.

Table showing there has been little growth in the numbers of radiologist and radiographers over the last five years.

	2012	2013	2014	2015	2016	Percentage change 2012–2016
Radiologists	50.30	50.60	48.70	51.40	52.20	3.8%
Radiographers/ ultrasonographers	147.66	145.29	136.32	143.40	155.91	5.6%

Source: Wales Audit Office, **Radiology Health Board Survey**. Data is provided as at 31 March each year.

85 The continued increase in demand for complex imaging (CT and MRI scans) has outstripped service capacity across the UK. The mismatch in demand and capacity has been exacerbated by difficulties recruiting radiologists and other staff such as ultrasonographers. NHS Wales has historically had difficulty attracting radiology consultants from outside Wales and traditionally loses two out of every five trainee posts to England or outside of the UK[21]. Across Wales, there is a shortfall of consultant radiologists in interventional, breast, paediatric and nuclear radiology. Across the UK, the number of unfilled consultant radiologist posts in 2015 was 9%, with 7% in Wales[22].

86 As part of our review, we asked the Health Board to provide the number of vacancies as at 31 March 2016 within the radiology department at UHL and UHW. However, the Health Board was unable to provide this data.

87 Those interviewed expressed real concerns with staffing levels within the department. The Clinical Director explained that whilst the number of radiologists is relatively stable, the service needs more. Notwithstanding the national challenges mentioned earlier, the department has recently been successful in recruiting two radiologists, a chest specialist and a neurological specialist.

88 For radiographers, the service successfully recruits new graduates each year although the Radiography Professional Leads expressed concerns about the low numbers of radiographers graduating each year. As UHW is a specialist hospital, it provides more development opportunities and is seen as a more attractive workplace for graduates. However, this means the service finds it more difficult to attract graduates to UHL.

[21] NHS Wales, **NHS Wales Health Collaborative Diagnostic Services Modernisation Programme**, December 2015

[22] The Royal College of Radiologists, **Clinical radiology UK workforce census 2015 report**, 2016

89 A radiology service relies on a number of support staff such as nurses, porters, admin and booking clerks. Those interviewed as part of this review felt that the support staff were undervalued and overlooked when planning services. Since 2012, the Health Board has gained an additional nine (WTE) support staff, broken down as: 1.25 clerical staff, 2 porters, 2.75 radiology department assistants, and 3 radiology assistant practitioners.

90 The Directorate Manager told us that the service needs a better understanding of its interdependencies, for example for each scan how many radiologist, radiographers, porters, administrative staff, nurses and beds are needed. The Health Board reported that often when submitting a funding bid for a radiologist, the bid includes support staff but when the funding is awarded all but the radiologist funding is stripped out. For example, the service submitted a funding bid to the Welsh Health Specialised Services Committee (WHSSC) for three radiologists and support staff, because the one radiologist supporting 14 cardiologists was overstretched. However, the service was only awarded half of the funding requested, enough for one radiologist and an anaesthetist.

91 A lack of support staff causes delays because existing staff have to meet the extra demand. At UHL, radiographers often man reception and because of a lack of porters have to collect and return their patients to the wards. At UHW, again because of a lack of porters patients often have to wait on beds in corridors before their X-Ray and before returning to their ward.

92 Across Wales, the service is likely to lose many older and experienced members of its workforce to retirement in the very near future as 38% of consultant radiologists are aged 55 or over[23]. To provide a future sustainable consultant radiologist workforce, NHS Wales needs to train radiologists and retain them in NHS Wales. The National Imaging Academy for Wales project is being developed in 2016-2017 to achieve this aim.

93 Thirty-seven per cent of the consultant radiologists and 21% of radiographers at the Health Board are aged 50 and over and potentially within five years of retirement (Exhibit 11).

11

[23] NHS Wales Workforce, Education and Development Services, **NHS workforce census data for June 2016**, 2016

Exhibit 11: number and percentage of consultant radiologists and radiographers by age as at June 2016

Table showing that compared to the all Wales figures, the Health Board has a slightly higher percentage of radiologists aged 60 and over, and a higher percentage of radiographers aged under 39.

		Age					
		Under 39	40–44	45–49	50–54	55–59	60+
Consultant radiologists[1]	Cardiff & Vale University Health Board	6 (16%)	10 (26%)	8 (21%)	4 (11%)	4 (11%)	6 (16%)
	All Wales	**29 (18%)**	**43 (27%)**	**28 (17%)**	**20 (12%)**	**20 (12%)**	**21 (13%)**
Radiographers[2]	Cardiff & Vale University Health Board	101 (64%)	14 (9%)	10 (6%)	19 (12%)	6 (4%)	8 (5%)
	All Wales	**473 (45%)**	**106 (10%)**	**103 (10%)**	**170 (16%)**	**125 (12%)**	**74 (7%)**

[1] NHS workforce definition: staff with consultant grade code or job role working in radiology – note this includes both diagnostic and therapeutic radiologists.

[2] NHS workforce definition: Staff bands 5–9 with a diagnostic radiography occupation code (S*F).

Source: NHS Wales Workforce, Education and Development Services, **NHS workforce census data for June 2016**, 2016

94 Between 2011-12 and 2013-14 the Health Board did not use locums or agency staff. However, in 2014-15 this trend changed with 0.2% of the radiology budget attributed to locums and agency staff, the following year (2015-16) this increased to 0.9%. A directorate finance performance report (from May 2016) shows that radiology is overspending on medical staffing to cover consultant sickness, pay for additional sessions and temporary consultant sessions to cover retirement.

Staffing constraints hinder training opportunities and compliance with statutory and mandatory training is poor

95 Annual appraisals of staff performance, and continuing professional development (CPD) reviews are an important part of ensuring that the quality of radiology services is maintained and that staff training needs are properly addressed.

96 All radiologists, most radiographers and just under half of other radiology staff received an annual appraisal of their performance and a personal development plan in 2015-2016.[24] The Health Board keeps a register of all registered practitioners and operators engaged to carry out medical exposures, including the date the training was completed and the nature of the training undertaken. The records are kept under Ionising Radiation Medical Exposure Regulation (IRMER) requirements for radiographers and assistant practitioners within the Radiology department, and trainee radiologist records are kept with the Trainee Programme Director (South Wales).

97 Radiographers told us that they were happy with training at the beginning of their careers when they receive training for the various modalities. However, due to the size of the team and demand on the service, once initial training is over it is difficult to release staff. If a member of the team is training, the rest of the team have to cover their shifts. Because UHW is a specialist hospital, radiographers based at UHL often work shifts at UHW to develop their skills and to help with staffing levels. Radiographers were positive about gaining experience within a specialist environment but at times felt unsupported and left to deal with patients on their own. Whilst consultant radiologists can be called upon for support they are not always available because of their heavy workloads.

98 Radiographers confirmed that their training needs are discussed through their annual performance appraisal, but they also said that whilst they receive the recommended six hours per year for CPD, they felt this was insufficient.

99 Exhibit 12 shows that compliance with statutory and mandatory training is generally poor and presents corporate and operational risks. Radiographers are more compliant than radiologists and other radiology department staff.

100 A review of Board papers show that low levels of statutory and mandatory training compliance is a Heath Board wide concern. In order to address the issue the Heath Board has set an 85% compliance target for all UK Core Skills, this objective is detailed in their workforce and organisational development plan (2016-17). The Health Board has also set up a mandatory training steering group, chaired by the Director of Workforce and Organisational Development, which meets monthly to track delivery of improvement actions.

[24] 100% of radiologists, 81% of radiographers/ultrasonographers and 47% of other radiology staff received an appraisal of their performance and 100% of radiologists, 81% of radiographers/ultrasonographers and 47% of other radiology staff had a personal development plan.

Exhibit 12: percentage of staff compliant with statutory and mandatory training modules, as at July 2016

Table showing that radiologists are the least compliant with statutory and mandatory training modules and radiographers are the most compliant.

	Radiologists	Radiographers/ ultrasonographers	Other radiology department staff
Equality, Diversity and Human Rights	52%	81%	47%
Health, Safety and Welfare	54%	87%	75%
Fire Safety	33%	73%	59%
Infection Prevention and Control	57%	86%	73%
Moving and Handling	11%	85%	71%
Safeguarding Adults	26%	57%	52%
Safeguarding Children	24%	75%	57%
Resuscitation	2%	46%	41%
Information Governance	33%	66%	61%

Source: Wales Audit Office, **Radiology Health Board Survey**

The radiology workforce profile generally compares favourably with the rest of Wales, although there are limitations on the staffing comparisons due to the tertiary nature of the service and difficulties accounting for complexity

101 We reviewed the numbers of FTE radiologists and radiographers in-post at each of the Health Board's main hospital sites, relative to both population and workload. Such measures provide an overall guide to the appropriateness of the number of staff to meet demand. However, these measures do not take account of the complexity of the imaging undertaken, and thus need to be treated with the appropriate caution.

102 The number of FTE consultant radiologists per 100,000 people in the UK in 2015 was 4.8 (4.8: Wales, 4.7: England, 5.4: Scotland, and 6.2: Northern Ireland)[25]. Exhibit 13 shows that the number of radiologists and radiographers relative to population and workload is larger than the all-Wales average, suggesting a more

[25] The Royal College of Radiologists, **Clinical radiology UK workforce census 2015 report**, 2016

generous staffing establishment when compared to the all-Wales position. As a tertiary and specialist hospital UHW receives patients from other health board areas, as such, the population served would be greater than the catchment population. Therefore the measure based on local population for this Health Board needs to be treated with caution.

Exhibit 13: FTE of in-post radiologists and radiographers, per 100,000 population, June 2016

Table showing, compared to the all-Wales average, the Health Board has more radiologist and radiographers, per 100,000 population.

	In-post FTE consultant radiologists[1] per 100,000 population	In-post FTE radiographers[2] per 100,000 population
Health Board	7.0	30.0
All Wales	4.8	27.2

[1] NHS workforce definition: staff with consultant grade code or job role working in radiology – note this includes both diagnostic and therapeutic radiologists.

[2] NHS workforce definition: Staff bands 5–9 with a diagnostic radiography occupation code (S*F).

Source: NHS Wales Workforce, Education and Development Services, **NHS workforce census data for June 2016**, 2016; and Welsh Government, **Local Authority Population Estimates for Wales**, 2015, accessed 20 October 2016

103 When measuring radiology activity, care is needed to ensure that comparisons are like for like. A single image may count as one unit of activity; however, where a patient receives complex or multiple images this may count as one or more units depending on the Health Board's view. There is no standardised activity measurement in use in radiology in Wales or the UK.

104 In the absence of standard activity count, the medical classification system – the Systematised Nomenclature of Medicine Clinical Terms (SNOMEDCT) – has enabled some activity measurement. SNOMEDCT allows clinical data to be recorded in a consistent way, as it uses a standardised set of clinical terminology and codes. NHS England is adopting SNOMEDCT as the universal classification and terminology for all health organisations and for all aspects of health. However, in Wales it has only been adopted in radiology and a small number of other specialties. SNOMEDCT provides a standardised way of describing radiology examinations, and automatically applies multiplication for some activities depending on the coding applied. However, comparisons of radiology activity between radiology departments has to be treated with caution as any count of

activity is reliant on organisations recording activity using SNOMEDCT consistently. Currently in Wales radiology activity is not consistently recorded which makes it difficult to provide a true comparison of activity.

105 The Health Board measures imaging activity by 'investigation' which means each part of the body scanned counts as one investigation. The Health Board expressed concerns that the NHS Wales waiting times target for radiology may be too simplistic as it is based on the number of patients scanned and as such does not recognise that some parts of the body take longer and are more complicated to scan.

106 Exhibit 14 highlights that the number of examinations per FTE in-post radiologist is lower than for other parts of Wales. The lower number of examinations per FTE radiologist could be attributed to the Health Board having a higher number of radiologists per 100,000 population, as demonstrated in Exhibit 13. A comparison of large specialist teaching hospitals would provide a helpful benchmark.

Exhibit 14: number of examinations per FTE in-post radiologist 2015–16

Table showing the number of examinations undertaken per full-time equivalent in-post radiologist at the Health Board compared to Wales. This shows that the Health Board undertakes less examinations per full-time radiologist.

	Number of examinations per in-post FTE radiologist		
	All examinations	CT	MRI
Health Board	7,348	934	399
All Wales[1]	**13,742**	**1,989**	**724**

[1] All-Wales figures excludes Powys Teaching Health Board.

Source: NHS Wales Workforce, Education and Development Services, **NHS workforce census data for June 2016**, 2016; and Wales Audit Office, **Radiology Health Board Survey**

107 Exhibit 15 highlights that the number of examinations per FTE in-post radiographer/ultrasonographer is higher than for Wales.

Exhibit 15: number of examinations per FTE in-post radiographer/ultrasonographers and ultrasonographers per 100,000 examinations 2015–16

Table showing the number of examinations undertaken per full-time equivalent (FTE) in-post radiographer/ultrasonographer compared to Wales. This shows that the Health Board undertakes more examinations per FTE in-post radiographer/ultrasonographer.

	Number of examinations per in-post FTE radiographer/ultrasonographer			
	All examinations	CT	MRI	US
Health Board	2,862	364	155	539
All Wales[1]	**2,465**	**357**	**130**	**523**

[1] All-Wales figures exclude Powys Teaching Health Board.

Source: NHS Wales Workforce, Education and Development Services, **NHS workforce census data for June 2016**, 2016; and Wales Audit Office, **Radiology Health Board Survey**

108 The NHS Benchmarking Network (NHSBN) annual radiology survey compares around 80 radiology departments including large teaching hospitals each year. The audit uses various measures to compare staffing with establishment, other than staff in-post, as the workforce measure. For example, bed days and outpatient activity are used as the denominator. The Health Board should draw on various workforce measures, including NHS benchmarking data to determine how the radiology staffing compares to inform their workforce planning.

Compared to Wales, there is an above average number of scanners, with longer operating hours, and whilst there is potential to further optimise weekend usage this may cost the service more

109 The UK has a low number of scanners compared with other OECD countries. Across the UK there are 8 CT scanners and 7 MRI scanners per million population; Germany has 19 CT scanners and 11 MRI scanners, Spain has 17 CT scanners and 15 MRI scanners, and France has 14 CT scanners and 9 MRI scanners per million population[26]. Data are not available for the separate countries in the UK.

110 Exhibit 16 shows the number of scanners per million population for Wales. The Health Board has a higher number of MRI scanners when compared to Wales, but a lower number of CT and US scanners. When compared to OEDC countries it has significantly fewer CT and MRI scanners.

[26] Organisation for Economic Cooperation and Development, **OECD Health Statistics 2014 – Frequently Requested Data**, 2014

Exhibit 16: number of CT, MRI and US scanners per million population as at September 2016

Table showing, compared to the all Wales average, the Health Board has more MRI scanners and less CT and US scanners per million of the population.

	CT	MRI	US
Health Board	8.3	8.3	43.3
All Wales[1]	**10.1**	**7.5**	**46.1**

[1] Please note that the number of equipment recorded for one health board is as at 2014, not September 2016.

Source: Wales Audit Office, **Radiology Equipment Age Survey**; and Welsh Government, **Local Authority Population Estimates for Wales**, 2015, accessed 20 October 2016

111 One way for health boards to ensure that patients waiting for diagnostic radiography scans wait as short a time as possible is to maximise the opening hours. The longer the opening hours, the more patients can be seen; however, there are extra costs associated with longer operating hours. Operating longer results in increased staff costs and scanning equipment lifespans are shortened. This factor has to be considered when assessing the potential for extending operating hours.

112 Most recent data from 2014 (Exhibit 17) shows that on average, the Health Board operated their scanners for between 7 and 11 hours on week days, but made less use of scanners on weekends.

11

Exhibit 17: percentage usage of CT, MRI and US scanners, 2014 (verified and updated in 2015)

Table showing that compared to the Wales average, the Health Board has a higher percentage of usage for CT and MRI scanners, but not US scanners.

Type of scanner	Average number of operating hours per scanner on each day		Percentage usage of equipment[1]	
	Monday to Friday	Saturday to Sunday	Health Board	**Wales average**
CT	10.0	0.0	60%	**52%**
MRI	10.8	4.5	75%	**66%**
US	7.4	0.0	44%	**46%**

[1] Based on the planned operating hours as a percentage of potential operating hours (seven days a week and 12 hours a day).

Source: **NHS Wales All-Wales Gantry Usage/Capacity Report**, November 2015. Data based on the operating hours in 2014, and the data was verified and updated in 2015.

113 If hospitals at the Health Board were operating 12 hours a day and seven days a week, we estimated that it may be possible to undertake a minimum of 130 CT scans, 55 MRI scans and 1,500 US scans a week

114 Data from 2014 (and updated in 2015) shows that on average, the Health Board operated their scanners for between 7 and 11 hours on week days, but made less use of scanners on weekends.

115 However, radiographers and service leads said that due to the age of the scanners, particularly MRI scanners, there are frequent ‘down-times’, so the operating hours shown in Exhibit 17 are not a true reflection of the actual hours of operation.

11

Poor strategic planning and lack of equipment replacement programme presents a significant risk, however management structures are clear and there is good Board and corporate oversight of the service

The Health Board does not have a radiology strategy nor detailed operational and workforce plans, however, the service is taking steps to address this

116 The Health Board should have a clear strategic plan that sets out how it will meet current and future demand for radiology services. The plan should set out how the Health Board will meet current and future demand for radiology services.

117 There is no strategy for the radiology service. Some radiology priorities are outlined within the Health Board's Integrated Medium Term Plan (IMTP)[27] but the detail is insufficient to understand the strategic approach and intent. Within the IMTP there is no dedicated section to detail the vision, challenges and strategic priorities for the service. There is some mention, but little detail, about the imbalance of supply and demand within the service, priority to reduce backlogs and radiology services moving into the new children's hospital.

118 Without a strategy, it is difficult for the service to set out how to meet future demands. The service leads have identified that the radiology service does not understand its baseline capacity, as in what can be delivered by the service at any given time or day of week, which makes forward planning difficult. Current demand and capacity modelling is done manually as the Radiology Information System (RADIS) used to extract radiology information does not support demand/capacity modelling. Service and performance leads told us that waiting lists and appointments slots are manually sorted which is time and resource intensive. Work is now underway to establish a 'zero base' capacity for the service, but it is anticipated that this will take approximately six months to complete, as it will need to be done manually.

119 The absence of a clear strategy for the Health Board's radiology service constrains its ability to set out sound operational plans.

120 Each radiology service should have an agreed documented annual operational/ delivery plan. The plan should clearly identify service demand, the workforce and equipment capacity required to meet this demand as well as the finances available and required to deliver the service safely, efficiently and effectively.

[27]At the time of this review, the Health Boards IMTP had yet to be approved.

121 The Health Board does not currently have an overarching radiology operational / delivery plan nor does it have a workforce plan. There are a number of contributory factors including the absence of a strategy and the poor understanding of capacity and demand. However, the service recognised a gap in business planning and at the time of this review had very recently recruited a Directorate Manager whose role involves business, financial and project planning.

122 Radiology operational plans should be informed by service changes and developments in the wider organisation. Almost all clinical specialties rely heavily on radiology to help diagnose, treat or monitor disease or injury. Radiology staff should, therefore, be appropriately involved in any decision making on service developments that will lead to an increase to the number of patients referred for radiology imaging, such as new consultant posts, clinics and services.

123 Across Wales our review found that there was variation in the degree to which radiology teams were involved in decisions made outside of the team that impact on radiology services. The radiology service at the Health Board told us that while the radiology team is very involved in decisions to introduce new interventional radiology procedures, they are rarely involved in decisions to introduce a new consultant or introduce a new clinic/service. Even if the change impacts on the service. For example, earlier this year UHL opened a new mental health unit. Radiographers told us that the unit has created extra workload for the team but there is no provision for extra staff or portering. In addition, if there are new trials, the radiography team get told after the changes are implemented, even if this means there is an increase in work. It was felt the value and cost of radiology is not considered, for example when the NICE guidelines on head trauma (all head trauma cases have to be scanned) were released the cost and demand on the radiology service was not factored in.

124 However, to try and stop business cases overlooking the radiology service, a new process has been introduced. Any new service which requires a business plan cannot be approved without being reviewed and signed off by the Clinical Board Director of Operations, who has responsibility for the radiology service; this process has been in place for 12 months. In addition, the service is strengthening its relationship with other Clinical Boards and the Chief Operating Officers team get sight of business plans through weekly meetings.

The management structure and lines of accountability are clear, however management meetings require a greater strategic focus

125 Effective leadership and clear lines of accountability are vital components of any healthcare service. Radiology is a complex service which comprises radiologists, radiographers and nursing staff working together to produce and interpret images. For a health board to deliver effective radiology services, it needs clear executive leadership, a designated overarching service lead, and a clear operational and

professional management structure with clear lines of accountability. It also needs to have sufficient capacity to meet service demand and need in a safe and effective way.

126 Radiology sits within the Radiology, Medical Physics and Clinical Engineering (RMPCE) Directorate and is part of the Clinical Diagnosis and Therapeutics Clinical Board.

127 The Clinical Director is responsible for the directorate, and reports to the Clinical Board Director. At the time of this review, the directorate had recently changed its management structure to improve business planning and management. The change aims to create a balance between clinical and business expertise and leadership. For example by splitting the roles of directorate manager and radiography professional lead, the roles were previously held by one person. There are now two professional leads, based at UHW and UHL, their role is to manage and support the radiographers. The Directorate Manager, who was recruited from outside the NHS, reports to the Clinical Director and is responsible for business management for example; financial, programme/project management and service improvement and efficiency.

128 Those interviewed generally felt the structure worked well and that there are clear lines of accountability. However, it was felt that further work was needed to bring the different teams within the directorate together. Some of the teams need to work together, for example medical physics who prepare some injections for radiology. However, the clinical engineering team, who repair medical equipment across all Clinical Boards, do not fit neatly into the directorate structure.

129 The main forum for the radiology service is the Radiology, Medical Physics and Clinical Engineering Directorate Management Team (DMT). The team meets monthly and includes a multi-skilled membership: the clinical director, directorate manager, admin manager, senior representative from each of the teams within the directorate, senior radiology nurse and site superintendents. DMT reports up to the Clinical Diagnosis and Therapeutics Clinical Board. There is a terms of reference for the group and whilst the aims, membership and practicalities of the group are set out it does not list the sub-groups (eg health and safety) and needs to be reviewed to reflect the new management changes.

130 A review of DMT minutes show the meetings are well attended and it is a good forum for raising concerns such as workforce capacity, staffing changes, equipment issues and financial concerns across the directorate. However, those interviewed raised concerns that the meetings were too operational which left little room for strategic discussions and made it less relevant for non-radiology attendees. The directorate manager is starting to address these concerns by introducing highlight reports for each modality, which creates time to discuss financial, and project risks and making minutes open access.

131 Radiologists hold a weekly lunchtime catch-up meeting but the Clinical Director said this is often cancelled due to service pressures. The radiography professional leads are reinstating a radiographers team meeting which will also include

administrative staff and nurses. Both meetings are important communication channels for the radiology department, where staff can discuss common concerns and receive wider updates cascading from DMT and for collating feedback to be fed up to DMT.

The service is well represented on Board committees and sub-committees

132 If radiology is to have sufficient profile within the Health Board, radiology staff should have a regular presence on key Health Board's committees such as the Quality Safety and Experience Committee and the People, Planning and Performance Committee. Radiology should feature sufficiently often on committee agendas to help ensure wider awareness of the service and its issues.

133 Across Wales we found variation in the degree of radiology team representation on key board committees. We found that the radiology service in the Health Board was represented on the key Board committees for information and technology, performance, information governance and quality and safety. At Board level radiology issues, risk and updates are highlighted through Quality Safety Experience Committee, the committee meetings are regularly attended by the responsible Chief Operating Officer and the committee has sight of the Clinical Board Health and Safety group minutes. A review of minutes show that key policy updates and changes are also taken to Quality Safety and Experience Committee for approval, for example in May 2016 the non-medical referrers policy was presented to the committee.

In recent years the service overspent against its budget and missed its savings target and whilst finance performance reports are clear, remedial actions are not included

134 Ongoing financial monitoring is necessary for radiology services to ensure that the service is operating within budget, to anticipate potential budget overspend, and to take remedial action where necessary. The radiology service does not have a strategic financial plan, but the RMPCE directorate prepares a financial performance report for the Clinical Diagnostics and Therapeutics Clinical Board. The Board meets every two months. The financial report clearly sets out the financial position for the radiology service and the reasons for any over or underspend. The report however does not set out any remedial actions.
The RMPCE performance dashboard, which is reviewed by the Clinical Board also monitors in-year financial spend on a rolling basis. In 2014-15 the service overspent by £277,000 and in 2015-16 by £216,000.

Exhibit 18: radiology service budget comparison with expenditure (£ million) 2014-15 and 2015-16

Table showing variance between radiology service budget and actual expenditure. In both 2014-15 and 2015-16, expenditure was greater than the allocated budget.

		2014–15	2015–16
Health Board	Budget (£ million)	£18.5	£19.3
	Expenditure (£ million)	£18.8	£19.5
	Variance	1.5%	1.1%

Source: Wales Audit Office, **Radiology Health Board Survey**

135 Over the last three years the service's cost improvement programme has become increasingly difficult to meet. Over these years the radiology service has achieved cost saving through measures such as; changing the skill mix in teams, offering voluntary redundancy, reviewing contracts, purchasing annual leave and by using different products. During the three years between 2013-14 and 2015-16, the service missed its savings targets by:

- £35,000 in 2013-14, target was £734,000;
- £85,000 in 2014-15, target was £767,000; and
- £152,000 in 2015-16, target was £609,000.

11

Despite equipment at or reaching the end of life expectancy, and frequent breakdowns, there is no equipment replacement programme in place

136 NHS bodies need to have comprehensive arrangements in place for the maintenance and replacement of radiology imaging equipment. Older imaging equipment has a higher risk of failure and maintenance costs increase, and the image quality declines with age. Radiology equipment more than ten years old is typically considered to no longer be state of the art and technical advances will render the equipment obsolete. The lifespan of equipment shortens with increased use.

137 The main equipment concern for most of those interviewed was the age of equipment, especially at UHW. There are particular concerns about the MRI scanners, which are reaching the point where parts will become obsolete. Radiographers and service leads said that MRI scanner maybe out of service for 2-3 days, which has an adverse effect on appointments. Frequent breakdowns cause delays in treatment and waiting times. At peak times the service uses mobile vans

for scanning (such as MRI) and has also sent patients to the Royal Glamorgan Hospital for their scans. The service has a critical need for MRI scanners and this is reflected in the directorate's risk register; however, we were told there has not been funding provision.

138 The Health Board does not have an equipment replacement programme. The radiology asset register lists details such as; equipment age, location, make and model, date purchased, purchase price and current value. Those interviewed were concerned about the lack of equipment replacement planning and about the way funding for equipment was released. The Health Board has limited discretionary capital to fund the replacement of equipment alongside its broader estates and ICT requirements. However, given the Health Board does not have overarching radiology plans, and the absence of an equipment replacement programme to support a prioritisation process, there is significant scope for improvement to help address the equipment replacement challenges.

139 This year, Welsh Government released £16 million of capital funds for scanning equipment. The Health Board's share of the fund is £4.5 million and the service is prioritising the purchase of three gamma cameras. The Health Board reported they have the oldest MRI scanners in Wales, but have prioritised gamma cameras because installation of MRI scanners would need additional capital funding. The service is working closely with the Health Board's estates team and Welsh Government to make sure there is long-term consideration for radiology equipment.

140 The European Society of Radiology[28] advocates that equipment aged:

- up to five years old reflects the current state of technology, and can be upgraded;
- between six and ten years old is fit to use if properly maintained, but require replacement strategies to be in place; and
- 11 or more years old requires replacement.

141 In November 2015, NHS Wales anticipated that 87% of imaging department scanners would require replacement by 2017[29]. Exhibit 19 shows that there are a number of scanners, at both UHW and UHL, that are either approaching or have exceeded their life expectancy. In the context of the Health Board's role as a tertiary and specialist centre, it is concerning to find that it houses some of the oldest scanners in Wales. Clinical staff expressed concerns about patients having their initial scans at hospitals with newer scanners and then receiving specialist services on older scanners at UHW. Radiographers at UHW told us that equipment breaks down on most days, which disrupts patients' treatment and causes delays because appointments have to be rebooked. UHL experience fewer issues with

[28] European Society of Radiology, **Renewal of Radiological Equipment**, September 2014

[29] Diagnostic Service Programme NHS Wales, **All Wales Gantry (MRI, CT, Gamma Camera and Ultrasound) Usage/Capacity**, November 2015

breakdowns. The Health Board reported that data on scanning days lost has been collected since October 2015, and that the service keeps a log of equipment faults. However, the frequency of downtime caused by faulty equipment is difficult to determine because not all faults result in equipment downtime.

Exhibit 19: age of CT, MRI and US equipment at the Health Board as at September 2016

Table showing that based on high and low usage, a number of the Health Boards scanners have or are reaching end of equipment life expectancy

		CT	MRI	US
Age of scanners at the Health Board (years)[1]	University Hospital Llandough	5	10	4 (average age based on 9 scanners)
	University Hospital of Wales	2, 5, 11	13, 13	4 (average age based on 12 scanners)
	Children's Hospital for Wales	none	1	4
Average device life expectancy based on utilisation (years)	High	8	8	7
	Mid	10	10	8
	Low	12	12	9

[1] Where there are more than five scanners, the average age has been provided.

Source: Wales Audit Office, **Radiology Equipment Age Survey**; and European Society of Radiology, **Renewal of Radiological Equipment**, September 2014 (average device life expectancy)

Generally, radiology ICT systems do not serve the Health Board's needs

142 Having effective IT systems plays a central role in delivering efficient radiology services. In Wales, the Radiology Information System (RADIS) is a national system created and run by NHS Wales Informatics Service. It is used by all health boards. RADIS supports the scheduling of radiology investigations, provides a clinical record of scans received by patients and allows health boards to generate reports and statistics on performance. Other systems link to RADIS to provide additional functionality; these different systems must integrate well with each other to ensure that information easily transfers and updates between systems.

143 Our review found that across Wales, health boards have mixed views on RADIS. Some health boards told us they felt that RADIS is adequate in terms of patient scheduling, clinical reporting and management reporting. However, some health boards expressed concerns that RADIS does not integrate with other systems in use by health boards, and also about the quality of the management reporting, limitations of the clinical reporting and management reporting functions.

144 Electronic requesting systems can enable clinicians referring patients for diagnostic imaging to request and receive updates and the outcomes of radiology requests quickly. In Wales, the functionality of request software is generally limited to providing a template for a request which then has to be emailed to the radiology service.

145 All health boards use Picture Archiving Systems (PACS). PACS software acquires and archives radiology images, and enables the safe distribution of the image with other health professionals. The report and the scan image together comprise the clinical record of the image. When reporting on images, radiologists can choose to use voice-activated dictation systems to record their report.

146 The Health Board, in general, is dissatisfied with RADIS as its core radiology information system, as they feel it does not serve their needs well. This is because it was felt that RADIS is not good enough for business intelligence. Although there is a lot of data captured on the system, the Health Board believes it lacks the functionality to produce the reports that the service needs. Where reports are run from RADIS the service has little confidence in the accuracy of the data, it is therefore necessary to calculate data manually, which as previously stated is time consuming. Those we spoke to felt that RADIS was already out dated by the time it was introduced to the Health Board. More and better use of data is needed to manage the growing demands on the service and it was felt that RADIS does not have the scope to meet the challenge.

147 As discussed earlier (paragraph 70), the Health Board does not have an electronic system to manage radiology requests. The paper-based system could cause clinical mistakes because of illegible referrer's handwriting, or GPs faxing a form and then posting it as well, which in some cases can lead to a duplicate referral if not checked thoroughly. The Health Board has systems in place to mitigate risks but occasionally mistakes still happen.

148 The service is generally satisfied with their PACS system. The system allows radiologists to see digital images for all modalities at home when covering out of hours shifts. All PACS users within the Health Board have access, and images are available to some GPs and NHS staff outside of the Health Board. Radiographers raised that 3D imaging is not possible on the PACS system. 3D images allow information from other diagnostic tests or scans to be layered on top of a radiology scan, such as a CT scan, meaning that the different sources of information have to be viewed side by side instead. However, the Health Boards PACS Manager confirmed that 3D imaging was possible; this highlights the need for training on the full functionality of the PACS system. There were no real concerns expressed

about the number of workstations but more about the positioning because of the availability of space in the department. Some workstations are positioned in corridors or central areas where people are walking past and there is limited space, the alternative for radiographers is to use a workstation in a radiologist's office, which is not always practical.

149 To save time when reporting on images, radiologist and radiographers use speech recognition software. The software used by the Health Board is called G2 and it is fully integrated with RADIS and PACS. However, the service is generally dissatisfied with the software. This is because whilst advanced, the speech recognition rate is not as good as some other available systems. The PACS Manager explained that the software will format a report as requested, but cannot create a structured report (nor can RADIS). Developing a function that creates structured reports is gaining momentum in radiology ICT circles.

150 The Health Board's PACS system contract is with Agfa and this expired in December 2015. The contract has been temporarily extended while preparations are made for the all Wales PACS contract with Fuji. However, the Health Board would prefer a fully integrated radiology system because it better suits their needs. The preferred integrated system would include the functionality of RADIS, PACS, speech recognition and patient administration. A system that tracks referrals from the beginning right through to imaging reports being acted upon. It was felt that buying separate systems for different functions increased the risk of interface problems. The service is aware of integrated products on the market and of them being used at other health boards in England.

Radiology performance is regularly reviewed at corporate and management level, however the performance dashboard needs to be strengthened and used to its full potential

151 Effective monitoring and scrutiny of radiology service performance is important in assessing if the service is supporting delivery of the organisational goals and objectives, and identifying the need to take remedial action. Health boards should use performance data and audit results to monitor and evaluate outcomes delivery and the performance of the radiology departments. Performance monitoring and review should take place at all levels within the organisation, from the operational level up to board level. Performance should be analysed, assessed and monitored at an operational level and reported to and scrutinised by relevant health board committees and the board.

152 Benchmarking enables health organisations to improve performance through comparison with other similar organisations. One source of comparative data that heath boards have access to is NHSBN radiology data. The NHSBN collects and analyses radiology data from health organisations across the UK annually and publishes an analysis of its findings. All health boards and trusts in Wales are

members of the NHSBN but not all participate in each audit.[30] The Health Board contributes to NHSBN audits and use the benchmarking data to identify areas for service improvement.

153 The RMPCE Directorate has a performance dashboard that is reviewed at the monthly DMT meeting and performance is reviewed at the two monthly Clinical Diagnostics and Therapeutics Clinical Board. In addition, the Executive team receive weekly updates on Tier 1 targets.

154 The RMPCE performance dashboard monitors:

- levels of activity and demand;
- waiting times over 8 weeks;
- reporting backlogs (in excess of 10 weeks);
- cancer imaging times;
- finance measures;
- workforce measures, which include sickness and appraisal rates; and
- incidents and complaints.

155 The dashboard works on a red, amber, green rating system (RAG). However the target for some measures is not displayed. It also includes a set of measures and targets for internal referrals and reporting times, however, these are not monitored. The performance dashboard needs to be used to its full potential and strengthened, to give a better understanding of service strengths and weaknesses.

11

[30] Hywel Dda University Health Board and Powys Teaching Health Board do not participate or provide data to the radiology module.

Appendix 1

Audit approach

We carried out a number of audit activities between July and September 2016. Details of these are set out below.

Exhibit 20: audit approach

Table outlining audit approach used for this review.

Method	Detail
Information and data collection	We used health-board-level and hospital-site-level survey forms to capture data and information on radiology services, which were completed by the Health Board. We also utilised data and information from a number of other sources, including: • NHS Benchmarking Network radiology 2015 and 2016 data collection (data collection period 2 May to 8 July 2016); • The All Wales Equipment Capacity Report, NHS Wales Health Collaborative (December 2015); • Stats Wales: Radiology Diagnostic Waiting Times; • National Reporting and Learning System (NRLS) data: Patient safety incidents; and • HIW IH(ME)R (Ionising Radiation (Medical Exposure) Regulations): diagnostic incidents by Health Board between 2010 and 2016
Document request	We requested and reviewed documents from the Health Board including: • terms of reference and membership of the Health Board's main radiology group, together with a sample of minutes from the previous meetings; • examples of condition pathway documents (for stroke, cancer or heart disease) illustrating radiology service provision requirements; • relevant radiology papers to the board and committees along with operational papers including safety reports; • examples of the Health Board's main radiology service performance reports or performance scorecards from the past six months; • the most recent financial report showing progress towards the savings/cost improvement plan; • the radiology equipment replacement plan; • the radiology risk register;

Method	Detail
	• guidance provided to hospital referrers and GPs on expectations when referring patients to the service; and • examples of any work carried out over the past two years to measure radiology patient experience.
Interviews	We interviewed a small number of staff including: • Director of Operations • Clinical Lead for Radiology Service • Radiology Service Managers – Directorate Manager – Service Manager • Radiography Professional Leads • Quality and Safety Lead • Performance Lead • Consultant Physician • EU Consultant • GP Cluster Lead/Primary Care Assistant Medical Director.
Focus groups	• We carried out focus groups with radiographers at both University Hospital Wales and University Hospital Llandough.

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

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

WALES AUDIT OFFICE TRACKING REPORT – April 2017

Executive Lead : Director of Corporate Governance
Author : Director of Corporate Governance
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" element of the Health Board's Strategy.
Financial impact : N/A
Quality, Safety, Patient Experience impact : The areas reviewed by the WAO may have an impact on quality, safety and patient experience.
Health and Care Standard Number – Governance, Leadership and Accountability **CRAF Reference Number –** Areas that are subject to review will be captured in a range of risks on the CRAF**.**
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** this report and the arrangements for ensuring that all WAO actions have been tracked.

SITUATION

The Cardiff and Vale University Health Board (the UHB) has arrangements in place to ensure that reports produced by the Wales Audit Office (WAO) are received by the Board or an appropriate Committee(s). This is in support of the WAO NHS Performance Work Protocol which was considered by the Audit Committee in February 2014. The purpose of this report is to update the Committee regarding the arrangements for formally receiving and responding to WAO reports received since the last committee meeting.

12

BACKGROUND

In response to the WAO NHS Performance Work Protocol the UHB and the Audit Committee is required to establish and maintain its own arrangements in terms of tracking progress in response to audit recommendations. To achieve this, the Board or the appropriate Committee is required to consider the detail of WAO reviews undertaken, together with the action plan.

Wales Audit Office Annual Audit Report and Structured Assessment

In January a draft Wales Audit Office Annual Audit Report and Structured Assessment reports were received and discussed at Management Executive meeting. The draft was agreed on 6 February 2017. The Management Response was approved at Management Executive in February, which is reported to Audit Committee in April 2017.

The Annual Report was also received at the Board meeting held on 30 March 2017. Following discussion at the Audit Committee each of the recommendations will be presented to the relevant Committee to receive assurances on their implementation.

Following receipt of the Wales Audit Office Annual Report, the UHB will be looking at 'best practice' regarding audit tracking / monitoring tools with the intention of this new system being introduced in 2017.

ASSESSMENT

This tracking report provides assurance that the Board or the relevant Committee/sub-Committee has received reports and action plans in response to the WAO reports received during 2014/15 and 2015/16 as set out in the Appendix. Whilst this demonstrates that there are arrangements in place to ensure that the actions identified continue to be monitored until they have been satisfactorily resolved the WAO have asked for this to be considered further. A more robust approach has been agreed with the Chair. The Board Secretary will ensure that reports are not removed from the Tracking Log or Board and Committee work plans until:

- all actions have been completed or,
- it has been determined that no further action is possible a robust assessment has been undertaken to identify any remaining risk to the Health Board. Where appropriate a decision may be made to tolerate the risks.

Date of Report	Title of Review	Summary of Findings/Recommendations (as reported to Audit Committee)	Executive Lead	Management Response to date	Status (On-going /Complete)	Assurance Committee & Chair	Date Reported to Assurance Committee
01 Dec 2014	Community Nursing Workforce - District Nursing (2013)	WAO concluded that the UHB has a clear vision and good structures for district nursing with regular performance monitoring and reporting, although there is limited information on patient experience. Work is on-going to better match resources to demand although it is unclear whether staff are being effectively deployed. - There is a clear vision for district nursing, clear lines of accountability and good structures that support the delivery of services. - The UHB has a good understanding of the demand for district nursing services and it is working to align resources to match demand. - It is unclear whether staff are effectively deployed because there is an absence of national guidance on community staffing levels and tools to measure patient acuity. - Performance is regularly monitored and reported but information on patient experience is limited.	Executive Nurse Director	Action plan approved by the PPD Committee in March 2015. All actions should be completed by March 2016. The actions identified are being progressed as part of core business. The Action Plan was submitted to the Nursing and Midwifery Board in October 2015 and is being monitored via the Clinical Board Quality, Safety and Experience sub-Committee. An update report will be requested for consideration at the PPP Committee in February 2017.	On-going	People, Planning and Performance - Prof Marcus Longley	31/03/2015
01 Jan 2014	Combined follow-up review of progress made against recommendations relating to disaster recovery, data back-up arrangements, Caldicott and data quality (Local Work 2013)	The WAO work summarised the key messages and recommendations raised from their previous work on waiting lists, data quality, disaster recovery and business continuity, Caldicott, and data backup and recovery arrangements. It also concluded that there are a number of issues facing the UHB's IM&T service: • Financial investment in IM&T has been low historically, and the UHB's own figures indicate it compares unfavourably with the Welsh NHS as a whole. As a result, much of the IT infrastructure is now approaching the end of its useful life. • The IM&T risk assessment process does not seem to be escalating risks appropriately to a corporate level. WAO recent work in several areas had highlighted this issue. • The structure of the IM&T Department is uneven, with a concentration of expertise residing in a small number of individuals. • The replacement programme for aging servers is not keeping pace with need so the volume of obsolete and unsupported equipment is rising. • The UHB's strategic approach to IM&T is unclear. There is an Implementation programme but this has not been formally agreed and falls between the functions of a strategy and an operational plan, in WAO view satisfying neither. Without such a strategy, it will be difficult both to prioritise work and to evaluate progress.	Director of Finance	Action Plan produced and received by PPD Committee in January 2014. Recognised that there was a need for additional investment which were captured in the Integrated Medium Term Plan and Capital Plan as appropriate. The IM&T Programme Board and the Information Governance (IG) Group were both re-established in 2014/15 as sub-Committees of the PPD Committee under the Chair of the Independent Member - Information, Communication and Technology. This has ensured that appropriate scrutiny has started to be provided. A follow up review has been undertaken and the final report was received on 10 February 2015 (see below)	On-going	People, Performance and Delivery - Prof Marcus Longley/Information Governance sub-Committee - Eileen Brandreth	28/01/2014 - initial report 26/02/2015 - Follow-up Report See below for update. IGSC 23.03.16
01 Jan 2015	Structured Assessment (2014)	The UHB's Medium Term Plan addresses the £19.177 million deficit incurred in 2013-14, but operational pressures and a failure to deliver planned cost savings mean it is now forecasting a deficit of £24.9 million at the end of 2014-15 Overall governance arrangements have continued to evolve and mature, although some aspects of arrangements need to be further improved - The UHB has adopted a clear and robust approach to strategic planning although a slow pace of change and financial constraints is affecting its delivery - The organisational structure is maturing but there are a number of risks which impact on its effectiveness to support operational delivery - Board effectiveness, assurance and internal controls continue to be strengthened and are largely effective although there remain some important areas which need to be addressed - Performance management arrangements have been strengthened with a specific focus on the top five priorities but some services are becoming disengaged and there is a need for the organisation to more explicitly challenge its performance and delivery - The UHB continues to focus positively on quality and safety but there remains a number of issues to address, including capacity to support shared learning and responding to concerns in a timely manner. - The UHB has continued to provide the mechanisms to facilitate change but the ability to sustain change is a concern. - The Board is now much better informed of the significant risks associated with its assets but resources are limited.	Board Secretary	The majority of actions have been completed and previously reported to the Audit Committee. Only outstanding actions relate to the role of the People, Planning and Performance Committee re monitoring performance and the resources within the Governance Team. Both were highlighted in the 2015 Structured Assessment (see below). The Committee will be appraised of action under that report in future.	On-going	Chair of Board and Committees	To be reported to the Audit Committee and relevant Committees of the Board. Audit 12.04.16
01 Jan 2015	Arrangements for responding to and tracking progress against recommendations (2014)	This work sought assurance that the UHB has appropriate corporate processes for responding to Wales Audit Office reports, tracking implementation of audit recommendations and reporting to the appropriate committee. It found that there are generally effective arrangements in place to manage and respond to audit recommendations although there are opportunities for a more consistent approach to the management responses, and not all action plans are monitored through to completion. Good progress is being made against audit recommendations with many of them completed in a timely manner, however as some recommendations are not always tracked through the committees, particularly in relation to my recommendations relating to ICT arrangements, we are unable to comment on whether all of previous recommendations are being actioned.	Board Secretary	Report considered by Board on 27th January 2015 as part of Structured Assessment. Action Plan drafted and shared with Executive leads. Discussions held with the Chair and Board Secretary to discuss and agree a more robust approach to tracking. The reports are not "Complete" until all actions have been completed or a position has been reached where no further action is possible and the resulting risk will be assessed and if appropriate tolerated. The Board Secretary and the Committee secretariat ensure, as far as is practicable that Committee's are clear and record when they expect to receive assurance reports.	On-going	Audit - Ivar Grey	As above 12.04.16
01 Feb 2015	Orthopaedics (2012)	Orthopaedic services are generally coping with demand, which is consistently low, but MRI waits are long, the inpatient pathway needs to be improved to make better use of resources and although outcomes are generally positive, revision rates and missed follow-up appointments are some of the highest in Wales - Investment in primary care services is increasing and there is a consistently lower rate of GP referrals, although the impact of the Clinical Musculoskeletal Assessment and Treatment Service (CMATS) is unclear. - Outpatient and physiotherapy services are generally meeting demand, although a reduction in did not attend rates for outpatient appointments and the availability of direct access to physiotherapy could further improve waiting times. Access to MRI for GP referred patients is problematic. - More timely pre-operative assessment, increased day surgery rates, maximised bed occupancy and a reduction in prosthetic costs could improve the use of inpatient resources; and - Patients generally have positive outcomes with the exception of revision rates, which are some of the highest in Wales and not all patients are followed-up.	Chief Operating Officer	Report received and action plan approved by PPP Committee in July 2015. Interim report received in January 2016 and a full report in 12 months February 2017)	On-going	People, Planning and Performance - Prof Marcus Longley	21/07/2015 18.01.16

Date of Report	Title of Review	Summary of Findings/Recommendations (as reported to Audit Committee)	Executive Lead	Management Response to date	Status (On-going /Complete)	Assurance Committee & Chair	Date Reported to Assurance Committee
01 Feb 2015	Combined follow-up review of Informatics and Communication Technology Audits (2013)	The combined follow-up review examined progress against recommendations relating to the WAO previous work on disaster recovery and business continuity, data back-up arrangements, Caldicott and data quality (see above). The UHB has made progress in addressing some of the issues raised in previous reviews but the WAO have made seven new recommendations to ensure that key areas continue to be addressed - The Information Governance Committee and Data Quality Group are in their infancy but provide a good foundation to provide the Board with assurance on data quality - The UHB does not have a standard approach to disaster recovery and business continuity planning, with plans less established in clinical departments, than in the ICT department. Testing of disaster recovery and business continuity plans and training in clinical areas is also limited - Caldicott governance arrangements have been strengthened but there remains a need to develop training on Caldicott, data protection and information confidentiality - Clinical departments and ICT have agreements in place to identify data owners and responsibilities for backups but some agreements remain unsigned and the testing of backups remains ad hoc	Director of Therapies and Health Science (IM&T)/Director of Public Health (Data Quality)/Director of Strategic Planning (Business Continuity Planning)/Medical Director (Information Governance and Caldicott)	As the report related to a number of different areas of work agreement of the action plan took longer than anticipated. The PPP Committee received and approved the action plan on 10 November 2015. It was agreed that responsibility for monitoring the implementation of the actions would be remitted to the Information Governance sub-Committee and the Information Management and Technology sub-Committee as appropriate.	On-going	Information Management and Technology sub-Committee/Information Governance sub-Committee - Eileen Brandreth	10/11/2015 IM&T 7.03.16 IM&T 10.06.16 IGSC 18.12.16
01 Jun 2015	Medicines Management (2014)	The work reviewed medicines management arrangements in the acute sector to assess scope for making improvements in relation to the quality and efficiency of services. The review concluded that there are strengths in the way the Health Board managed medicines but there were also issues associated with the strategic approach, storage facilities, transfer of medicines information and performance monitoring. - There was clear executive leadership, regular financial monitoring and improved clinical engagement but there was scope to raise pharmacy's profile, clarify accountabilities and strengthen the strategy. - Pharmacy staff costs per bed day were lower than the Welsh average and workload pressures were similar to the rest of Wales. There was scope to dedicate more resource to training and improve access to the pharmacy team outside normal hours. - Pharmacy facilities largely comply with key requirements although there were risks associated with storage of medicines, monitoring the temperature of ward fridges and infrequent audit of injectable medicine preparation on the ward. - There were some strengths to medicines management processes but there were risks related to information transfer between primary and secondary care, timeliness of reconciliations, non-medical prescribing and supporting patients to take their medicines properly. - There is scope to improve performance reporting, mixed evidence about the effectiveness of learning processes and a need to understand more about the root causes of the pharmacy team's safety interventions.	Medical Director	Report agreed and action plan developed. Action plan presented to and agreed by the PPP Committee in January 2016. Whilst the Committee did not agree when a follow-up would be received it will be added to the workplan for February 2017 by which time most actions will have been completed.	On-going	People, Planning and Performance - Prof Marcus Longley	18.01.16
01 Oct 2015	Management of follow-up of outpatient appointments (2014)	The WAO review concluded that from a difficult starting point, the Health Board was taking appropriate action to identify the volume of its outpatient follow-up need but too many patients are delayed, the trend is worsening and it needs to do a lot more to develop sustainable follow-up outpatient services. The reason for their conclusion was that: - The Health Board has taken a pragmatic approach to determining the volume of outpatient follow-up demand, but it needs to better understand clinical risks to patients. - While follow-up waiting lists are more accurate, too many patients are delayed, the trend is worsening, and scrutiny and assurance arrangements needs strengthening - The Health Board is improving the administration of follow-up waiting lists but needs to develop a planned approach to modernise outpatient services.	Chief Operating Officer	Action plan approved by the PPP Committee on 10 November 2015. The Committee received a further report regarding Outpatients Follow-ups in March 2016 where it was agreed to receive a report at every meeting. The Committee has been advised that further work is required regarding pathway redesign and the Committee will be kept appraised of this via the regular reports. To report to Private Session of Board 28 July 2016	On-going	People, Planning and Performance - Prof Marcus Longley	10/11/2015 & 15/03/16 12.07.16
01 Nov 2015	Diagnostic review of IT capacity (2014)	This high-level diagnostic work assessed whether budgetary pressures were affecting capacity within informatics teams and the IT infrastructure, and provided an independent comparative analysis of the capacity of IM&T teams and resources across Wales. Despite above-average investment in ICT, their diagnostic work indicated that there were some weaknesses in the Health Board's arrangements and its clinical ICT infrastructure was not fully effective in supporting the delivery of healthcare. - Overall spend on ICT is just above the all-Wales average but remains below the recommended level of spend despite substantive additional funding in the past year. - Staffing levels for ICT are some of the lowest in Wales. - The Health Board is committed to ICT but there is a mixed level of integration of both systems and resources, and doctors' perception of IT facilities is not as positive as others across Wales. - The Health Board has a low number of devices and access to PCs was perceived as problematic. - A considerable amount of ICT equipment has reached its end of life and, although systems were generally reliable, downtime records were incomplete for many systems. - Despite some positive aspects, refresher information governance training was not mandated and training arrangements for some temporary staff were weak. - The mainstream clinical ICT systems were not fully effective in supporting doctors to provide patient care.	Director of Therapies and Health Science	Report received by UHB on 24 Nov 2015. Management response has been developed and considered by the Information Management and Technology sub-Committee. It will be received by the PPP Committee in May 2016 when the arrangements for receiving assurance regarding completion of all action highlighted will be agreed. There will be a workshop at end of September 2016 for all clinicians	On-going	Information Management and Technology sub-Committee/Information Governance sub-Committee - Eileen Brandreth	02.05.16 (PPP)
26 Jan 2016	Review of Operating Theatres (Jan 2016)	1) The theatre improvement project is driving change through a clear focus on improving processes and performance management to improve efficiency 2) Theatre utilisation and productivity have improved but the Health Board has not clearly demonstrated that its investment has led to cashable financial savings. 3) Problems with staff engagement and workforce capacity mean there are risks to maintaining momentum 4) The focus on utilisation has not been matched by a strong enough focus on quality, although staff have positive views about surgical safety.	Chief Operating Officer	To be considered by the PPP Committee in May 2015 To report to PPP Committee January 2017 meeting.	On-going	People, Planning and Performance - Prof Marcus Longley	02.05.16 12.07.16

Date of Report	Title of Review	Summary of Findings/Recommendations (as reported to Audit Committee)	Executive Lead	Management Response to date	Status (On-going /Complete)	Assurance Committee & Chair	Date Reported to Assurance Committee
27 Jan 2016	Structured Assessment 2015	1) Further refine the People, Planning and Performance Committee to strengthen its ability to provide appropriate levels of assurance to the Board. 2) The Health Board should review its governance capacity, to ensure that there is sufficient capacity to enable the governance team to provide greater support to Clinical Boards around risk management, to ensure that all external action plans are appropriately monitored and that written assurances are provided to the Board on key matters arising from Committees. 3) Attendance by the nominated Executive Officer at Clinical Board meetings needs to be improved to ensure that in their capacity as 'independent Member' they provide appropriate scrutiny and challenge at a Clinical Board level. 4) The condition of the Health Board's estate is a significant risk. The Health Board now needs to accelerate its actions to ensure that its estate is fit-for-purpose and specifically, that it is compliant with statutory requirements.	Director of Governance	Management response was presented to the Audit Committee on 12 April 2016.	On-going	Audit - Ivar Grey	12.04.16
01 Sep 2016	Consultant Contract: Follow-up of previous audit recommendations	1) Processes to review job plans annually 2) Guidance and training 3) Appropriate involvement 4) Information and outcome setting 5) Appraisal 6) Monitoring arrangements 7) Service improvement 8) Supporting processional activities 9) Wider benefits realisation	Medical Director	Draft being prepared. To go forward to PPP in May 2017	Ongoing	People, Planning and Performance - Prof Marcus Longley	Audit 28.02.17
01 Nov 2016	Review Delayed Transfers of Care	1) **Discharge Planning Audit** - address the findings from the Delivery Units discharge planning audit either by: developing an action plan; or incorporating actions into existing service improvement action plans. 2) **Imtermediate Care Fund (ICF)** - Explore ways of mainstreaming services funded through the ICFG to ensure services remain resilient	Chief Operating Officer	Draft being prepared. To go forward to next QSE meeting in April 2017.	Ongoing		Audit 28.02.17
01 Jan 2017	Review of Estates	1) To ensure thte estates service is represented at board level, priortise recruiting an independent board member for estates. 2) Create a central log of estates related issues and actions resulting from Clinical Board meetings. 3) Develop a fully costed Estates Management Strategy. 4) Develop a zero based estates budget that makes provision for likely revenue costs arising from changes to the Health Board estate, such as new buildings. 5) Introduce a system to inspect a percentage of repairs each month. 6) Strengthen performance management by: extending the performance dashboard to include Key Performance Indicators (KPIs) for the other serices covered by the Service Board; and making greater use of the data captured through the Backtraq repairs maintenance system. 7) To ensure repairs are correctly priortised: run Backtraq refresher training for helpdesk staff; and review questions on call handlers' script	Director of Strategic Planning	Draft being prepared. To go forward to next PPP meeting in May 2017	Ongoing	People, Planning and Performance - Prof Marcus Longley	Audit 28.02.17
01 Jan 2017	Structured Assessment 2016	1) Financial Reporting - strengthen financial reporting arrangements: a dashboard summarising performance against against key financial performance indicators and the issues and detail of actions being taken to manage overspend and deliver necessary savings by clinical area 2) Development of Plans: clear connectivity between the medium term plan and its longer term strategy, as well as its other strategic plans 3) Monitoring and scrutiny of plans 4) Planning capacity 5) Board and assurance framework 6) Transparency of public reporting 7) Board membership, vacancies to be filled and support quorate running of committees 8) Scrutiny of performance: Establish new Resources and Delivery Committee as a matter of urgency to ensure robust scrutiny is given to HBs performance and ensure relevant information is provided to Committee including sharing of clinical board reviews to focus attention on areas which need greatest scrutiny. 9) Governance capacity: to undertake further evaluation. The views of IMs on what assurances are needed should be sought as part of evaluation 10) Tracking arrangements: Strengthen tracking arrangements for external audit recommendations by providing more detailed information to the Audit Committee	Director of Governance	Draft being discussed by the Management Executive and prsnted to Audit Committee in April	Ongoing	Audit - Ivar Grey	28.02.17 24.04.17
01 Jan 2017	Annual Audit Report	Key findings from the Annual Report included: 1) Comments on financial management 2) Governance and asssurance arrangements 3) Performance audit reviews 4) Internal controls 5) Arrangements for securing efficiency , effectiveness and economy in the use of services 6) Issues relating to estates management 7) Capacity of the corporate governance team 8) Monitoring of previous recommendations	Director of Governance	Management Executive provided comments on the draft report and two meetings were arranged to discuss with WAO. Final version agreed. Presented to the Board 30 March 2017 and to be 'tracked ' by Committees	Ongoing	Audit - Ivar Grey	28.02.17 30.03.17 - Board
Feb-17	Discussion Paper: The Governance Challenges Posed by Indirectly Provided, Publicly Funded Services in Wales	No recommendations Its contents are relevant to policymakers, officials, practitioners and academics, as well as those who oversee, provide and receive indirectly provided services that are funded with public money. This paper will help to spread good practice, generate new ideas, support beneficial change and so contribute to the good governance of public services in Wales		To be taken to the Management Executives Team to note and consider.		Audit - Ivar Grey	24.04.17

12

Date of Report	Title of Review	Summary of Findings/Recommendations (as reported to Audit Committee)	Executive Lead
01 Jan 2017	Annual Audit Report	Key findings from the Annual Report included: 1) Comments on financial management 2) Governance and asssurance arrangements 3) Performance audit reviews 4) Internal controls 5) Arrangements for securing efficiency , effectiveness and economy in the use of services 6) Issues relating to estates management 7) Capacity of the corporate governance team 8) Monitoring of previous recommendations	Director of Governance
Feb-17	Discussion Paper: The Governance Challenges Posed by Indirectly Provided, Publicly Funded Services in Wales	No recommendations Its contents are relevant to policymakers, officials, practitioners and academics, as well as those who oversee, provide and receive indirectly provided services that are funded with public money. This paper will help to spread good practice, generate new ideas, support beneficial change and so contribute to the good governance of public services in Wales	

Management Response to date	Status (On-going /Complete)	Assurance Committee & Chair
Management Executive provided comments on the draft report and two meetings were arranged to discuss with WAO. Final version agreed. Presented to the Board 30 March 2017 and to be 'tracked ' by Committees	Ongoing	Audit - Ivar Grey
To be taken to the Management Executives Team to note and consider.		Audit - Ivar Grey

12

Date Reported to Assurance Committee
28.02.17 30.03.17 - Board
24.04.17

WALES AUDIT OFFICE MANAGEMENT RESPONSE – April 2017

Executive Lead : Director of Corporate Governance
Author : Director of Corporate Governance
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" element of the Health Board's Strategy.
Financial impact : N/A
Quality, Safety, Patient Experience Impact: The areas reviewed by the WAO may have an impact on quality, safety and patient experience.
Health and Care Standard Number: Governance, Leadership and Accountability **CRAF Reference Number –** Areas that are subject to review will be captured in a range of risks on the CRAF**.**
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Audit Committee is asked to:

- **ENDORSE** the Management Response to the Annual Report / Structured Assessment
- **NOTE** each recommendation will be monitored by the relevant Committee as shown in the Management Response

SITUATION

The Cardiff and Vale University Health Board (the UHB) has arrangements in place to ensure that reports produced by the Wales Audit Office (WAO) are received by the Board or an appropriate Committee(s). This is in support of the WAO NHS Performance Work Protocol.

13

BACKGROUND

In response to the WAO NHS Performance Work Protocol the UHB and the Audit Committee is required to establish and maintain its own arrangements in terms of tracking progress in response to audit recommendations.

Wales Audit Office Annual Audit Report and Structured Assessment

In early 2016, the Annual Report and Structured Assessment for 2016 were presented to the last meeting of the Audit Committee and to the Board at its meeting in March 2017. A Management Response to the recommendations in the report is required.

A draft Management Response to the Annual Report / Structured Assessment was presented to the Management Executive meeting in March 2017 and approved for submission to the Audit Committee.

The Management Response is now attached and the Committee will note that each recommendation in the Management Response need to be monitored by the appropriate Committee to receive assurance that work on the recommendations is appropriately actioned.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Management response

Report title: Structured Assessment 2016 – Cardiff & Vale University Health Board

Completion date: February 2017

Document reference: 706A2016

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
R1	Strengthen financial reporting arrangements by including additional information within the financial report to the Board and the new Finance Committee relating to: a) A dashboard summarising performance against key performance indicators; and	Greater clarity for Board members on financial performance when considering the Health Board's financial position.	Yes	Yes	Noted - Currently the dashboard for finance is in the Board Performance Report presented to the Board. This will be reviewed and included in the Finance Report which will facilitate the dashboard being sighted at the Finance Committee also.	April 2017 (2017/2018)	Director of Finance	Finance Committee

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
	b) The issues and detail of actions being taken to manage budget overspend and deliver necessary savings by clinical area.	Greater clarity for Board members on the issues affecting the financial position and the actions being taken.	Yes	Yes	Details of overspends are included in the Finance Report to the Board, but not the recovery actions. A summary of actions will be included for 2017/18 and a summary of delivery against the CRP programme for clinical boards/departments. It is not planned to take to the Board more detailed recovery measures but to the Finance Committee. The report for the Finance Committee has yet to be designed but under consideration for introduction for 2017/2018 and will include financial performance of clinical board/departments, CRP performance and recovery plans.	April 2017	Director of Finance	
R2	Ensure cost reduction plans are adequately supported prior to the start of the financial year.	Realistic cost reduction plans are developed ahead of the financial year which enables the Health Board to provide a robust financial plan for the year ahead.	Yes	Yes	Primary budget holders have been instructed to identify opportunities for CRP using local knowledge, benchmarking and transformation of services. In addition to populating the red CRP pipeline an additional document has been requested to provide assurance of opportunities available prior to the start of the financial year 2017/18. In addition the “Turning the	31.03.17	Director of Finance (With support from all primary budget holders)	Finance Committee

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
					Curve" exercise will provide wider opportunities available to the UHB beyond the annual CRP target.			
R3	When developing the 2017-18 three-year plan, ensure that there is: a) clear connectivity between the medium term plan and its longer term strategy, as well as its other strategic plans and requirements such as the Health & Social Care Wellbeing Act and Future Well Being Generations Act; and	The three-year plan provides a comprehensive understanding on how the Health Board will deliver its longer term strategy alongside its other strategic requirements.	Yes	Yes	The IMTP/annual plan will be set out in a way that aligns the 1/3 year actions with the strategic objectives of Shaping Our Future Wellbeing. The IMTP/annual plan will also confirm the actions being taken to deliver the requirements of the SSWB Act and WBFG Act- although in relation to the former, there is also an implementation plan approved and overseen by the Regional Partnership Board. The IMTP will not duplicate all of the detail.	March 30th 2017	Director of Strategy & Planning	People, Planning and Performance and Strategy and Engagement Committee

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
	b) a clear understanding of the benefits expected from the actions and priorities set out in its plan.	The intended outcomes and benefits of the plan are clearly set out and understood.			The IMTP/annual plan will set out the expected outcomes and measure for the actions detailed within it.	March 30th 2017	Director of Strategy & Planning	
R4	Establish the new Strategic Planning Committee as a matter of urgency to ensure that sufficient time is allocated to scrutinise the development of the 2017-18 three-year plan.	Scrutiny of the Health Board's plan in more detail than that current allowed within the Board agenda.	Yes	TBC	The Board will confirm new arrangements for Committees by the end of March 2017. Subject to their approval new arrangement will be implemented for April 2017.	May 2017	Director of Corporate Governance	Strategy and Engagement Committee
R5	Strengthen progress reporting on delivery against plan by including aspects identified in our comparative review of progress reports and ensure that this is considered on a regular basis by the Strategic Planning committee in line with the new requirements of the NHS Planning Framework for 2017-20.	Regular scrutiny of delivery against plan in line with the requirements of the NHS Planning Framework for 2017-20.		TBC	Reporting against the IMTP/annual plan to be reviewed and most effective mechanism for ensuring comprehensive report will be provided to the Board and Strategic Planning Committee (if the Board supports the establishment of the Committee)	June 2017	Director of Strategy & Planning	Strategy and Engagement Committee

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
R6	Undertake an evaluation of planning capacity to provide assurance to the Board that the Health Board has sufficient planning capacity and capability within the organisation. This evaluation should also include its change management capacity to minimise the continuous need for the Health Board to commission external support.	Assurance that the Health Board has sufficient planning capacity to support the development of plans and the associated change required to implement the plans.	Yes	Yes	Planning/PMO/Service change capacity requirements will be considered as part of the development of management arrangements required to support the transformation programme.	June 2017	Interim Chief Executive Officer	Strategy and Engagement Committee
R7	Review the way objectives are defined in the Corporate Risk Assurance Framework to facilitate the ability to identify what success looks like and what needs to be done to achieve these objectives, ensuring that these are further aligned with those set out in the ten year plan.	A CRAF that sets out what success looks like, what needs to be done, and what assurances are needed to achieve the Health Boards strategic objectives.	Yes	Yes	The Board Development full day session on 27th April 2017 has been dedicated to review the CRAF and explore new approach to risk management for the Health Board. The outcome of the day will be reported to the Audit Committee on the 23rd April 2017 with recommendations.	May 2017	Director of Corporate Governance	Audit Committee and Board

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
R8	Ensure compliance with all requirements of the Welsh Health Circular (reference WHC/2016/22) on transparent public reporting. Specifically, the Health Board should ensure that the following are easily accessible via the Health Board's website: • citizen engagement plan; • complaint/concerns raising policy; and • flexible visiting times policy.	The Health Board will be compliant with the Welsh Health Circular.	Yes	Yes	A review of the Boards website will be undertaken to ensure compliance with the issues raised plus compliance with our policies	June	Director of Corporate Governance	Quality, Safety and Experience Committee
R9	As a matter of urgency, ensure that all independent member vacancies are filled and that post holders are in post to support quorate running of committees.	Scrutiny and challenge is provided by a full establishment of independent members and the risk of attendance at committee meetings not being quorate is minimised.	Yes	Yes	**COMPLETED.** All current vacancies now filled with 1 additional Associate Board Member. To note Planning in conjunction with Welsh Government has already commenced for recruitment of 3 Independent vacancies for October 2017	January 2017	Director of Corporate Governance	

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
R10	Establish the new 'Resources and Delivery' Committee as a matter of urgency to ensure that robust scrutiny is given to the Health Board's performance.	Regular scrutiny of the Health Board's performance in more detail than that current allowed within the Board agenda.	Yes	Yes	Same as recommendation 7	May 2017	Director of Corporate Governance	
R11	Ensure that relevant performance information is made available to the new 'Resources and Delivery' Committee, including the sharing of the clinical board performance reviews, to enable it to focus its attention on the areas of performance which need the greatest scrutiny.	The focus of scrutiny and challenge is on areas that require the greatest attention.	Yes	Yes	This will be a standard agenda item for the Committee and summary/dashboard updates will be provided on a quarterly basis.	June 2017	Chief Operating Officer	Resource and Delivery Committee
R12	Undertake a further evaluation of the corporate governance capacity to ensure that the Health Board has sufficient governance capacity and capability within the organisation to provide	Assurance that the Health Board has sufficient capacity to ensure that all required assurances are in place.	Yes	Yes	Discussions have commenced with the Interim Chief Executive and Director of Corporate Governance to agree a plan to address the recommendations. The outcome of this will be shared with the Governance Co-ordinating Group (Chair and Independent Members) at their	May 2017	Director of Corporate Governance	Audit Committee

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer	Responsible Committee
	the necessary assurances to the Board. The views of independent members on what assurances are needed should be sought as part of this evaluation.				meeting in May 2017			
R13	Strengthen tracking arrangements for external audit recommendations by providing more detailed information to the Audit Committee on the extent to which both performance and financial audit recommendations have been completed, and ensure that all action plans are monitored through to completion by the relevant committees of the Board.	Effective arrangements are in place to ensure that external audit recommendations are implemented and have the required impact			Paper presented to the Management Executive meeting on 20th March 2017 IM&T sub committee receive a report of all IT related audits and actions, as well as update of outstanding actions at every meeting Nutrition and Catering committee receive a report on all audits – including WAO audits with updates on actions, at every meeting. This is also reported to the QSE committee. Learning disabilities HIW audit actions and progress reported to QSE committee HIW eye care AMD audit actions and progress reported to Cardiff and vale UHB eye healthcare group and QSE committee	March 2017 5/12/16 14/12/16 13/12/16 10/2/17 21/2/17	Director of Finance Director of Therapies and Health Sciences	Audit Committee

Cardiff & Vale University Health Board

Post Payment Verification progress report for the period 1st April 2016 – 31st March 2017
Cardiff & Vale University Health Board

Issued: March 2017
Prepared by: Mr Scott Lavender (Post Payment Verification Location Manager)

This document has been prepared for the internal use of Cardiff & Vale University Health Board.

For any queries or further information relating to this report, please contact Mr Scott Lavender at scott.lavender@wales.nhs.uk.

1. Introduction

This report has been prepared for the Audit Committee of Cardiff and Vale University Health Board. The aim of this report is to summarise the work undertaken by the South East Wales Post Payment Verification (PPV) department in accordance with the Welsh Government (WG) directions in respect of General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS).

The purpose of a GMS PPV audit is to ensure that claims submitted by General Practitioner contractors in respect of GMS Enhanced Services are correct and in accordance with the Statement of Financial Entitlement (SFE) and service specifications set by WG and Health Boards (HB).

The purpose of a GOS PPV audit is to ensure that claims submitted by ophthalmic contractors in respect of GOS are correct and in accordance with the relevant NHS General Ophthalmic Services regulations and any specific specification set by WG and HBs.

The purpose of a GPS PPV audit is to ensure that claims submitted by pharmaceutical practitioner contractors in respect of GPS are correct and in accordance with the GPHC, CPW and HBs.

The probity checks conducted during a PPV visit will provide assurance to the University Health Board that public money has been used appropriately. The process ensures contractors submit accurate claims in accordance with relevant service specifications and that they have robust clinically sound internal procedures and protocols in place.

2. Post Payment Verification process

The PPV team carry out routine audits to all General Practitioner contractors on a three year cycle. During a GMS visit, the PPV team will analyse a sample of 20 claims or 10% of the total number of claims submitted during the year prior to the audit (whichever is the greater) for each enhanced service commissioned to the Practice.

The PPV team carry out routine visits to ophthalmic contractors based on the average number of GOS3 claims submitted during the year. The following table is used when determining the GOS visit schedule for a three year cycle period:

Average monthly GOS3 submissions	Number of visits within a three year cycle
Up to 200	1
201 – 400	2

401 – 600	3

During a GOS visit, the PPV team will analyse a sample of 100 claims consisting of GOS1 (Sight tests), GOS3 (Vouchers), GOS4 (Repairs and replacement) and Eye Health Examination Wales (EHEW) claims.

The PPV team carry out routine visits to pharmaceutical contractors on a three year cycle. During a GPS visit, the PPV team will analyse a sample of 25% of the total number of claims submitted during the year prior to the audit.

The PPV team also carry out Clinical Waste audits when undertaking GMS and GPS visits. It is the role of PPV to go through a questionnaire with the practitioner and then to do a visual check of the premises to ensure the standards are in keeping with the protocols. There are no monetary recoveries for a Clinical Waste audits.

Following a visit, an initial report is sent to the General Practitioner/ Ophthalmic contractor/Pharmaceutical contractor summarising the observations and findings of the visit and request further information from the contractor to queries that arise from the visit. The contractor is given 28 days to reply to the queries. If no response is provided by the contractor, it will be assumed that they are satisfied with the report findings. If the contractor provides feedback, the PPV department will consider this information and assess whether it clarifies the queries.

Once this stage in the process is complete, the report is finalised with recommended recoveries (if appropriate) and sent to the UHB Finance and Primary Care lead for approval.

If the report is approved, the PPV team will instruct the Payments department within NHS Wales Shared Services Partnership (NWSSP) to make the recovery against the contractor's next monthly payment.

Where the PPV team identify a high number of claim errors for a particular service (10% for GMS & GPS and 5% for GOS), a recommendation will be made to the UHB that a more substantive review of that service needs to be carried out. If this is agreed, the PPV team will carry out an additional visit to the contractor within twelve months of the routine visit. During this visit all claims submitted by the contractor, for the identified services only, for a three year period will be analysed.

In addition to carrying out visits, the PPV team continually monitor claims submitted by GMS, GOS and GPS contractors to assist in the identification of trends and outliers. This information is used to assist in the preparation of visit samples and to alert the UHB and Local Counter Fraud Specialist if suspicious claiming patterns emerge.

The PPV team are also available to provide advice, support and guidance to contractors and UHBs when required.

3. Summary of findings and observations

General Medical Services

Planned visits for C&V UHB	Completed visits	Visits on-going	Total visits carried out	Variance
9	6	3	9	0

During the period 1st April 2016 to 31st March 2017, the PPV team has visited nine GMS contractors as per the visit plan agreed with Cardiff and Vale UHB. The PPV team have recovered £2,385.40 from completed visits to GMS contractors in the Cardiff and Vale UHB area due to errors identified in contractor's enhanced service claims. A summary of the GMS visits can be found in appendix one of this report.

The overall claim error rate for the locality was 5.78% from all claims sampled. A graphical representation of the claim error rates following GMS visits can be found in appendix two of this report.

The main errors identified during quarter one were in respect of Near Patient Testing and Minor Surgery (in particular Fee A claims).

A summary of the PPV teams findings from routine visits by service from GMS visits can be found in **Appendix 1** of this report with a graphical representation of the error rates by service can be found in **Appendix 2.**

General Ophthalmic Services

Planned visits for C&V UHB	Completed visits	Visits on-going	Total visits carried out	Variance
33	32	1	33	0

During the period 1st April 2016 to 31st March 2017, the PPV team has visited seven GOS contractors as per the visit plan agreed with Cardiff and Vale UHB. The PPV team have recovered £8,558.25 from completed visits to GOS contractors in the Cardiff and Vale UHB area due to errors identified in contractor's ophthalmic claims. A summary of the GOS visits can be found in **Appendix 3** of this report.

The overall claim error rate for the locality was 6.95% from all claims sampled. A graphical representation of the claim error rates following GOS visits can be found in Appendix 4 of this report.

The main errors identified during quarter one were in respect of EHEW and GOS 3 claims.

A summary of the PPV teams findings from visits by service can be found in **Appendix 3** of this report with a graphical representation of the error rates by service can be found in **Appendix 4.**

Pharmaceutical Services

Planned visits for C&V UHB	Completed visits	Visits on-going	Total visits carried out	Variance
47	40	7	47	0

During the period 1st April 2016 to 31st March 2017, the PPV team has visited twelve GPS contractors as per the visit plan agreed with Cardiff and Vale UHB. The PPV team have recovered £532.00 from completed visits to GPS contractors in the Cardiff and Vale UHB area due to no errors being identified in contractor's medical use review claims. A summary of the GPS visits can be found in **Appendix 3** of this report

The overall claim error rate for the locality was 0.75% from all claims sampled. A graphical representation of the claim error rates following GPS visits can be found in Appendix 6 of this report.

Main errors consist of no record being available, the wrong MUR category being selected or pharmacists not being registered to provide the service within Wales.

A summary of the PPV teams findings from visits by service can be found in **Appendix 5** of this report with a graphical representation of the error rates by service can be found in **Appendix 6**.

4. Conclusions and recommendations

During the first quarter of 2016/2017, PPV have observed a marked improvement in contractor's compliance with GMS, GOS and GPS protocols in comparison to contractor's compliance in the last financial year.

The PPV team will continue to provide training, support and guidance to contractors and their staff both formally and informally. The PPV team will

continue to meet with Health Board colleagues to discuss the findings of visits and consider strategies to improve the accuracy of claim submissions.

From an All Wales Approach the PPV team now offers a survey to practices to obtain feedback on how they feel the service runs and how they feel supported by the process. We have also developed a training presentation package which is available for us to deliver to practice managers who are looking for guidance on the PPV process.

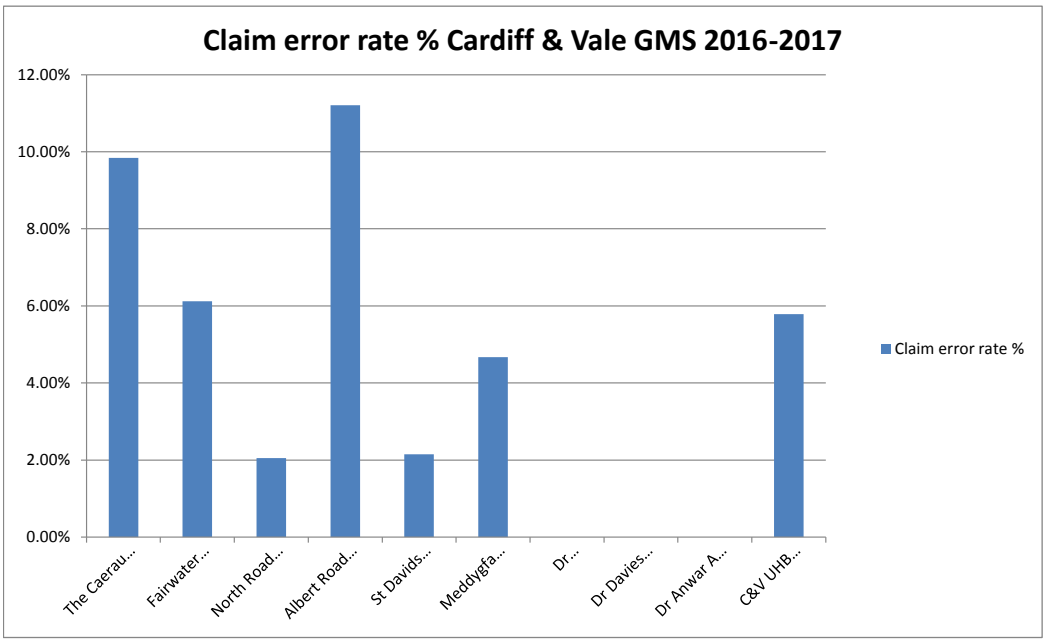
The PPV Manager will continue to participate in the Primary Care Assessment Panel which includes the Head of Primary Care Services Operations & Delivery, Assistant Head of Finance
Primary, Community and Intermediate Care Clinical Service Board and Counter Fraud Manager.

The Audit Committee are asked to note the findings of this report.

Cardiff & Vale University Health Board
GMS PPV Progress Report: 2016/17

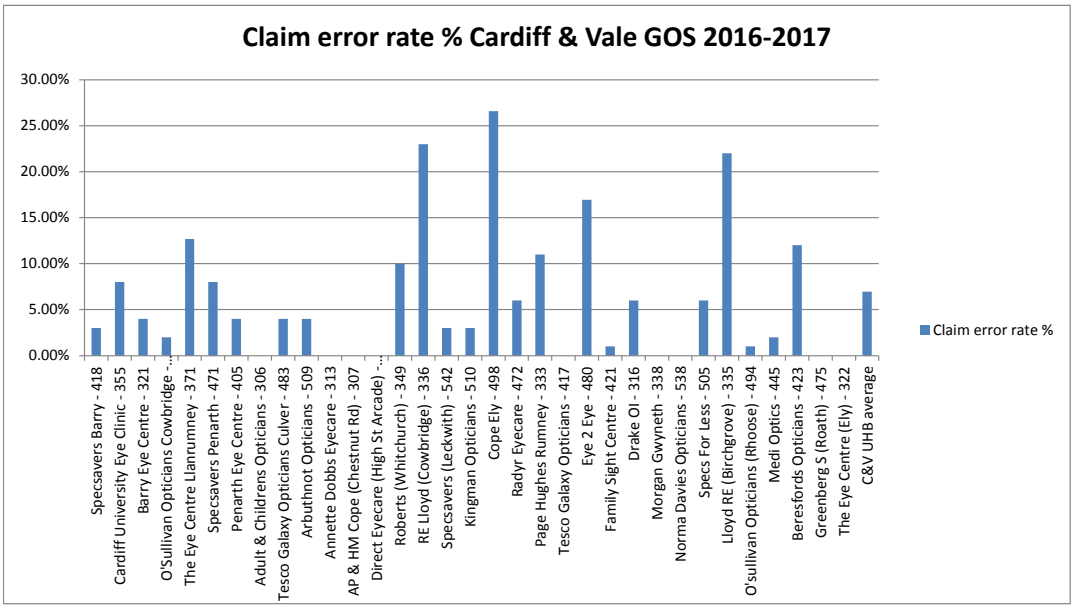
Completed GMS visits

Practice Name	Visit Status	Actual Visit Date	Draft Report Issued to contractor	Comments received back from contractor	Final report issued to HB DoF	Final Report (agreed by DOF)	Sample Size (numeric)	Errors found (numeric)	Claim error rate %	Recovery	Main error areas
The Caerau Lane Surgery - W97068	Revisit	5/27/2016	6/3/2016	6/28/2016	7/5/2016	7/15/2016	122	12	9.84%	£527.31	Areas with errors include Near Patient Testing and Minor Surgery (Fee A)
Fairwater Health Centre - W97047	Routine	6/20/2016	6/23/2016	7/4/2016	8/15/2016	8/16/2016	247	15	6.12%	£407.39	Areas with errors include Near Patient Testing, Minor Surgery (Fee A), Administration of Gonadorelins and MMR
North Road Medical Practice - W97020	Routine	10/12/2016	10/14/2016	10/20/2016	11/1/2016	11/2/2016	146	3	2.05%	£65.68	One Homeless, One Anti-Coagulation Monitoring and One Pertussis claim where the procedures did not meet the requirements of the specifications.
Albert Road Surgery - W97057	Routine	11/2/2016	11/3/2016	11/16/2016	12/20/2016	12/21/2016	107	12	11.21%	£225.35	Three Minor Surgery, Three Anti-Coagulation Monitoring and Seven Flu claims where the procedures did not meet the requirements of the specifications.
St Davids Medical Centre - W97065	Routine	12/14/2016	12/19/2016	No response	1/18/2017	1/20/2017	233	5	2.15%	£36.72	One flu, One Learning disability invite, One MMR, One Near patient testing and One Nursing home where the procedures did not meet the requirments of the specifications
Meddygfa Llwyncelyn Practice - W97059	Revisit	12/15/2016	1/16/2017	2/17/2017	3/16/2017	3/22/2017	407	26	4.67%	£1,122.95	Ten Minor Surgery and Nine Near Patient Testing procedures where the procedures did not meet the requirements of the specfications
Dr Mcgovern DJ - W97052	Routine	2/14/2017	2/22/2017	3/20/2017	3/24/2017						
Dr Davies EW - W97005	Routine	3/14/2017	3/23/2017								
Dr Anwar A - W97063	Routine	3/24/2017	3/28/2017								
C&V UHB average							**1,262**	**73**	**5.78%**	**£2,385.40**	


Claim error rate % Cardiff & Vale GMS 2016-2017
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
The Caerau...
Fairwater...
North Road...
Albert Road...
St Davids...
Meddygfa...
Dr...
Dr Davies...
Dr Anwar A...
C&V UHB...
Claim error rate %

14

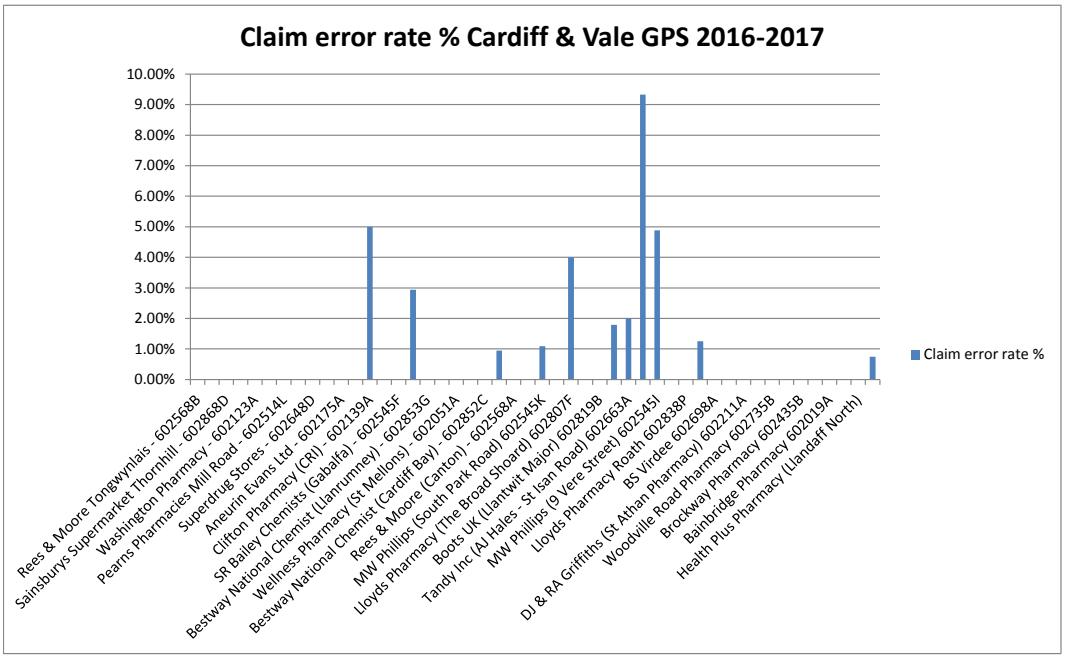
Practice Name	Visit Status	Actual Visit Date	Draft Report Issued to contractor	Comments received back from contractor	Final report issued to HB DoF	Final Report (agreed by DOF)	Sample Size (numeric)	Errors found (numeric)	Claim error rate %	Recovery	Main error areas
Specsavers Barry - 418	Routine	4/13/2016	4/14/2016	4/28/2016	5/5/2016	5/5/2016	100	3	3.00%	£140.00	Two EHEW claims where no referral letter to GP was present in the patient record and one EHEW claim where a Band 3 had been claimed with a Band 1 before it
Cardiff University Eye Clinic - 355	Routine	4/21/2016	5/3/2016	5/5/2016	5/10/2016	6/1/2016	100	8	8.00%	£254.00	Five EHEW claims where there was no GP referral report, no indication of banding or record availabe and three GOS 3's where the cinilcal reason for tint was not recorded
Barry Eye Centre - 321	Routine	4/29/2016	5/5/2016	5/19/2016	6/30/2016	6/30/2016	100	4	4.00%	£119.40	Three early retests where they did not meet the criteria and one tint with no clincally acceptable reason
O'Sullivan Opticians Cowbridge - 473	Routine	5/12/2016	5/13/2016	No response	7/22/2016	8/1/2016	100	2	2.00%	£0.00	Issue with two EHEW claims, however due to adjustments there were no financial recoveries
The Eye Centre Llanrumney - 371	Revisit	5/13/2016	5/20/2016	6/14/2016	6/15/2016	6/28/2016	300	38	12.67%	£1,760.00	38 EHEW claims that did not meet the specification requirments
Specsavers Penarth - 471	Routine	5/24/2016	5/24/2016	No response	6/28/2016	8/16/2016	100	8	8.00%	£492.70	Five EHEW claims where there was no GP referral report, two GOS 3 claims that were duplicated and a GOS 4 claim where there was no record of it in the patient record
Penarth Eye Centre - 405	Routine	6/24/2016	6/29/2016	7/18/2016	7/29/2016	8/1/2016	100	4	4.00%	£148.40	Two EHEW claims where there were more than one band 1 claimed in a year for the same symptoms and a band 2 that should have been a band 3 was adjusted. A GOS 3 was recovered for no clinical reason for tint.
Adult & Childrens Opticians - 306	Routine	7/7/2016	7/7/2016	No response	8/15/2016	8/16/2016	100	0	0.00%	£0.00	No recoveries. File closed.
Tesco Galaxy Opticians Culver - 483	Routine	7/8/2016	7/8/2016	No response	8/12/2016	8/16/2016	100	4	4.00%	£135.70	One GOS 3 claim where there was no reason for an early re-test and three GOS 4 claims where it was not documented in patient record.
Arbuthnot Opticians - 509	Routine	7/26/2016	8/31/2016	8/1/2016	11/16/2016	11/21/2016	100	4	4.00%	£40.00	Two claims where the incorrect band level was claimed and a claim where the GP referral letter was not sent within 7 days.
Annette Dobbs Eyecare - 313	Routine	8/5/2016	8/10/2016	8/16/2016	8/16/2016	9/5/2016	100	0	0.00%	£0.00	No recoveries. File closed.
AP & HM Cope (Chestnut Rd) - 307	Routine	8/18/2016	8/18/2016	8/24/2016	8/24/2016	9/5/2016	100	0	0.00%	£0.00	No recoveries. File closed.
Direct Eyecare (High St Arcade) - 522	Routine	8/23/2016	8/24/2016	9/19/2016	9/23/2016	9/27/2016	100	0	0.00%	£0.00	No recoveries. File closed.
Roberts (Whitchurch) - 349	Routine	9/16/2016	9/20/2016	10/3/2016	11/3/2016	11/4/2016	100	10	10.00%	£422.90	Six EHEW claims where no letter was sent to GP and four GOS 4 claims where there was no record of service or no reason for the GOS 4 to take place documented
RE Lloyd (Cowbridge) - 336	Routine	9/22/2016	9/26/2016	10/26/2016	10/31/2016	11/2/2016	100	23	23.00%	£907.30	One GOS 4 claim where there was no record of service and twenty-two EHEW claims where there was no letter for GP or the wrong band selection was claimed.
Specsavers (Leckwith) - 542	Routine	9/26/2016	9/26/2016	No response	11/9/2016	11/14/2016	100	3	3.00%	£120.00	Three EHEW claims where there was no GP letter or there was no Band 1 to initiate a Band 3
Kingman Opticians - 510	Routine	10/14/2016	10/17/2016	11/10/2016	12/23/2016	12/23/2016	100	3	3.00%	£160.00	Three EHEW claims where there was no GP letter
Cope Ely - 498	Revisit	10/17/2016	10/20/2016	11/15/2016	11/21/2016	11/30/2016	158	42	26.58%	£792.95	42 GOS 4 claims where there was no reason for GOS 4 documented and no record of service provided
Radyr Eyecare - 472	Routine	10/20/2016	10/24/2016	10/25/2016	11/21/2016	11/30/2016	100	6	6.00%	£248.40	Five EHEW claims where there was no GP referral letter or it had been sent after the 7 day deadline and one GOS 4 where no clinically necessary reason was provided for a tint.
Page Hughes Rumney - 333	Routine	10/21/2016	10/28/2016	11/30/2016	12/22/2016	12/22/2016	100	11	11.00%	£428.30	Eight EHEW and Three GOS 4 claims where the claims did not meet the required specifications
Tesco Galaxy Opticians - 417	Routine	10/24/2016	10/28/2016	No response	12/6/2016	12/8/2016	100	0	0.00%	£0.00	No recoveries. File closed.
Eye 2 Eye - 480	Revisit	10/31/2016	10/31/2016	11/16/2016	11/16/2016	11/30/2016	59	10	16.95%	£84.80	Nine GOS 3 claims where no clinically necessary reason for tint was provided and one GOS 3 claimed in error
Family Sight Centre - 421	Routine	11/11/2016	11/11/2016	12/1/2016	12/22/2016	12/23/2016	100	1	1.00%	£60.00	One EHEW where there was no GP referral letter in the patient record
Drake OI - 316	Routine	11/16/2016	11/23/2016	12/22/2016	1/17/2017	1/20/2017	100	6	6.00%	£298.70	Three EHEW where there was no GP letter or it was past deadline, Two EHEW where the patient was a contact lens wearer and one GOS 3 where there was no reason for an early re-test
Morgan Gwyneth - 338	Routine	11/24/2016	11/28/2016	12/22/2016	12/23/2016	12/23/2016	100	0	0.00%	£0.00	No recoveries. File closed.
Norma Davies Opticians - 538	Routine	12/6/2016	12/7/2016	12/21/2016	12/23/2016	12/23/2016	34	0	0.00%	£0.00	No recoveries. File closed.
Specs For Less - 505	Routine	12/12/2016	12/12/2016	No response	1/10/2017	1/13/2017	100	6	6.00%	£298.70	Five EHEW claims where there was no reason for EHEW recorded or there was no GP letter in the record and one GOS 3 where there was no record available
Lloyd RE (Birchgrove) - 335	Routine	1/24/2017	2/2/2017	3/2/2017	2/9/2017	2/10/2017	100	22	22.00%	£907.30	Thirteen EHEW and one GOS 3 where the claims did not meet the required specification
O'sullivan Opticians (Rhoose) - 494	Routine	1/26/2017	1/31/2017	2/7/2017	2/9/2017	2/10/2017	100	1	1.00%	£60.00	One EHEW where there was no GP referral letter in the patient record
Medi Optics - 445	Routine	1/30/2017	1/30/2017	2/27/2017	3/9/2017	3/10/2017	100	2	2.00%	£80.00	One EHEW where the GP letter was past the deadline and one EHEW where the patient was a contact lens wearer
Beresfords Opticians - 423	Routine	1/31/2017	2/7/2017	2/13/2017	2/27/2017	3/1/2017	100	12	12.00%	£598.70	Eleven EHEW and one GOS 4 where the claims did not meet the required specification
Greenberg S (Roath) - 475	Routine	2/13/2017	2/15/2017	3/15/2017	2/27/2017	3/1/2017	100	0	0.00%	£0.00	No recoveries. File closed.
The Eye Centre (Ely) - 322	Routine	2/22/2017	2/24/2017								
C&V UHB average							**3,351**	**233**	**6.95%**	**£8,558.25**	


Claim error rate % Cardiff & Vale GOS 2016-2017
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Specsavers Barry - 418
Cardiff University Eye Clinic - 355
Barry Eye Centre - 321
O'Sullivan Opticians Cowbridge -...
The Eye Centre Llanrumney - 371
Specsavers Penarth - 471
Penarth Eye Centre - 405
Adult & Childrens Opticians - 306
Tesco Galaxy Opticians Culver - 483
Arbuthnot Opticians - 509
Annette Dobbs Eyecare - 313
AP & HM Cope (Chestnut Rd) - 307
Direct Eyecare (High St Arcade) -...
Roberts (Whitchurch) - 349
RE Lloyd (Cowbridge) - 336
Specsavers (Leckwith) - 542
Kingman Opticians - 510
Cope Ely - 498
Radyr Eyecare - 472
Page Hughes Rumney - 333
Tesco Galaxy Opticians - 417
Eye 2 Eye - 480
Family Sight Centre - 421
Drake Ol - 316
Morgan Gwyneth - 338
Norma Davies Opticians - 538
Specs For Less - 505
Lloyd RE (Birchgrove) - 335
O'sullivan Opticians (Rhoose) - 494
Medi Optics - 445
Beresfords Opticians - 423
Greenberg S (Roath) - 475
The Eye Centre (Ely) - 322
C&V UHB average
Claim error rate %

Cardiff & Vale University Health Board
GOS PPV Progress Report: 2016/17

Completed GPS visits

Practice Name	Visit Status	Actual Visit Date	Draft Report Issued to contractor	Comments received back from contractor	Final report issued to HB DoF	Final Report (agreed by DOF)	Sample Size (numeric)	Errors found (numeric)	Admin error rate %	Claim error rate %	Recovery	Main error areas
Rees & Moore Tongwynlais - 602568B	Routine	4/12/2016	4/21/2016	No response	6/2/2016	6/2/2016	42	0	52.38%	0.00%	£0.00	No claim errors were found. File closed
Bestway National Chemists Rhadyr - 602852I	Routine	4/12/2016	4/21/2016	No response	5/19/2016	6/2/2016	51	0	0.00%	0.00%	£0.00	No claim errors were found. File closed
Sainsburys Supermarket Thornhill - 602868D	Routine	4/12/2016	4/13/2016	No response	5/12/2016	5/12/2016	17	0	17.65%	0.00%	£0.00	No claim errors were found. File closed
Sully Pharmacy - 602703A	Routine	4/19/2016	5/17/2016	No response	5/18/2016	6/1/2016	8	0	0.00%	0.00%	£0.00	No claim errors were found. File closed
Washington Pharmacy - 602123A	Routine	4/19/2016	4/20/2016	No response	5/19/2016	6/1/2016	24	0	45.83%	0.00%	£0.00	No claim errors were found. File closed
Pearns Pharmacies Wilson Road - 602514K	Routine	5/4/2016	5/6/2016	No response	6/15/2016	6/28/2016	48	0	16.67%	0.00%	£0.00	No claim errors were found. File closed
Pearns Pharmacies Mill Road - 602514L	Routine	5/4/2016	5/6/2016	5/20/2016	6/15/2016	8/16/2016	100	0	5.00%	0.00%	£0.00	No claim errors were found. File closed
Lloyds Pharmacy Wilson Road - 602807H	Routine	5/4/2016	5/6/2016	5/11/2016	5/12/2016	6/8/2016	100	0	11.00%	0.00%	£0.00	No claim errors were found. File closed
Superdrug Stores - 602648D	Routine	6/6/2016	6/14/2016	6/27/2016	6/28/2016	6/28/2016	49	0	67.35%	0.00%	£0.00	No claim errors were found. File closed
Bestway National Chemists City Road - 602852E	Routine	6/6/2016	6/8/2016	No response	7/19/2016	8/16/2016	76	0	52.63%	0.00%	£0.00	No claim errors were found. File closed
Aneurin Evans Ltd - 602175A	Routine	6/28/2016	7/1/2016	7/14/2016	7/29/2016	8/1/2016	23	0	4.35%	0.00%	£0.00	No claim errors were found. File closed
TH & L Jones Ltd - 602381B	Routine	6/28/2016	7/1/2016	7/8/2016	7/12/2016	8/16/2016	20	0	10.00%	0.00%	£0.00	No claim errors were found. File closed
Clifton Pharmacy (CRI) - 602139A	Routine	7/6/2016	7/7/2016	No response	8/15/2016	8/16/2016	20	1	30.00%	5.00%	£28.00	A general MUR was performed with only one drug listed on the review, a general MUR requires a minimum of two drugs
DH Pearn (Crwys) - 602512B	Routine	7/6/2016	7/6/2016	7/12/2016	7/12/2016	8/16/2016	67	0	0.00%	0.00%	£0.00	No claim errors were found. File closed
SR Bailey Chemists (Gabalfa) - 602545F	Routine	7/6/2016	7/6/2016	No response	8/15/2016	8/16/2016	82	0	80.49%	0.00%	£0.00	No claim errors were found. File closed
Pearns Pharmacies (Penarth) - 602514C	Routine	8/5/2016	8/10/2016	8/24/2016	8/24/2016	9/5/2016	34	1	2.94%	2.94%	£28.00	One MUR was performed where there was no record of service in the Patient Medical Record
Bestway National Chemist (Llanrumney) - 602853G	Routine	8/11/2016	8/17/2016	9/14/2016	9/23/2016	9/27/2016	96	0	40.63%	0.00%	£0.00	No claim errors were found. File closed
Boots UK Ltd (St Mellons) - 602819C	Routine	8/12/2016	8/16/2016	9/5/2016	9/8/2016	9/8/2016	103	0	8.74%	0.00%	£0.00	No claim errors were found. File closed
Wellness Pharmacy (St Mellons) - 602051A	Routine	8/12/2016	8/18/2016	9/9/2016	9/12/2016	9/16/2016	59	0	86.44%	0.00%	£0.00	No claim errors were found. File closed
Judith Evans - 602180A	Routine	9/2/2016	9/5/2016	9/8/2016	9/12/2016	9/19/2016	12	0	25.00%	0.00%	£0.00	No claim errors were found. File closed
Bestway National Chemist (Cardiff Bay) - 602852C	Routine	9/2/2016	9/2/2016	9/30/2016	10/11/2016	10/17/2016	69	0	11.59%	0.00%	£0.00	No claim errors were found. File closed
Lloyds Pharmacy (Birchgrove) - 602807A	Routine	9/28/2016	10/7/2016	10/11/2016	10/17/2016	10/17/2016	104	1	8.57%	0.95%	£28.00	One MUR was performed where there was no record of service in the Patient Medical Record
Rees & Moore (Canton) - 602568A	Routine	9/28/2016	10/7/2016	10/14/2016	10/20/2016	11/2/2016	100	0	100.00%	0.00%	£0.00	File still open, awaiting Health Board response
Danescourt Pharmacy - 602512A	Routine	9/28/2016	9/29/2016	10/7/2016	10/13/2016	10/17/2016	99	0	11.11%	0.00%	£0.00	No claim errors were found. File closed
MW Phillips (South Park Road) 602545K	Routine	12/5/2016	12/6/2016	No response	1/9/2017	1/13/2017	92	1	4.35%	1.09%	£28.00	One MUR where the pharmacist wasnt registered to perform in Wales
Lloyds Pharmacy (Wellfield Road) 602807L	Routine	12/5/2016	12/6/2016	12/9/2016	12/22/2016	12/23/2016	100	0	8.04%	0.00%	£0.00	No claim errors were found. File closed
Lloyds Pharmacy (The Broad Shoard) 602807F	Routine	12/6/2016	12/8/2016	No response	1/16/2017	1/20/2017	96	4	21.00%	4.00%	£112.00	Four MUR claims where no record was available
Lloyds Pharmacy (Bishop Street) 602808C	Routine	12/7/2016	12/16/2016	1/4/2017	1/10/2017	1/13/2017	96	0	40.63%	0.00%	£0.00	No claim errors were found. File closed
Boots UK (Llantwit Major) 602819B	Routine	12/7/2016	12/16/2016	12/28/2016	1/13/2017	1/20/2017	100	0	6.00%	0.00%	£0.00	No claim errors were found. File closed
Pearns Pharmacy (Caerau Lane) 602514D	Routine	1/5/2017	1/9/2017	1/16/2017	2/3/2017	2/3/2017	74	1	1.79%	1.79%	£28.00	One MUR claim where no record was available
Tandy Inc (AJ Hales - St Isan Road) 602663A	Routine	1/12/2017	1/17/2017	1/23/2017	1/31/2017	2/7/2017	100	0	0.00%	2.00%	£0.00	No claim errors were found. File closed
Evans Pharmacy Barry 602421D	Routine	2/3/2017	2/13/2017	3/2/2017	3/7/2017	3/10/2017	76	7	22.67%	9.33%	£196.00	Seven MUR claims that did not meet the specification requirments
MW Phillips (9 Vere Street) 602545I	Routine	2/8/2017	2/10/2017	No response	3/22/2017	3/22/2017	41	2	34.15%	4.88%	£56.00	One MUR where the pharmacist wasnt registered to perform in Wales and One MUR where no record was available
MW Phillips (Cadoxton) 602545J	Routine	2/8/2017	2/9/2017	2/23/2017	3/7/2017	3/10/2017	54	0	16.67%	0.00%	£0.00	No claim errors were found. File closed
Lloyds Pharmacy Roath 602838P	Routine	2/10/2017	2/13/2017	2/22/2017	2/27/2017	3/1/2017	19	0	10.53%	0.00%	£0.00	No claim errors were found. File closed
Tesco Stores Penarth 602870E	Routine	2/10/2017	2/10/2017	2/28/2017	3/8/2017	3/10/2017	100	1	36.25%	1.25%	£28.00	One MUR where the incorrect category was selected
BS Virdee 602698A	Routine	2/24/2017	3/1/2017									
Well Pharmacy Holmesdale Street 602853F	Routine	2/24/2017	3/6/2017									
DJ & RA Griffiths (St Athan Pharmacy) 602211A	Routine	3/1/2017	3/2/2017									
Byrom LTD (Rhoose) 602572A	Routine	3/1/2017	3/2/2017	3/17/2017	3/22/2017	3/22/2017	41	0	24.39%	0.00%	£0.00	No claim errors were found. File closed
Woodville Road Pharmacy 602735B	Routine	3/7/2017	3/7/2017	3/13/2017	3/13/2017	3/22/2017	33	0	0.00%	0.00%	£0.00	No claim errors were found. File closed
Boots (Wellington Street) 602818J	Routine	3/7/2017	3/8/2017	3/8/2017	3/8/2017	3/10/2017	20	0	0.00%	0.00%	£0.00	No claim errors were found. File closed
Brockway Pharmacy 602435B	Routine	3/10/2017	3/10/2017									
St Brides Pharmacy 602481A	Routine	3/10/2017	3/16/2017	3/21/2017	3/22/2017	3/22/2017	88	0	1.14%	0.00%	£0.00	No claim errors were found. File closed
Bainbridge Pharmacy 602019A	Routine	3/21/2017	3/21/2017									
Pentyrch Pharmacy 602516B	Routine	3/21/2017	3/21/2017									
Health Plus Pharmacy (Llandaff North)	Routine	3/21/2017	3/24/2017									
C&V UHB average							**2533**	**19**		**0.75%**	**£532.00**	


Claim error rate % Cardiff & Vale GPS 2016-2017
10.00%
9.00%
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Claim error rate %
Rees & Moore Tongwynlais - 602568B
Sainsbury's Supermarket Thornhill - 602868D
Washington Pharmacy - 602123A
Pearns Pharmacies Mill Road - 602514L
Superdrug Stores - 602648D
Aneurin Evans Ltd - 602175A
Clifton Pharmacy (CRI) - 602139A
SR Bailey Chemists (Gabalfa) - 602545F
Bestway National Chemist (Llanrumney) - 602853G
Wellness Pharmacy (St Mellons) - 602051A
Bestway National Chemist (Cardiff Bay) - 602852C
Rees & Moore (Canton) - 602568A
MW Phillips (South Park Road) 602545K
Lloyds Pharmacy (The Broad Shoard) 602807F
Tandy Inc (Al Hales - St Isan Road) 602819B
Boots UK (Llantwit Major) 602663A
MW Phillips (9 Vere Street) 602545I
Lloyds Pharmacy Roath 602838P
DJ & RA Griffiths (St Athan Pharmacy) 602698A
BS Virdee 602211A
Woodville Road Pharmacy 602735B
Brockway Pharmacy 602435B
Bainbridge Pharmacy 602019A
Health Plus Pharmacy (Llandaff North)

14

MONITORING OF DECLARATIONS OF INTEREST AND GIFTS, HOSPITALITY AND SPONSORSHIP	
Name of Meeting : Audit Committee	**Date of Meeting : 24 April 2017**

Executive Lead : Director of Corporate Governance
Author : Director of Corporate Governance
Caring for People, Keeping People Well: This, underpins the Health Board's "Values", element of the Strategy
Financial impact : N/A
Quality, Safety, Patient Experience impact : N/A
Health and Care Standard Number : 1
CRAF Reference Number : 1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION this will provide the basis of the minute

ASSURANCE is provided by:

- Regular or reminders to manage to ensure declarations are made…..

The Committee is asked to:

- **NOTE** Declarations of interest from April 2016 to September 2016
- **AGREE** to receive an update on progress for March 2017 to September 2017 (at the September meeting)

SITUATION

In accordance with the Annual Work plan of the Audit Committee a report providing an update regarding the implementation of the Standards of Behaviour Policy, incorporating Gifts, Hospitality and Sponsorship was scheduled for presentation to the September meeting. A further update is scheduled for September 2017.

BACKGROUND

The Board approved the Standards of Behaviour Policy incorporating Declarations of Interest, Gifts, Hospitality and Sponsorship (the Framework) in June 2014. The aim of this Policy is to ensure that arrangements are in place to support employees to act in a manner that upholds the Standards of Behaviour Framework as well as setting out specific arrangements for the appropriate declarations of interests and acceptance / refusal and record of offers of Gifts, Hospitality or Sponsorship. The Policy also aims to capture

public acceptability of behaviours of those working in the public sector so that the University Health Board (the UHB) can be seen to have exemplary practice in this regard.

ASSESSMENT AND ASSURANCE

The Gifts, Hospitality and Sponsorship Register has been maintained throughout this period. Extracts from the Register for the period September 2016 – February 2017 to date is attached as an Appendix.

The UHB remains committed to ensuring that it is open and transparent. The Declarations of Interest Register is published on the UHB Internet and Intranet sites. There are plans to publish the Gifts, Hospitality and Sponsorship Register early in the New Year.

The Standards of Behavior Policy is due for review in January 2017. It is suggested that this would be an appropriate time to re-invigorate the policy.

DECLARATIONS OF INTEREST REGISTER (BOARD MEMBERS)

SURNAME	FORENAME	POSITION ON BOARD	DATE FORM RETURNED	INTERESTS TO DECLARE? YES/NO	DETAILS To include Directorship, Interests in Companies & Securities, Other Positions of Authority, Personal or Department Sponsorship, Other Interests	PERIOD OF INVOLVEMENT	FINANCIAL TRANSACTIONS/BENEFITS	THIRD PARTY DECLARATION? YES/NO
Antoniazzi	John	Independent Member	08/02/2017	Yes	1. Chairman of Premier Forest Ltd 2. Maggies Cancer Charity	1. Apr 2012 - Ongoing 2. 2011 - Ongoing		Yes
Bailey	Susan	Clinical Board Director for Quality, Safety and Experience	02/02/2017	No				No
Battle	Maria	Chair	02/02/2017	Yes	1.Non Exec Director of the Principality Stadium 2.Council member Cardiff University	1.May 2013 - 4 year term 2.Tenure as University Health Board Chair	1. Tickets/ Invitations/Dinner	No
Brandath	Eileen	Independent Member	23.01.2017	Yes	Director of Information Technology (Cardiff University)	Dec 2008 - Ongoing	Salary	No
Casey	Alice	Executive Program Director Unsceduled Care	24/01/2017	No		N/A	N/A	N/A
Cassley	Julie	Interim Director of Workforce and OD	27/01/2017	No				No
Chadwick	Robert	Director of Finance - from 9 December 2015	24/01/2017	No				No
Curry	Steve	Interim COO	24/01/2017	No				No
Egan	Stuart	Independent Member - Trade Union	24/01/2017	Yes	1. Mayor of Vale of Glamorgan 2. Councillor of Barry Town Council 3. Vale of Glamorgan County Council member, Health social care and scrutiny committee	1. May 2016- Ongoing 2. Not specified - May 2017 3. May 2008 - ongoing	None Declared 2. N/A 3. May 2008 - ongoing	No
Elsmore	Susan	Independent Member: Local Authority	09/02/2017	Yes	Member and Cabinet Member for Health Housing & Wellbeing for Cardiff Council	Apr 14 - Ongoing	Allowance	No
Evans	Philip	Officer Board Member Vale Representative	14/02/2017	Yes	1. Undertaking Community Development in Rhondda Cynon Taff 2. Director of Social Services in the Valeof Glamorgan	Ongoing Ongoing	None declared None Declared	No
Grey	Ivar	Independent Member - Finance	23/01/2017	Yes	1 - Non Executive Director - Finance Wales PLC	1. 2006 - Ongoing	1. £20,000	Yes
Haruk	Akmal	Independent Member	23.01.2017	Yes	IBFC - UK	2009 - Ongoing	None Declared	No
Harris	Abigail Indiana	Executive Director of Planning	25/01/2017	No	UHB rep on the Welsh Wound Innovation Clinic	Dec 2016 - Ongoing	None declared	Yes
Hopkins	Sharon	Director of Public Health	25/01/2017	No	Chair of Public Health Advisory Committee NICE	June 2015- Ongoing	Honorarium/ Expenses	Yes
Jenkins	Fiona	Director of Therapies and Health Science	23/01/2017	Yes	Director of JJ Consulting Healthcare Ltd	April 2012 - Ongoing	Related to Publications and Consultancy work	No
Kinghorn	Fiona	Interim Director of Public Health	30/01/2017	No				Yes
Lewis	Christopher Phillip James	Deputy Director of Finance	24/01/2017	Yes	President of the Wales Branch of the Healthcare Financial Management Association which is a registered charity	Oct 09 - Ongoing	None anticipated	Yes
Longley	Marcus	Vice Chair	04/02/2016	Yes	Director Welsh Institite for Health and Social Care, Prof of Applied Health Policy, University Of South Wales	Date Unknown - Ongoing	1. Remumerated public appointment 2. Salary	Yes
McLaughlin	Margaret	Independent Member - Third Sector	01/02/2017	Yes	1. Trustee of Safer Wales 2. Trustee of Women Connect First 3. Development Work with VCS Cymru 4. Assistance to CAVAMH, VCS Cymru and GVS with a Big Lottery Funding Application 5. PQASSO Mentor and Assessor under the auspices of WCVA for the PQASSO in Wales Project 6. Member of a small research team reviewing substance misuse services in Cwm Taf	1. 2009 - Ongoing 2. 2015 - Ongoing 3. June'15 - Dec'15 4. Oct'15 - Dec '15 5. June'15 - present 6. 2016 - Ongoing	1. None Declared 2. None declared 3. None Declared 4. None Declared 5. None Declared 6. None Declared	Yes
Martyn	Paula	Associate Board Member	03/02/2017	Yes	1. Independent Advisor to Care Forum Wales 2. Chair of Stakeholder Reference Group - Hwyel Dda Health Board	1.Ongoing 2. Ongoing	1. Hourly rate invoiced monthly when applicable 2. None Declared	No
Shortland	Graham	Medical Director	13/02/2017	No				Yes
Treasure	Elizabeth	Independent Member - University	31/01/2017	Yes	1. Director/Trustee Cathedral School, Llandaff 2. Co-opted Member UCAS Finance Committee, Cheltenham 3. Deputy Vice Chancellor, Cardiff University 4. Employed by Aberystwyth University	1. June 2010 - Ongoing 2. March 2013 - Ongoing 3. Aug 2010 - Ongoing 4. Apr 2017 - Ongoing	1. None Declared 2. None Declared 3. Salaried 4. None declared	No
Walker	Ruth	Executive Nurse Director	26/01/2017	Yes	1. Council Member of the Nursing and Midwifery Board 2. Cardiff and Vale Charity	1. Sept 2016 - Ongoing 2. None Declared	1. Salary 2. None Declared	No
Waygood	Martyn John	Independent Member - Legal	23/01/2017	No				Yes
Welsh	Peter	Director of Corporate Governance	21/01/2017	Yes	Justice of the Peace	Ongoing	None Declared	Yes
Young	Tony	Independent Mmember	02/02/2017	No				No

pted

Date Form Completed	Date Approved by Director	Date Received/ Recorded by Governance Department	Start Date of Event (if applicable)	End Date of Event (if applicable)	Form Completed before event	Description	Gift/ Hospitality or Sponsorship	Name of Doner / Sponsor	Value (if known)	Study Leave	Comments
4/13/2015	4/21/2015	4/28/2015	4/23/2015	4/23/2015	Yes	Provsion of refreshments for lunchtime meeting	Hospitality	Menarini Diagnostics Ltd	£40-60	No	
4/26/2015	4/28/2015	5/5/2015	5/12/2015	5/16/2015	Yes	Flights, Hotel Accomodation for Society meeting in Boston, USA	Sponsorship	Medtronic Inc Boston USA	£2,500	Yes	Emailed for more information to accompany form
4/28/2015	5/1/2015	5/12/2015	1/22/2015	1/23/2015	No	Attendance at Training Meeting for Spinal Cord Stimulator Service	Honoraria	Boston Scientific	£193	No	D.O.I. form completed also
4/29/2015	4/29/2015	5/6/2015	4/30/2015	4/30/2015	Yes	Considerate Constructor Awards Lunch in relation to a nomination for the CHoW. Travel to London from Cardiff	Hospitality	Carl Read Regional Construction Manager Interserve Construction Ltd	£150	No	
6/2/2015	6/24/2015	6/30/2015	6/4/2015	6/6/2015	Yes	Visit to Imminoglobulin plant with Grifols to see Manufacturing facilities	Hospitality	Grifols	N/A Covered by Company	No	
6/3/2015	6/24/2015	6/30/2015	6/4/2015	6/6/2015	Yes	Invitation from Grifols IVIG Plant	Hospitality	Grifols	N/A Covered by Company	No	
5/3/2015	7/4/2015	5/14/2015	5/13/2015	5/15/2015	Yes	Presenting at the Ecumas conference	Sponsorship	CTD Business Development Manager Peterborough	£450	No	
5/7/2015	5/26/2015	7/9/2015	1/22/2015	1/23/2015	No	Real World Practgices in Spinal Cord Stimulation.	Sponsorship	Boston Scientific	£200	Yes	
5/12/2015	10/11/2015	7/1/2015	6/22/2015	6/24/2015	No	This is sponsorship in the form of travel, hotel costs and conference fees to attend he 2015 Euromedlab IFCC meeting in Paris.	Sponsorship and Hospitality	Abbot Diagnostics Abbot House Vanwall Road Maidenhead	£1,500	Yes	
5/12/2015	10/11/2015	7/1/2015	6/22/2015	6/24/2015	No	This is sponsorship in the form of travel, hotel costs and conference fees to attend the 2015 Euromedlab IFCC meeting in Paris. There will also be an opportunity to visit the Abbot Innovation room to see latest analysers.	Sponsorship and Hospitality	Abbot Diagnostics Abbot House Vanwall Road Maidenhead	£1,500	Yes	
7/23/2015	8/4/2015	8/5/2015	7/1/2015	7/3/2015	No	Attended Edwards Life Sciences sponsored training course on master class on Mitral Repair as part of implementing Minimally Invasive Valve Surgery Programme in Cardiff and Vale UHB. Sponsored course including travel, accomodation and food for 2 nights and 3 days in Paris, France.	Sponsored	Edwards Life Sciences	£500	Yes	
8/7/2015	8/12/2015	10/12/2015	10/15/2015	10/16/2015	Yes	The Art National Conference 2015, The Nottingham Belfry, Nottingham	Sponsorship	Baxter Healthcare Wallingford Road Compton Newbury RG20 7QW	£330	Yes	
9/1/2015	9/22/2015	10/5/2015	10/5/2015	10/5/2015	Yes	Payment of travel to National Podopardiatrics meeting SOCAP offices London	Sponsorship	On Examination/Bus Route Gleider House Ty-Glas Road Llanishen Cardiff	£60	Yes	

16

Date Form Completed	Date Approved by Director	Date Received/ Recorded by Governance Department	Start Date of Event (if applicable)	End Date of Event (if applicable)	Form Completed before event	Description	Gift/ Hospitality or Sponsorship	Name of Doner / Sponsor	Value (if known)	Study Leave	Comments
10/9/2015	11/4/2015	11/6/2015	11/12/2015	11/12/2015	Yes	Training Workshop on Stent Assissted Coiling of Intracranial Aneurysm	Sponsorship	Stryker NeuroVascular Stryker House Hambridge Rd Newbury Berkshire RG14 5EG	£450	Yes	
10/20/2015	Waiting on returned form	10/23/2015	10/28/2015	10/31/2015		Writing a report for the recently published Resuscitation Guidelines. Attendance will greatly enhance the implementation of the guidelines within the UHB	Hospitality	The Cardiac Services, The Acumen Centre, First Avenue, Poynton, Cheshire, SK12 1FJ	£900	Yes	Saved and also Sent back electronicaaly for date and value
10/20/2015	Waiting on returned form	10/23/2015	10/28/2015	10/31/2015		Writing a report for the recently published Resuscitation Guidelines. Attendance will greatly enhance the implementation of the guidelines within the UHB	Hospitality	The Cardiac Services, The Acumen Centre, First Avenue, Poynton, Cheshire, SK12 1FJ	£900	Yes	Saved and also Sent back electronicaaly for date and value
8/27/2015	11/3/2015	11/5/2015	11/3/2015	11/6/2015	Yes	BSIR annual conference	Sponsorship	Bird LTD, Forest House, Brighton Rd, Crawley, West Sussex, RH11 9BP	£700	Yes	
12/31/2015	1/22/2016	3/23/2016	11/26/2015	11/26/2015	No	ICD Implant training Nov 26th 2015 Amsterdam, The Netherlands.Travel and Accomodation, Honoraria	Sponsorship	Boston Scientific	£500	Yes	
12/31/2015	1/22/2016	3/23/2016	7/1/2015	7/3/2015	No	Mitral Valve Repair - Master Course July 1st - 3rd 2015, Paris, France. Registration, Travel, Accomodation, Honoraria	Sponsorship	Edwards Life Sciences, UK & Ireland	£1,000	Yes	
1/16/2016	6/24/2016	3/10/2016	N/A	N/A		Gift of £10	Gift		£10	No	Emailed asking for a form to be completed
2/17/2016		3/10/2016	11/15/2016	11/17/2016	Yes	Entrance tickets and flights paid for three to attend Medica exhibition in Germany by Germany medical company to gain valuable information on new types of medical equipment coming onto the market place to ensure the correct choices are made and advice is given when purchasing equipment in furture	Sponsorship	Intersurgical Ltd	£200	Yes	
2/17/2016	2/24/2016	3/10/2016	11/15/2016	11/17/2016	Yes	Entrance tickets and flights paid for three to attend Medica exhibition in Germany by Germany medical company to gain valuable information on new types of medical equipment coming onto the market place to ensure the correct choices are made and advice is given when purchasing equipment in furture	Sponsorship	Intersurgical Ltd	£200	Yes	
2/15/2016	2/24/2016	3/10/2016	11/15/2016	11/17/2016	Yes	Entrance tickets and flights paid for three to attend Medica exhibition in Germany by Germany medical company to gain valuable information on new types of medical equipment coming onto the market place to ensure the correct choices are made and advice is given when purchasing equipment in furture	Sponsorship	Intersurgical Ltd	£200	Yes	
2/25/2016	3/9/2016	3/16/2016	5/24/2016	5/28/2016	Yes	Espghan Conference, Flights, Transfers, Melas, Accomodation	Sponsorship	Nestle Nutrition UK	£1,000	Yes	

16

Gifts, Hospitality and Sponsorship Register - April 2014 - March 2015 - Declined

Surname	Forename	Title	Designation	Division	Date Form Completed	Date Approved by GM/ Director	Date Received/ Recorded by Corp Mgt	Start Date of Event (if applicable)	End Date of Event (if applicable)	Form Completed before event	Description	Gift/ Hospitality or Sponsorship	Name of Doner / Sponsor	Value (if known)	Study Leave/ Annual Leave
Daniel	Hwyel	Mr	Head of Workforce & OD	Surgery	11/25/2014	11/25/2014	11/25/2014	N/A	N/A	N/A	Christmas Hamper	Gift	Medacs Healthcare	£10	No

Comments

Division	Clinical Board Director
Children and Women	Jenny Thomas
Clinical Diagnostics and Therapeutics	Dr. Mike Bourne
Dental	Prof. Mike Lewis
Medicine	Dr. Richard Evans
Mental Health	Dr Annie Proctor
Primary, Community and Intermediate Care	Dr. Brendan Boylan
Specialist Services	Dr. Nav Masani
Surgical Services	Mr Alun Tomkinson

CORPORATE RISK AND ASSURANCE FRAMEWORK – UPDATE REPORT
Name of Meeting : Audit Committee **Date of Meeting** 24th April 2017

Executive Lead : Director of Corporate Governance
Author : : Health and Safety Advisor Rachael.sykes@wales.nhs.uk
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy. Further information can be found here
Financial impact : Not applicable – where a risk has a financial impact this should be known by the Executive Lead and/or Risk Owner.
Quality, Safety, Patient Experience impact : : The Corporate Risk and Assurance Framework (the CRAF) includes a number of risks that impact on quality, safety or patient experience.
Health and Care Standard Number 2.1 The full Standards document can be found here
CRAF Reference Number Not applicable
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

The Corporate Risk and Assurance Framework details the high and extreme risks that have been identified.

Mitigation of the risk is being progressed and is being closely monitored by the Committee

The Audit Committee is asked to:

- **REVIEW** the risks assigned to the Audit Committee and provide assurance to the Board, identify any gaps in assurance and agree further actions.

SITUATION

Risks contained within the Corporate Risk and Assurance Framework is kept under review. At the beginning of each month the updated CRAF is published on the UHB intranet and internet pages. The latest published CRAF includes any amendments made up to 03 April 2017.

BACKGROUND

The purpose of this report is to update the Audit Committee regarding any notable amendments or additions to the CRAF.

ASSESSMENT AND ASSURANCE

The CRAF has been updated and was published on 3rd April 2017 - there have been no changes to the total number of risks assigned to the Committee and risk scores have not changed since the report presented in February. The profile of risks assigned to the Committee is as follows:-

Risk Rating	Number of Risks Assigned to Committee or sub-Committees	CRAF Ref
25	0	
20	1	8.2.3
16	1	8.2
15	0	
12	3	6.5, 8.1, 8.3
Total	5	

The risks assigned to the Committee are detailed in Appendix 1. The Committee has a role in assuring the Board that risks are being appropriately managed. To allow this the committee must review the risks and update the status of the assurance, gaps in assurance and further action being taken.

The risk register process will be reviewed at the Board development day on 27th April 2017.

The latest version of the CRAF can be found at via the following link:-

http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/248865

Appendix 1

BOARD RISK ESCALATION REPORT Note: Risks scoring 12 and above are escalated to Corporate level)			
Originator:	Corp Spec	**CRAF Ref:**	8.2.3
Escalation date:		**Probability (Likelihood) Rating (1-5):**	4
Risk score change date:			
Risk:	Comply with relevant, up to date and accessible policies, procedures and other control documents	**Impact Rating (1-5)**	5
		Risk Score (Max 25)	20
Executive Lead	DoG		
Lead Committee	Audit		
Controls - What are we doing about it (Mitigating Action Taken to Date): (Detail the actions already undertaken to mitigate the risk impact)			
Policy on Policies and other written control documents - revised in July 2014 to make process much simpler. New format approved for all other documents in September 2014. Staff training and awareness Intranet and internet access arrangements Re-enforced with all Clinical Boards the need to have arrangements in place to respond to Royal College and other documents. Proforma sent to them all for them to complete or advise of alternative format. Information regarding review of database presented to Lead Executive for their advice and oversight regarding their regarding their on-going review and maintenance. Specialist Services - Non standardisation of policy and protocols in satellite dialysis units. Risk in relation to patients moving from one satellite unit to another and particularly those with complex disease being transferred from in house unit i.e. Suite 19 to satellite unit: Controls - Directorate Manager and Lead Nurse have visited all satellite units to start discussions around standardisation. Every satellite unit has associated named Consultant Neohrologist			
Assurances (How does the Board know if we are doing it)			
Full review completed and reported to Management Executive in June 2014. Quality, Safety and Experience Committee have received report re documents assigned to that Committee. Health and Safety Committee receive update at every meeting. Internal Audit (2015/16) Satellite Dialysis Units - KPIs, All Wales KPIs being developed by Renal Network			
Gaps in Assurance			
A number of documents have exceeded their review date. Some shortfalls in internal processes and full implementation of policy. Satellite Dialysis Units - differing practices			
Further Action being taken: (What action will the Corporate Functions/Clinical Boards/Directorate take to further mitigate the risk)			
Refresh list of out of date documents and provide information to Executive Leads. Satellite Dialysis Units - Working group consisting of Directorate and satellite unit staff to develop protocols that all can implement. Renal Unit are considering KPIs but being developed on All Wales basis			
Are there any existing controls that are not listed?			
Is the Risk Rating /Score Accurate? If not what should it be?			
Recommended Response: (What action would you like to see or what action is the recommended response)			
Risk Appetite - what will the Board do with this risk?			
Terminate		Tolerate	
Treat		Transfer	

Appendix 1

BOARD RISK ESCALATION REPORT Note: Risks scoring 12 and above are escalated to Corporate level)			
Originator:	Corp	**CRAF Ref:**	8.2
Escalation date:		**Probability (Likelihood) Rating (1-5):**	4
Risk score change date:	16-Nov-15		
Risk:	Failure to have and deliver robust and effective governance framework including system of risk management and assurance resulting the lack of a co-ordinated and targetted response to risk.	**Impact Rating (1-5)**	4
		Risk Score (Max 25)	16
Executive Lead	DoCG		
Lead Committee	Board / Audit		
Controls - What are we doing about it (Mitigating Action Taken to Date): (Detail the actions already undertaken to mitigate the risk impact)			
Corporate Risk Assurance Framework, Risk policies and procedures Risk Management training Executive oversight of risk registers Health and Care Standards 2.1 - Managing Risk and Promoting Health and Safety Clinical Boards contributing to the Corporate Risk and Assurance Framework although it is accepted that they are at varying stages of development. Audit Committee Sponsored Board Development Session reviewed "extreme risks" in Aug 2015			
Assurances (How does the Board know if we are doing it)			
Internal Audit (Annual Review) Health and Care Standards self-assessment, Exec and IM review, audit			
Gaps in Assurance			
Internal Audit Limited Assurance - CB and corporate departments Risk Registers incomplete Recent review undertaken following governance shortfalls in other Health Boards has re-enforced the previously identified need for additional resources within the Governance Team.			
Further Action being taken: (What action will the Corporate Functions/Clinical Boards/Directorate take to further mitigate the risk)			
Key element of CB authorisation process Follow-up action plan in the process of being prepared. Ensure that Governance Team has the required resource to support the organisation in the delivery of the Governance and Risk Management Framework Investigate the introduction of eDatix for Risk Assessment Repeat the Audit Committee Sponsored Workshop on an annual basis as required within the Risk Assessment and Risk Register Procedure			
Are there any existing controls that are not listed?			
Is the Risk Rating /Score Accurate? If not what should it be?			
Recommended Response: (What action would you like to see or what action is the recommended response)			
Risk Appetite - what will the Board do with this risk?			
Terminate		Tolerate	
Treat		Transfer	

Appendix 1

BOARD RISK ESCALATION REPORT Note: Risks scoring 12 and above are escalated to Corporate level)			
Originator:		**CRAF Ref:**	6.5
Escalation date:		**Probability (Likelihood) Rating (1-5):**	3
Risk score change date:			
Risk:	Procurement, supply and storage (including pathological storage) arrangements do not meet service needs	**Impact Rating (1-5)**	4
		Risk Score (Max 25)	12
Executive Lead	DoF		
Lead Committee	Audit		
Controls - What are we doing about it (Mitigating Action Taken to Date): (Detail the actions already undertaken to mitigate the risk impact)			
O4E enablers project on Better Value Supply Chain Increased clinical engagement in procurement arrangements Clinical Board Account Managers established			
Assurances (How does the Board know if we are doing it)			
Internal Audit (Inc Clinical Storage) 2015/16 & 2016/17 Audit Committee receives report detailing any contract extensions. This also now includes Single Tender Actions.			
Gaps in Assurance			
Further Action being taken: (What action will the Corporate Functions/Clinical Boards/Directorate take to further mitigate the risk)			
Are there any existing controls that are not listed?			
Is the Risk Rating /Score Accurate? If not what should it be?			
Recommended Response: (What action would you like to see or what action is the recommended response)			
Risk Appetite - what will the Board do with this risk?			
Terminate		Tolerate	
Treat		Transfer	

Appendix 1

BOARD RISK ESCALATION REPORT **Note: Risks scoring 12 and above are escalated to Corporate level)**			
Originator:	Corp	**CRAF Ref:**	8.1
Escalation date:		**Probability (Likelihood) Rating (1-5):**	3
Risk score change date:			
Risk:	Meet Legislative requirements	**Impact Rating (1-5)**	4
		Risk Score (Max 25)	12
Executive Lead	DoCG		
Lead Committee	Audit		
Controls - What are we doing about it (Mitigating Action Taken to Date): (Detail the actions already undertaken to mitigate the risk impact)			
Important documents control process ensuring all inspections are recorded and compliance monitored. Detailed Scheme of delegation. Register of Executive responsibilities covering all legal requirements Reports presented to appropriate assuring Committee detailing any regulatory visits and tracking report also presented to the Audit Committee on a regular basis.			
Assurances (How does the Board know if we are doing it)			
Internal Audit (2015/16)			
Gaps in Assurance			
Safety Notices and Important Document Policy has exceeded review date of August 2014. Executive responsibilities need updating following departure of Director of Workforce and Organisational Development and Deputy Chief Executive.			
Further Action being taken: (What action will the Corporate Functions/Clinical Boards/Directorate take to further mitigate the risk)			
Complete review of Safety Notices etc. Policy. Review Executive responsibilities and ensure clear.			
Are there any existing controls that are not listed?			
Is the Risk Rating /Score Accurate? If not what should it be?			
Recommended Response: (What action would you like to see or what action is the recommended response)			
Risk Appetite - what will the Board do with this risk?			
Terminate		Tolerate	
Treat		Transfer	

Appendix 1

BOARD RISK ESCALATION REPORT **Note: Risks scoring 12 and above are escalated to Corporate level)**			
Originator:	Corp	**CRAF Ref:**	8.3
Escalation date:		**Probability (Likelihood) Rating (1-5):**	4
Risk score change date:			
Risk:	Prevent fraud, theft and corruption	**Impact Rating (1-5)**	3
		Risk Score (Max 25)	12
Executive Lead	DoF		
Lead Committee	Audit		
Controls - What are we doing about it (Mitigating Action Taken to Date): (Detail the actions already undertaken to mitigate the risk impact)			
Fraud and bribery policies and procedures. Counter-fraud awareness programme. National Fraud Initiative and annual work plan			
Assurances (How does the Board know if we are doing it)			
Routine counter-fraud reports Internal Audit (2011/12 & 2016/17)			
Gaps in Assurance			
Further Action being taken: (What action will the Corporate Functions/Clinical Boards/Directorate take to further mitigate the risk)			
Are there any existing controls that are not listed?			
Is the Risk Rating /Score Accurate? If not what should it be?			
Recommended Response: (What action would you like to see or what action is the recommended response)			
Risk Appetite - what will the Board do with this risk?			
Terminate		Tolerate	
Treat		Transfer	

REGULATORY AND REVIEW BODIES TRACKING REPORT **1 FEBRUARY 2016 – 31 MARCH 2017**	
Audit Committee	**24 April 2017**

Executive Lead : Director of Corporate Governance
Author :
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy
Financial impact: Not applicable
Quality, Safety, Patient Experience impact: Not applicable
Health and Care Standard Number: Governance, Leadership and Accountability Standard
CRAF Reference Number: 8.1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE is provided by:

- Receiving reports and information regarding inspections undertaken by the various inspection / review bodies.

The Committee is asked to:

- **NOTE** the Regulatory and Inspections Visits Tracking Report

SITUATION

This report is presented to the Committee to track the relevant Board Committees are receiving reports and information regarding inspections undertaken by the various inspection / review bodies as a key source of assurance. The report provides information for the period 1 February 2016 to 31 March 2017 and includes:

a) New inspections undertaken during the period as recorded in the post log or notified by Clinical Boards
b) Formal reports received during the period. Some reports are received a number of months after the actual inspection.

BACKGROUND

The statutory obligations of the University Health Board (the UHB) are wide ranging and complex; the UHB must comply with general law as well as NHS specific legislation. The majority of regulatory visits monitored by the Health and Safety Committee fall into the following categories:

- Food hygiene inspections undertaken by the Local Authorities
- Inspections undertaken by the Health and Safety Executive
- Fire Safety inspections undertaken by South Wales Fire and Rescue Service

ASSESSMENT AND ASSURANCE

The attached report provides evidence that each category of review is assigned to an appropriate Board Committee or sub-Committee. It contains a summary of inspection or regulatory visits of which updates on outstanding actions are provided.

Health and Safety Executive Enforcement Notice

During this period the UHB was issued with an Improvement Notice in November 2016 following the identification of breaches in the Control of Substances Hazardous to Health (COSHH) and an action plan was put in place. The HSE confirmed compliance with this Notice in relation to Legionella by 31 January 2017. This was reported to the Water Safety Group and the Health and Safety Committee to provide assurance.

Fire Service Informal Notices

These are reported to and monitored by the Fire Safety Group which then provides assurances to the Health and Safety Committee.

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
2	**Cardiff Council**								**Health and Care Standards** **Theme 1: Staying Healthy** ***Standard 1.1 Health Promotion, Protection and Improvement*** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.5 Nutrition and Hydration***							
3	9/12/2016	8-Sep-16	WBC, UHW	Planning	Periodic EHO Review of catering facility in accordance with Food Safety legislation	Catering areas scored 5 out of 5 in the National Food Hygiene Rating Scheme.	Action plan was developed to address the issues raised. To be monitored by the PFI/Compliance Manager on behalf of the Assistant Director and Head of Facilities.	Director of Planning		Action plan developed and all actions completed	Complete	Health and Safety - Martyn Waygood		**11-Oct-16**		
4	9/10/2016	9-Aug-16	Rookwood Hospital	Planning	Periodic EHO Review of catering facility in accordance with Food Safety legislation	Catering areas scored 5 out of 5 in the National Food Hygiene Rating Scheme.	Action plan was developed to address the issues raised. To be monitored by the PFI/Compliance Manager on behalf of the Assistant Director and Head of Facilities.	Director of Planning		Action plan developed and all actions completed	Complete	Health and Safety - Martyn Waygood		**11-Oct-16**		
5	8 August 2016	28 July 2016	Food Production, Restaurant Services and Wards, UHL	Capital, Estates and Facilities	Periodic EHO review of catering facility in accordance with Food Safety Legislation	Catering areas scored 4 out of 5 in the National Food Hygiene Rating Scheme	Action plan developed to address the issues raised. To be monitored by PFI/Compliance Manager on behalf of the Director of Capital, Estates and Facilities	Director of Capital, Estates and Facilities		Action plan developed		Health and Safety Committee - Martyn Waygood		11 October 2016		
6	8 August 2016	4 August 2016	Teddy Bear Nursery, UHL	Workforce and OD	Periodic EHO review of catering facility in accordance with Food Safety Legislation	Catering areas scored 4 out of 5 in the National Food Hygiene Rating Scheme	Action plan developed to address the issues raised.	Director of Workforce & OD		Action plan developed		Health and Safety Committee - Martyn Waygood		11 October 2016		
7	10/28/2016	26-Oct-16	Iorwerth Jones Unit	Planning	Periodic EHO Review of catering facility in accordance with Food Safety legislation	Catering areas scored 5 out of 5 in the National Food Hygiene Rating Scheme.	Action plan was developed to address the issues raised. To be monitored by the PFI/Compliance Manager on behalf of the Assistant Director and Head of Facilities.	Director of Planning		Action plan developed and all actions completed	Complete					
8	10/28/2016	26-Oct-16	Park Lodge Whitchurch Hospital	Planning	Periodic EHO Review of catering facility in accordance with Food Safety legislation	Catering areas scored 5 out of 5 in the National Food Hygiene Rating Scheme.	Action plan was developed to address the issues raised. To be monitored by the PFI/Compliance Manager on behalf of the Assistant Director and Head of Facilities.	Director of Planning		Action plan developed and all actions completed	Complete					
9	Not known	20-Apr-15	Whitchurch Hospital	Planning	Periodic EHO Review of catering facility in accordance with Food Safety legislation	Catering areas scored 5 out of 5 in the National Food Hygiene Rating Scheme.	Action plan was developed to address the issues raised. To be monitored by the PFI/Compliance Manager on behalf of the Assistant Director and Head of Operational Services.	Director of Strategic Planning		Action plan developed and all actions completed	Complete	Health and Safety - Martyn Waygood		28 July 2015		No

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
10	Not known	16 June 2015	Central Production Unit, UHW	Planning	Periodic EHO Review of catering facility in accordance with Food Safety legislation	Catering areas scored 2 out of 5 in the National Food Hygiene Rating Scheme.	Action plan was developed to address the issues raised. To be monitored by the PFI/Compliance Manager on behalf of the Assistant Director and Head of Operational Services.	Director of Strategic Planning		Action plan developed.	On-going	Health and Safety - Martyn Waygood	Private Board Meeting - 7 July 2015	28 July 2015		No
11	Not known	30 June 2015	Heathfields Restaurant, Catering outlet in Theatres, Aroma Coffee Unit in Childrens Hospital and the Teddy Bear Nursery	Planning	Periodic EHO Review of catering facility in accordance with Food Safety legislation	Catering areas scored 2 out of 5 in the National Food Hygiene Rating Scheme.	Action plan was developed to address the issues raised. To be monitored by the PFI/Compliance Manager on behalf of the Assistant Director and Head of Operational Services.	Director of Strategic Planning		Action plan developed.	On-going	Health and Safety - Martyn Waygood	Private Board Meeting - 7 July 2015	28 July 2015		No
12	23-Mar-17	10-Mar-17	Lakeside CPU, UHW	Planning	Food Hygiene Inspection	Food Hygiene scored 5. There were no contraventions in relation to food hygiene and safety procedures - score 0. Structural / Cleaning issues: high standard of compliance with statutory obligations - risk score 5.	All recommendations will be actioned	Director of Strategic Planning			Ongoing	Health and Safety - Martyn Waygood				
13	**Vale of Glamorgan Council**								**Health and Care Standards** **<u>Theme 1</u>: Staying Healthy** ***Standard 1.1 Health Promotion, Protection and Improvement*** **<u>Theme 2</u>: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.5 Nutrition and Hydration***						
14	23 February 2015	16 February 2015	Llanfair Unit, UHL	Planning	Periodic EHO Review of catering facility in accordance with Food Safety legislation	Llanfair Unit was given a score of 5 (very good) in the National Food Hygiene Rating Scheme.	Action plan was developed to address the issues raised. To be monitored by the PFI/Compliance Manager on behalf of the Assistant Director and Head of Operational Services.	Director of Strategic Planning	18 May 2015	Senior EHO'S do not intend to check compliance with the report. A copy will be kept on file and will be referred to during the next routine inspection.	Completed	Health and Safety - Martyn Waygood		28 April 2015		No
15	Not known	15 June 2015	Barry Hospital	Planning	Periodic EHO Review of catering facility in accordance with Food Safety legislation	Catering areas scored 5 out of 5 in the National Food Hygiene Rating Scheme.	Action plan was developed to address the issues raised. To be monitored by the PFI/Compliance Manager on behalf of the Assistant Director and Head of Operational Services.	Director of Strategic Planning		Senior EHO'S do not intend to check compliance with the report. A copy will be kept on file and will be referred to during the next routine inspection.	Completed	Health and Safety - Martyn Waygood		28 July 2015		No

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
16	**Natural Resources Wales**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety***							
17	Not known	March 2015	UHW	CD&T	Review of handling and disposal of radioactive materials.	Action Plan closed March 2015	Action Plan closed March 2015	Chief Operating Officer	01 March 2015	Closed	Completed	Quality, Safety and Experience Committee - Prof Elizabeth Treasure	CD&T Quality and Safety sub-Committee	16 June 2015		No
18	2 October 2015	1 October 2012	Nuclear Medicine Department, University Hospital Llandough		To ensure compliance against permits for the storage and disposal of radioactive waste.	The inspector noted that overall everything was good and all the previous actions had been closed out. Calibration, contamination monitoring and controls, and record keeping all good. General condition of the environment good with the following exceptions: - Ceiling tiles in scanner room in need of replacement - One cardboard box on the floor (absorbent material) - The fire door in the scanner room is an area of weakness as it could potentially be left open. Copies requested of internal audit and some documentation which we presented at inspection.	Action plan submitted. Most actions to be completed by December 2015; specialised training to be attended June 2016.	Chief Operating Officer		Link to Action Log	Completed	Quality, Safety and Experience Committee - Prof Elizabeth Treasure	CD&T Quality and Safety sub-Committee 11/11/15			No
19	**Community Health Council**								**Health and Care Standards** **Theme 2: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk*** **Theme 4: Dignified Care *Standard 4.1 Dignified Care*** **Theme 6: Individual Care *Standard 6.2 People's Rights,***							
20	Visits captured via different reporting system and assurance provided via Quality, Safety and Experience Committee.															

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
21	**Health Inspectorate Wales**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 6: Individual Care *Standard 6.2 People's Rights, Standard 6.3 Listening and Learning from feedback*** **Theme 3: Effective Care *Standard 3.1 Safe and Clinically Effective Care*** **Theme 4: Dignified Care *Standard 4.1 Dignified Care*** **Theme 2: Safe Care *Standard 2.3 Falls Prevention, Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk, Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.4 Infection Prevention and Control and Decontamination***								
31	12 February 2016		Llandough Hospital		Healthcare Inspection of East 10 and 18	Immediate Action Required		Ruth Walker	16 February 2016	Closed						
32	18 February 2016				NNI Acinetobacter Baumanii Outbreak				23 February 2016	Closed						
33	23 February 2016				Thematic Review of Opthalmology			Ruth Walker	01 March 2016	Closed						
34	2 March 2016				Review into care, medical history and events surrounding the homicide committeed at the Sirhowy Arms Hotel, Blackwood			Ruth Walker	02 March 2016	Closed						
35	3 March 2016		UHL		Immediate Assurance action letter and improvement plan			Ruth Walker		Closed						
36	7 March 2016				Thematic Review of Care and Support			Ruth Walker	not given	Closd						
37	9 March 2016				Haematology Cancer Peer Review 2016			Graham Shortland	09 March 2016	Closed						
38	10 March 2016				Notification of Ionising Radiation (Medical Exposure) Regulations Incident			Ruth Walker	14 March 2016	Closed						
39	8 March 2016				Argoed Homicide Review - Details of press event on 30 March & Action Plan			Ruth Walker	16 March 2016	Closed						
40	17 March 2016				Argoed Homicide Review			Ruth Walker	23 March 2016	Closed						
41	29 March 2016				Argoed Homicide Review - Collaborative Action Plan - Need to look at timeframes		No further action	Ruth Walker		Closed						
42	1 April 2016				Llandough Hospital - further actions following meeting to discuss HIW immediate assurance requirements			Ruth Walker	11 April 2016	Closed						
43	4 April 2016				Next steps for UHL Inspection Report					Closed						
44	19 April 2016				Mental Health Community Treatment Order			Ruth Walker		Closed						
45	29 April 2016				Hospital Inspection Report - Improvement plans update			Ruth Walker		Closed						
46	11 May 2016			Mental Health Clinical Board UHL	Hospital Inspection of CB Mental Health			Ruth Walker	11 May 2016	Closed						

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix 18

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
47	31 May 2016				Notification of Ionising Radiation (Medical Exposure) Regulations Incident - required to provide more information			Ruth Walker		Closed						
48	20 June 2016				Clinical Review Re: J.I.M.			Ruth Walker / Carol Evans	20 June 2016	Closed						
49	1 July 2016				UHB Children's Hospital Concerns			Ruth Walker	03 July 2017	Closed						
50	056/07/2016				Thematic Review of Opthalmology			Ruth Walker	19 July 2017	Closed						
51	8 August 2016				Notification of HIW Inspection of Nuclear Medicine at UHW			Ruth Walker	08 August 2016	Closed						
52	8 August 2016				Joint Learning Disability Review Cardiff West Improvement Plan			Ruth Walker	22 August 2016	Closed						
53	1 September 2016				Investigation into the death of JM whilst in custody			Ruth Walker	01 September 2016	Closed						
54	16 September 2016			UHL	IRMER Incident			Ruth Walker	14 October 2016	Closed						
55	30 September 2016				Review of Learning Disability Services for Cardiff West, C&V and ABM			Ruth Walker	30 September 2016	Closed						
56	3 October 2016				Monthly summary of outstanding matters			Ruth Walker	07 October 2016	Closed						
57	10 October 2016				IR (ME)R			Ruth Walker	10 Octoer 2016	Closed						
58	11 October 2016				IR(ME)R			Ruth Walker	14 October 2016	Closed						
59	2 November 2016				IR(ME)R			Ruth Walker	02 November 2016	Closed						
60	16 November 2016				Unannounced Inspection Reprt on Gerontology & Clinical Board Medicine			Ruth Walker		Closed						
61	17 November 2016				Visit to C6 & C7			Ruth Walker	25 November 2016	Closed						
62	18 November 2016				IR(ME)R Event at UHW			Ruth Walker	18 November 2016	Closed						
63	15 December 2016				IR(ME)R Inspection			Ruth Walker	15 December 2016	Closed						
64																
65	24 February 2015	5 February 2015	E3 Whitchurch	Mental Health	MH Act Monitoring Visit.	No breaches of the Act. Some improvements required in Environment of Care.	Estates issues resolved; Directorate Management Team considering the Consultant Psychiatrist arrangements in preparation for the enhanced bed numbers which may be utilitised at UHL in 2016. There are no issues currently with obtaining senior medical advice regarding patient care.	COO	18 April 2015	Estates issues resolved; Directorate Management Team considering the Consultant Psychiatrist arrangements in preparation for the enhanced bed numbers which may be utilitised at UHL in 2016. There are no issues currently with obtaining senior medical advice regarding patient care.	Partially completed.	Mental Health and Capacity Legislation Committee - Prof Marcus Longley		19 May 2015	Not specified	Yes
66	**Health and Safety Executive**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety*** **Theme 3: Effective Care *Standard 3.5 Record Keeping***							

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix 18

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
67	29 May 2015	14 May 2015	UHW	Various	Visit to consider compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations	Many areas of good practice found but also some failures which resulted in the serving of an Improvement Notice.	Action plan developed and Task and Finish Group formed.	Director of Strategic Planning	Original date = 27 August 2015. Extension sought and granted to 27 September 2015	Progress being made to ensure compliance by the 27 September 2015. Further update to be provided to the Health and Safety Committee on the 6th October 2015	Partially completed.	Health and Safety - Martyn Waygood		28 July 2015		Yes
68	1 June 2016	1 June 2016	Needle Exchange Department - CRI	Mental Health Clinical Board	Compliant received from member of staff	Inappropriate storage of used needles, reports received that inappropriate containers were being used and staff were in close contact to used needles brought in by clients.	Investigations commenced and meeting arranged with Procurement, Waste Management, Health and Safety and Needle Exchange Service	Head of Operations and Delivery - Mental Health	Completed	No further action being pursued by HSE	Complete	Health and Safety - Martyn Waygood	Operational Health and Safety Group	19 July 2016	Not applicable	No
69	19 September 2016	19 September 2016	Hydrotherapy Pool - Rookwood Hospital	Capital, Estates and Facilities/Clinical Diagnostics and Therapeutics Boards	Visit in conjunction with Environmental Health	A number of issues were raised in relation to the maintenance and management of the hydrotherapy pool.	Action Plan developed, documentation has been sent to the HSE	Director of Capital, Estates and Facilities/Head of Physiotherapy	On-going	Awaiting further communication the HSE.	On-going	Health and Safety - Martyn Waygood		11th October 2016		
70	22 September 2016	23 September 2016	University Hospital of Wales	Capital, Estates and Facilities	Fall of Contractor from Women's Unit	Currently being investigated internally and by the HSE.	Investigation commenced	Director of Capital, Estates and Facilities/Head of Health and Safety	On-going	Investigation commenced	On-going	Health and Safety - Martyn Waygood		11th October 2016		
71	**Human Tissue Authority (HTA)**								**Health and Care Standards** **<u>Overarching Theme</u>: Governance, Leadership and Accountability** **<u>Theme 2</u>: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety*** **<u>Theme 3</u>: Effective Care *Standard 3.5 Record Keeping***							
72	No visits during period															
73	**Medicines and Health Care Regulatory Agency (MHRA)**								**Health and Care Standards** **<u>Overarching Theme</u>: Governance, Leadership and Accountability** **<u>Theme 2</u>: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.9 Medical Devices, Equipment and Diagnostic Systems*** **<u>Theme 3</u>: Effective Care *Standard 3.1 Safe and Clinically Effective Care, Standard 3.5 Record Keeping***							
74	7 May 2015	12 March 2015	Blood Transfusion Laboratory, UHL	Clinical Diagnostics and Therapeutics Clinical Board	For cause inspection to assess compliance with the Blood Safety and Quality Regulations (SI2005/50 as amended) as the blood bank compliance report submitted for the site indicated a number of significant changes at the site in addition to poor traceability figures.	Some major deficiencies identified - 0 Critical, 3 Majors, 1 Other and 1 comment.	Management response received from the site on 10 April 2015. Following subsequent requests for further information, an acceptable final response was received on 29 April 2015. Letter from MHRA dated 16.07.15 indicates that UHB operations are accepted as in general compliance with the legislation	Medical Director	No inspection due until 2016/17 unless site is selected as a "control" inspection to verify the on-going effectiveness of the Compliance Report process. Similar letter also received for Blood Transfusion Lab at UHW.	The site operates in general compliance with the Blood Safety and Quality Regulations and EU Good Manufacturing Practice. Letter of compliance issued 7 May 2015.	Complete	Quality, Safety and Experience Committee - Prof Elizabeth Treasure	CD&T Quality and Safety sub-Committee 13 May 2015, CD&T QSE Delivery Group 21 April 2015	16 June 2015	Future assessments of compliance, including determination of the next inspection, are to be handled through the blood compliance reporting process.	No

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
75		30 April 2015	Radiopharmacy	Clinical Diagnostics and Therapeutics Clinical Board		0 Critical, 0 Majors and 8 Others	Action plan close out date agreed with Regulators - September 2015.	Medical Director	Sep-15			Quality, Safety and Experience Committee - Prof Elizabeth Treasure	CD&T Quality and Safety sub-Committee	16 June 2015		No
76		1 June 2015	Pharmacy	Clinical Diagnostics and Therapeutics Clinical Board				Medical Director				Quality, Safety and Experience Committee - Prof Elizabeth Treasure				No
77	**South Wales Cancer Network**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.6 Medicines Management, Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk, Standard 2.8 Blood Management*** **Theme 3: Effective Care** ***Standard 3.1 Safe and Clinically Effective Care, Standard 3.2 Communicating Effectively, Standard 3.4 Information Governance and Communications Technology, Standard 3.5 Record Keeping, Standard 3.3 Quality Improvement, Research and Innovation*** **Theme 4:** ***Dignified Care Standard 4.1 Dignified Care, Standard 4.2 Patient Information*** **Theme 6: Individual Care** ***Standard 6.1 Planning Care to Promote Independence, Standard 6.2 People's Rights, Standard 6.3 Listening and Learning from Feedback***						
78	3/9/2016		Haematology Cancers		HIW & South Wales Cancer Network - Haematology Cancer Peer Review			Medical Director	01 May 2016			Quality & Safety Experience Committee - Prof Elizabeth Treasure				

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
79	11 December 2014	24 September 2014	Head and Neck Cancers		Peer review for quality assurance against a framework of standards of care.	Good new patient processes but insufficient capacity to manage follow ups. Insufficient access to theatre lists to meet demand. Cohesive team providing high quality service. team should be commended for their collective approach to the information and supporting evidence provided as part of the peer review self assessment process. cohesive team who had developed good working relationships both within the MDT and with colleagues across south east Wales. The MDT delivers a patient centred service to the population of Cardiff and Vale as well as providing a specialist surgical tertiary service for patients across south east Wales	Theatre capacity project under way. Action plan developed to meet minor concerns.	Medical Director		Most actions completed. Review of theatre allocation within South Wales Plan and continuing GP education on-going.		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		Not known - evidence of written report.		
80	31 March 2015	30 January 2015	Gynae-oncology		Peer review for quality assurance against a framework of standards of care.	Surgical capacity limited. Brachytherapy service jeopardised owing to staffing issues. No lead nurse for cancer. Comprehensive information and supporting documentation submitted in support of the self assessment component of the Peer Review process. Collaborative approach to the information submitted. Team has good mix of professional groups and a strong relationship with oncology provided via a different organisation. The team displayed good interaction between each other and clear self awareness of the issues that faced the team. Serious concerns about maintaining oncology resource and MDT not adequately fulfilling its regional specialist function. Data management requires improvement. MDT needs more time.	Action plan developed.	Medical Director	Actions should be completed between July and November 2015.	On-going.		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		21 April 2015 (verbal report) and written report 1 September 2015.		Yes

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
81	10 June 2015	12 May 2015	Breast		Peer review for quality assurance against a framework of standards of care.	No workforce plan to address staff shortages. Limited MRI capacity. Large well resourced team with inbuilt resilience. Hosts the only Consultant Breast Cancer Nurse in Wales Concerns regarding the single handed oncology nurse in/from Velindre who cares for breast patients in need of oncological intervention. It was noted that the follow up protocol in use was not compliant with NICE guidance - the team had their own data in support of their preferred follow up protocol. It is recommended that the team share their findings with the relevant NSAG in order to discuss/formalise their approach. Some of the resource issues raised by the team alluded to infrastructure and noting the size and practice of the team this was felt to be an important part of the service to be delivered.	Action plan developed.	Medical Director				Quality, Safety and Experience Committee - Prof Elizabeth Treasure		21 April 2015 (verbal report)		Yes
82	19 October 2015	19 October 2015	Skin Cancer Peer Review													email on CE post log. Not saved in HQ filing
83					Haematology Cancer Peer Review	Reports will be formally published idn May 2016		Medical Director								
84	**South Wales Fire and Rescue**								**Health and Care Standards** **<u>Overarching Theme</u>: Governance, Leadership and Accountability** **<u>Theme 2</u>: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety***							

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
85	3 December 2014	28 November 2014	Anwen Ward, UHL	Surgical Services Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order - Enforcement notice	Capital, Estates and management issues	Director of Strategic Planning	05 September 2015	Task and Finish Group established to address the issues. First meeting due on 8 January 2015. Order rescinded: re-audit took place 25/8/15; letter to confirm rescinded received on 5/9/15 27/05/15: Letter received from SWFRS extending the time period for completion of the work: revised completion date now 26/08/15 Work completed: awaiting SWFRS to rescind order. Order rescinded: re-audit took place on 25/08/15. Letter of rescission received 05/09/15.	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	13/01/2015 Update provided 28.04.15 and 28.07.15		Yes Letter of rescission on CE post log
86	3 December 2014	28 November 2014	Day Surgery, UHL	Surgical Services Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order - Enforcement notice	Capital, Estates and management issues	Director of Strategic Planning	04 March 2016	Task and Finish Group established to address the issues. First meeting due on 8 January 2015. Compartmentation work outstanding: tenders received and requisition raised. All work completed except insatllaino of Fire Door - can only be done at a weekend when the unit is closed. REassessment tobe requested on completion. Extenstion to 28.12.15 agreed with SWFRS and received 14/9/15	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	13/01/2015 Update provided 28.04.15 and 28.07.15		Yes. Extension on CE post log.
87	3 December 2014	28 November 2014	Main Theatres, UHL	Surgical Services Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order - Enforcement notice	Capital, Estates and management issues	Director of Strategic Planning	14 September 2015	Task and finish group established to address the issues. First meeting due on 8 January 2015. Compartmentation work outstanding: tenders received and requisition raised. All work completed except insatllaino of Fire Door - can only be done at a weekend when the unit is closed. REassessment tobe requested on completion. Extenstion to 28.12.15 agreed with SWFRS and received 14/9/15	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	13/01/2015 Update provided 28.04.15 and 28.07.15	N/A	Yes. Extension on CE post log.

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
88	5 January 2015	11 and 17 December 2014	Wards E10, 12, 14, 16 and 18 (MHSOP UHL)	Mental Health	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order	Awaited	Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	1 issue outstanding	Ongoing	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
89	27 January 2015	19 November 2014	Whitchurch Hospital	Mental Health	Scheduled inspections for high risk premises	Enforcement Notice issued (EN56/14). Issues with compartmentation, furniture, smoking, emergency routes		Director of Strategic Planning	27 July 2017	SWFRS recognise that Whitchurch site will be closed as a hospital; 2 year completion date set. Occupation extended SWFS agreed extension till 27/07/2017	On-going Remains on-going	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	13 January 2015		Yes but not logged as an Enforcement Notice
90	13 February 2015	4 December 2014	MRC Medical Records UHL	Clinical Diagnostics and Therapeutics Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Completed	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
91	26 February 2015	23 February 2015	Tenovus Building	Cardiff University	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		On-going Remains on-going	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
92	4 March 2015	23 February 2015	E7 UHL	Mental Health	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Completed	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
93	4 March 2015	2 February 2015	Newid Ward, Llanfair Unit, UHL	Mental Health	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Completed	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	Building Closed	Yes
94	9 March 2015	2 February 2015	Gorwel Ward, Llanfair Unit, UHL	Mental Health	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Completed	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	Building Closed	Yes
95	12 March 2015	5 March 2015	Iorwerth Jones Unit	Mental Health	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		On-going. Remains on-going but note that Unit scheduled to transfer to Newid Ward, Llanfair, UHL in April 2016	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
96	7 April 2015	31 March 2015	Riverside Health Centre	Primary, Community and Intermediate Care Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		On-going Remains on-going	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
97	7 April 2015	31 March 2015	Community Building Sanatorium Road	Primary, Community and Intermediate Care Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Department now vacated	Closed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
98	7 April 2015	31 March 2015	Treasurer's Department Sanatorium Road	Primary, Community and Intermediate Care Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Department now vacated	Closed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
99	7 April 2015	31 March 2015	Flying Start and Health Visiting, Sanatorium Road	Primary, Community and Intermediate Care Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Department now vacated	Closed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
100	9 April 2015	8 April 2015	Community Mental Health Centre Cowbridge Road West	Mental Health Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		On-going Remains on-going	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
101	28 April 2015	24 April 2015	UHW Sterile Services HDSU and Workshops (Estates)	Planning/Surgery	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Completed	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
102	7 May 2015	20 April 2015	Rehabilitation Day Hospital MHSOP UHL	Mental Health	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Completed	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
103	8 May 2015	20 April 2015	Outpatients MHSOP UHL	Mental Health	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Completed	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
104	14 May 2015	13 May 2015	Medical Genetics UHW	Clinical Diagnostics and Therapeutics Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN02: non-compliance but issues so slight no return visit required. Advisory only.	Completed	Complete	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
105	18 May 2015	21 April 2015	Children's Assessment Centre UHL	Children and Women's Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Completed	Complete	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
106	11 June 2015	9 June 2015	C3 Coronary Care UHW	Medicine Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Completed	Complete	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
107	4 September 2015	25 August 2015	Medical Emergency Assessment Unit, UHL	Medicine Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Completed	Complete	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
108	10 September 2015	9 September 2015	Service Tunnels, UHW	Estates	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Ongoing	Ongoing	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
109	24 September 2015	3 September 2015	Ward West 5, UHL	Medicine Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN02 - all items satisfactory. No action required	Completed	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
110	24 September 2015	3 September 2015	High Dependency Unit, UHL	Medicine Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Completed	Complete	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	Yes
111	6 October 2015	1 October 2015	Ward A3 Adult ICU, UHW	Medicine Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included.		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Completed	Complete	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	Informal notices not reported in detail to Health and Safety Committee.	N/A	
112	11 January 2016		Day Surgery, Llandough	Surgery Clinical Board	Scheduled inspections for high risk premises	Failed to comply with Fire Safety Notice	Capital, Estates and management issues	Director of Strategic Planning		Completed	Completed	Health and Safety - Martyn Waygood			N/A	
113	22 January 2016		34 Wordsworth Avenue, Roath	Mental Health	Scheduled inspections for high risk premises	Fire Safety Notice		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		Ongoing	Health and Safety - Martyn Waygood			N/A	
114	12 February 2016		Cardigan House	Exec	Scheduled inspections for high risk premises	Fire Safety Notice		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check		Ongoing	Health and Safety - Martyn Waygood			N/A	
115	12 February 2016		Services Accommodation Centre, UHW	Exec	Scheduled inspections for high risk premises	Fire Safety Notice		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		Ongoing	Health and Safety - Martyn Waygood			N/A	
116	12 February 2016		Pentwyn Health Centre		Scheduled inspections for high risk premises	Fire Safety Notice		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Completed	Completed	Health and Safety - Martyn Waygood			N/A	

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
117	4 March 2016		Day Surgery, Llandough	Surgery Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order		Director of Strategic Planning		Completed	Completed	Health and Safety - Martyn Waygood			N/A	
118	8 March 2016		Ward B3 ICU UHW	Specialist Services Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order	Outstanding Capital issues that are being addressed in phased programme of remedationOutstanding Capital issues that are being addressed in phased programme of remedation	Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		Ongoing	Health and Safety - Martyn Waygood			N/A	
119	15 March 2016		Lansdowne Ward, St David's Hospital		Scheduled inspections for high risk premises	Fire Safety Order		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.			Health and Safety - Martyn Waygood			N/A	
120	15 March 2016		Rhydlafa Ward, St David's Hospital		Scheduled inspections for high risk premises	Fire Safety Order		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check			Health and Safety - Martyn Waygood			N/A	
121	18 March 2016		Stroke Unit, UHL	Medicine Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice.			Health and Safety - Martyn Waygood			N/A	
122	18 March 2016		Medical Records, UHL	CD&T	Scheduled inspections for high risk premises	Fire Safety Order		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice.	Completed	Completed	Health and Safety - Martyn Waygood			N/A	
123	5 April 2016		Longcross House Health Unit, Physiotherapy Unit	CD&T	Scheduled inspections for high risk premises	Fire Safety Notice		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.			Health and Safety - Martyn Waygood			N/A	
124	2 June 2016	25 May 2016	West 6 UHL	Medicine Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 1 x Compliance 5 x Management		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	1 x Compliance - Completed 2 x Management - Completed 3 x Management -	On-going	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	19 July 2016 11 October 2016	N/A	
125	9 June 2016	6 June 2016	Ward A7 UHW	Medicine Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 1 x Estates 4 x Management		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	2 x Management - Completed 2 x Management - Outstanding	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	19 July 2016 11 October 2016	N/A	
126	9 June 2016	6 June 2016	Ward C7 UHW	Medicine Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 2 x Management		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	1 x Management - Completed 1 x Management - outstanding	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	19 July 2016 11 October 2016	N/A	
127	9 June 2016	6 June 2016	Ward A5 UHW	Surgery Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 4 x Management		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	4 x Management - Outstanding	Ongoing	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	19 July 2016 11 October 2016	N/A	
128	9 June 2016	6 June 2016	Ward B5 UHW	Specialist Services Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 3 x Management		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	3 x Management - Outstanding	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	19 July 2016 11 October 2016	N/A	
129	27 July 2016	25 July 2016	Operating Theatres UHW	Surgery Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 3 x Estates 2 x Management		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	2 x Estates - Completed 1 x Management Completed 1 x Estates Outstanding 1 x Management - Outstanding	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	11 October 2016	N/A	

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
130	27 July 2016	25 July 20116	Laboratories Teaching Offices Link Block 5 First Floor	Clinical Diagnostics & Therapeutics Clinical Board	Scheduled inspections for high risk premises	Failed to comply with requirements of safety order. Schedule of works required included. 1 x Compliance 4 x Management		Director of Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	2 x Outstanding	Completed	Health and Safety - Martyn Waygood	Estate and Capital issues reported to Estates and Fire Safety meeting	11 October 2016	N/A	
131	12 October 2016		Ward A6, UHW	Surgery Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order	Outstanding Capital issues that are being addressed in phased programme of remedationOutstanding Capital issues that are being addressed in phased programme of remedation	Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.	Completed	Completed	Health and Safety - Martyn Waygood			N/A	
132	12 October 2016		Ward B4, UHW	Specialist Services Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order	Outstanding Capital issues that are being addressed in phased programme of	Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check		Ongoing	Health and Safety - Martyn Waygood			N/A	
133	12 October 2016		Ward A4, UHW	Medicine Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order	Outstanding Capital issues that are being addressed in phased programme of	Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check		Ongoing	Health and Safety - Martyn Waygood			N/A	
134	17 November 2016		Delivery Suite Maternity Block	Women's & Childrens	Scheduled inspections for high risk premises	Fire Safety Order		Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check	Completed	Competed	Health and Safety - Martyn Waygood			N/A	
135	17 November 2016		Ward C4, UHW	Specialist Services Clinical Board	Scheduled inspections for high risk premises	Fire Safety Order	Outstanding Capital issues that are being addressed in phased programme of remedationOutstanding Capital issues that are being addressed in phased programme of remedation	Director of Strategic Planning	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been done.		Ongoing	Health and Safety - Martyn Waygood			N/A	
136	9 December 2016															
137																
138	**Welsh Government Ministerial Unannounced Spot Check Visits to Older People's Mental Health Wards**								**Health and Care Standards** **Theme 6: Individual Care** ***Standard 6.2 People's Rights, Standard 6.3 Listening and Learning from feedback*** **Theme 3: Effective Care** ***Standard 3.1 Safe and Clinically Effective Care*** **Theme 4: Dignified Care** ***Standard 4.1 Dignified Care*** **Theme 2: Safe Care** ***Standard 2.3 Falls Prevention, 2.5 Nutrition and Hydration, Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk, Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.4 Infection Prevention and Control and Decontamination***							

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
139		10 December 2014	Coed y Felin Ward, Iorwerth Jones Unit	Mental Health	Spot check following the Andrews Report	Some good practice. Recommendations made regarding application of DoLS. General environment not suitable for current client group. Prescribing patterns required review. Lack of appropriate specific dementia training.	Training has been provided. CB exploring whether Llanfair Unit would be a suitable alternative site. Clinical Director has reviewed and approved prescribing patterns. 75% of staff to be trained.	Chief Operating Officer	Staff to be trained by end November 2015.			• Quality, Safety and Experience Committee - Prof Elizabeth Treasure. • Mental Health and Capacity Legislation Committee - Prof Marcus Longley		• 1 September 2015 • 2 November 2015		No
140		25 November 2014	St Barruc's Unit, Barry Hospital	Mental Health	Spot check following the Andrews Report	Some good practice. Recommendations made regarding application of DoLS. Prescribing patterns required review. Lack of appropriate specific dementia training.	Training has been provided. Clinical Director has reviewed and approved prescribing patterns.	Chief Operating Officer	Staff to be trained by end November 2015.			• Quality, Safety and Experience Committee - Prof Elizabeth Treasure. • Mental Health and Capacity Legislation Committee - Prof Marcus Longley		• 1 September 2015 • 2 November 2015		No
141		24 November 2014	Ward East 10, Llandough Hospital	Mental Health	Spot check following the Andrews Report	Some good practice. Recommendations made regarding medication administration and storage. Environment not as dementia friendly as it could be. Prescribing patterns required review. Lack of appropriate specific dementia training.	New treatment room created. Kings Fund guidance to be used to upgrade the environment. Clinical Director has reviewed and approved prescribing patterns.	Chief Operating Officer	Re-audit of environment due in November 2015. Staff to be trained by end November 2015.			• Quality, Safety and Experience Committee - Prof Elizabeth Treasure. • Mental Health and Capacity Legislation Committee - Prof Marcus Longley		• 1 September 2015 • 2 November 2015		No
142	**National Patient Safety Agency (NPSA)/Patient Safety Wales**								**Health and Care Standards** **Theme 6: Individual Care** ***Standard 6.2 People's Rights, Standard 6.3 Listening and Learning from feedback*** **Theme 3: Effective Care** ***Standard 3.1 Safe and Clinically Effective Care, Quality Improvement, Research and Innovation*** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety***						

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix 18

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
143	5 February 2007				Patient Safety Notice NPSA/2007/16: Early identification of failure to act on radiological imaging reports	Update to WG in July 2015: the UHB reported non-compliance in January 2015				The UHB has undertaken benchmarking work to establish how other organisations are achieving full compliance. Systems and processes rely on manual audit. Radiology has protocols in place but a review of systems in the Clinical Boards was not rigorous. In the absence of an electronic solution, the UHB needs to establish an audit process and consider whether a policy on this matter is required.		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
144	3 July 2007				Patient Safety Notice 24: Standardising wristbands improves patient safety	Update to WG in July 2015: Partial compliance; an electronic solution would ensure compliance and the UHB will reconsider funding a potential solution in the next financial year				The UHB has undertaken benchmarking work and concluded that other organisations have achieved compliance by implementation of an electronic solution. Investment in an electronic solution is necessary for the UHB to achieve compliance. Continued non-compliance with this Patient Safety Notice should be recorded formally on the corporate risk register. Reinforcement of the relevant patient identification policies will still be required even if electronic wristband solutions are funded.		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
145	24 June 2009				Patient Safety Notice NPSA/2009/SPN002: Risk to patient safety of not using the NHS number as the national identifier for all patients	Update to WG in July 2015: Partial compliance; an electronic solution would ensure compliance and the UHB will reconsider funding a potential solution in the next financial year				Investment in an electronic wristbands solution would assist progress in achieving compliance with this alert also. However, it should be noted that there is significant reliance on use of the local hospital number in favour of the NHS number.		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

18

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
146	12 September 2014				Alert PSA/002: The prompt recognition and initiation of treatment for sepsis for all patients	Update to WG July 2015: non-compliant			28 November 2014	Actions required to achieve compliance: • Implementation of NEWS in community hospitals – Resuscitation Service report staffing resource as a barrier to progress •Identify a clinical lead to participate in the national work to agree the systems and tools required to promote the early identification and treatment for sepsis in children – response outstanding from Children and Women Clinical Board An organisational lead for Sepsis has just been appointed to progress this work		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
147	18 July 2014				Notice PSN002: the surgical management of urinary incontinence and pelvic organ prolapse	Update to WG July 2015: non-compliant			31 July 2014	Actions required to achieve compliance: • The Assistant Clinical Director for Obs & Gynae is finalising plans to enable the reporting of all mesh related adverse events to the MHRA. This will facilitate the retrospective reporting from 2014 and allow prospective reporting going forward. The aim is for this to be in place by September 2015.		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
148	24 July 2015				Notice PSN015: The storage of medicines Refrigeratiors		Actions to achieve compliance are being led the Medication Safety Executive Group.		31 August 2015			Quality, Safety and Experience Committee - Prof Elizabeth Treasure	Internal audit report (Limited Assurance) on this went to Audit Committee 26 May and management action plan on 22 September.	1 September 2015		No
149	24 July 2015				Notice PSN016: Risk of inadvertently cutting in-line (or closed) suction catheters		Actions to achieve compliance are being led by the Lead Nurse for Acute Child Health and Lead Nurse for Adult Critical Care.		31 August 2015			Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
150	27 July 2015				Notice PSN014: Residual anaesthetic drugs in cannualae and intravenous lines		Actions to achieve compliance are being led by the Clinical Director for Anaesthetics		31 August 2015			Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
151	29 July 2015				Notice PSN017: Risk of using vacuum and suction drains when not clinically indicated		Actions to achieve compliance are being led by the Senior Nurse for Perioperative Directorate.		31 August 2015			Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
152	29 July 2015				Notice PSN018: Risk of severe harm and death from unintentional interruption of non-invasive ventilation		Further to correspondence from the Clinical Director Internal Medicine, the UHB will be able to report compliance with this notice.		31 August 2015			Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
153	**Wales Audit Office**															
154	Reports monitored via separate tracking report															
155	**ACCREDITATION VISITS**															
156	**Home Office**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.9 Medical Devices, Equipment and Diagnostic Systems*** **Theme 3: Effective Care** ***Standard 3.1 Safe and Clinically Effective Care, Standard 3.5 Record Keeping***							
157	Annual application made for licence to hold and test controlled drugs in the Toxicology laboratory. Licence applied for in February 2014 and received in July 2014. Licence has never been refused and there are no actions for the UHB to undertake as long as compliance is maintained. No report centrally captured.															
158	**British Standards Institute**															
159	No reports received															
160	**UK Accreditation Service (UKAS)**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.9 Medical Devices, Equipment and Diagnostic Systems*** **Theme 3: Effective Care** ***Standard 3.1 Safe and Clinically Effective Care, Standard 3.5 Record Keeping***							
161	No inspections during period															

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
162	**General Medical Council (GMC)**								**Health and Care Standards** **Theme 7: Staff and Resources *Standard 7.1 Workforce***							
163	Medical Director meets regularly with Local GMC representative. No routine inspections conducted.															
164	**Deanery Training Report**															
165	Medical Director meets regularly with Local Deanery representative. No routine inspections conducted. Questionnaires completed by students; if any major issues identified, Deanery discusses with Medical Director.															
166	**SGS United Kingdom Ltd**															
167	No reports captured.															
168	**WELSH RISK POOL**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.4 Infetion Prevention and Control and Decontamination, Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk*** **Theme 3: Effective Care *Standard 3.1 Safe and Clinically Effective Care, Standard 3.5 Record Keeping*** **Theme 6: Individual Care *Standard 6.3 Listening and Learning from Feedback***							
169	19 and 20/11/2014	24/06/2015 (emailed to GS, RW, Kieron Bhal and Eirlys Ferris)	Maternity Services		Annual review of high risk areas	Documentation Score: 99%, Interview Score 80%, Over all Assessment Score: 89%			Most actions to be completed by end 2015. Impact of South Wales Programme to inform implementation Sept 2016 1 April 2017. Birth Rate Plus data to inform correct staffing levels has been requested.			Quality, Safety and Experience Committee - Prof Elizabeth Treasure		1 September 2015		No
170	**INFORMATION COMMISSIONER'S OFFICE**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 2: Safe Care *Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk*** **Theme 3: Effective Care *Standard 3.4 Information Governance and Communications Technology, Standard 3.5 Record Keeping*** **Theme 4: Dignified Care *Standard 4.2 Patient Information***							

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
171	13 May 2015	February and March 2015	UHB- wide on-line survey	UHB-wide	Information Governance training review	A number of areas require attention, all of which indicate the need for a strengthened training framework. The UHB has a significant amount of work to do to meet the standards. It is required to develop a comprehensive training framework and integrate all current training delivery. This should be done in line with the Information Governance Policy and organisational arrangements.	The UHB's Learning, Education and Development department are fully involved in considering the outcome of the report and advising on the way forward.	G Shortland	No date specified	The UHB's Learning, Education and Development department are fully involved in considering the outcome of the report and advising on the way forward.	On-going	People, Performance and Planning - Prof Marcus Longley	Information Governance sub-Committee	IGSC 22/06/15 PPP on 21/07/15 via IGSC minutes		No
172	**JACIE (Joint Accreditation Committee-ISCT (Europe) & EBMT)**								**Health and Care Standards** **Overarching Theme: Governance, Leadership and Accountability** **Theme 1: Staying Healthy** ***Standard 1.1 Health Promotion, Protection and Improvement*** **Theme 2: Safe Care** ***Standard 2.1 Managing Risk and Promoting Health and Safety, Standard 2.4 Infection Prevention and Control and Decontamination, Standard 2.8 Blood Management, Standard 2.9 Medical Devices, Equipment and Diagnostic Systems*** **Theme 3: Effective Care** ***Standard 3.1 Safe and Clinically Effective Care, Standard 3.3 Quality Improvement, Research and Innovation, Standard 3.5 Record Keeping*** **Theme 4: Dignified Care Standard 4.2 Patient Information** **Theme 5: Timely Care** ***Standard 5.1 Timely Access*** **Theme 6: Individual Care** ***Standard 6.1 Planning Care to Promote Independence***						
173	Inspection at 4 year intervals. Annual reports required to be submitted.															
174–210																

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Date of Report	Date of Visit/Review	Site/Location	Clinical Board/Directorate/ Specialty	Brief Description of reason for visit/Review	Summary of Findings/Recommendations	Management Response	Executive/Operational Lead	Due Date	Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)	Status (Ongoing/Complete)	Assurance Committee & Chair	If reported to another group state here	Date Reported to Assurance Committee	Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)	Contained within CE Important Documents Log

18

Regulatory and Review Bodies Tracking Report - Reports and Inspections / Visits Undertaken - 1 February 2016 - 31 September 2016

Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	**Date of Report**	**Date of Visit/Review**	**Site/Location**	**Clinical Board/Directorate/ Specialty**	**Brief Description of reason for visit/Review**	**Summary of Findings/Recommendations**	**Management Response**	**Executive/Operational Lead**	**Due Date**	**Position as at 31 March 2017 (unless indicated otherwise by reference to receipt by Committees)**	**Status (Ongoing/Complete)**	**Assurance Committee & Chair**	**If reported to another group state here**	**Date Reported to Assurance Committee**	**Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)**	**Contained within CE Important Documents Log**
288																
289																
290																
291																
292																
293						On-going										
294						Complete										
295																
296						Audit Committee - Ivar Grey										
297						Quality & Safety - Prof Elizabeth Treasure										
298						Strategic Planning & Performance - Prof Howard Young										
299						Workforce & Organisational Development - Prof Howard Young										
300						Mental Health Act Monitoring - Mutale Merrill										
301						Charitable Funds - Martyn Waygood										
302						Health and Safety - Martyn Waygood										
303						Other										
304																
305																
306																
307						Cardiff Council										
308						Clinical Pathology Accreditation (UK) Ltd										
309						Environment Agency										
310						General Medical Council (GMC)										
311						Health and Safety Executive										
312						Healthcare Inspectorate Wales										
313						Human Fertilisation & Embryology Authority										
314						Human Tissue Authority										
315						Medicines and Healthcare										
316						South Wales Fire and Rescue										
317						Vale of Glamorgan Council										
318						Wales Audit Office										
319						Other										

18

AGENDA ITEM 4.1
Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Regulatory and Review Bodies Tracking Report - Reports Received and Inspections/Visits Undertaken - 1 February - 30 June 2015															
2	Date of Report	Date of Visit/Review	Site/Location	Clinical Board/Directorate/ Specialty	Brief Description of reason for visit/Review	Summary of Findings/Recommendations	Management Response	Executive/Operational Lead	Due Date	Position as at 31 January 2015	Status (Ongoing/Comp lete)	Assurance Committee & Chair	If reported to another group state here	Date Reported to Assurance Committee	Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)	Contained within CE Important Documents Log
3	**Health Inspectorate Wales**								**Standards for Health Services in Wales - Standard 1 - Governance and Accountability Framework Standard 2 - Equality, Diversity and Human Rights Standard 5 - Citizen Engagement and Feedback Standard 7 - Safe and Clinically Effecive Care Standard 10 - Dign**								

18

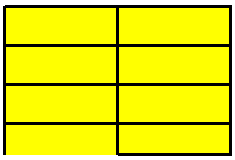
AGENDA ITEM 4.1
Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
2	Date of Report	Date of Visit/Review	Site/Location	Clinical Board/Directorate/ Specialty	Brief Description of reason for visit/Review	Summary of Findings/Recommendations	Management Response	Executive/Operational Lead	Due Date	Position as at 31 January 2015	Status (Ongoing/Comp lete)	Assurance Committee & Chair	If reported to another group state here	Date Reported to Assurance Committee	Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)	Contained within CE Important Documents Log
13	11 July 2014	18 & 19 June 2014	Wards 7 and 8, Rookwood Hospital		Dignity and Essential Care Inspection	The anticipated date of publication is 10 September 2014	Action plan in preparation	Executive Nurse Director	N/A	To provide update to QSE Committee at its next meeting.	Ongoing	Quality, Safety and Experience Committee - Prof Elizabeth Treasure		16 December 2014		Yes
14	################	30 June 2014	Cardiff and Vale Orthopeadic Centre (CAVOC), UHL	Surgical Services Clinical Board	Dignity and Essential Care Inspection	Awaiting report		Executive Nurse Director	N/A	To provide update to QSE Committee at its next meeting.	Ongoing	Quality, Safety and Experience Committee - Prof Elizabeth Treasure		16 December 2014		No
15	28 July 2014	22/23 July	Ward B6, UHW	Trauma and Otthopaedics	Dignity and Essential Care Inspection		Urgent action was taken to address some immediate feedback. An action plan has been submitted to HIW	Executive Nurse Director		Follow up visit undertaken on 20th January 2015. Feedback was positive whilst accepting that some areas still required action.	Deadlines for actions November 2014 at the latest	Quality, Safety and Experience Committee - Prof Elizabeth Treasure		16 December 2014		No
16	3 November 2014	8 August 2014	Sam Davies Ward, Barry Hospital	Older Persons' Acute and Intermediate Services	Dignity and Essential Care Inspection	HIW felt that the public could be confident that the service was well run and attention was being paid to delivering a safe service to patients.		Executive Nurse Director		Improvement plan has been submitted to HIW and is being monitored	Ongoing but deadline for most actions is January 2015	Quality, Safety and Experience Committee - Prof Elizabeth Treasure		16 December 2014		No
17	Not received	Not known - information provided to QSE Committee as part of a composite report. No dates provided.	Wards inspected were E4, E7, W2, Stroke Rehabilitation Ward at UHL, A1, C7		Dignity and Essential Care Inspection	Handwritten notes of each visit were shared at the end of each inspection. Some findings required urgent action e.g. a keypad as found to be faulty on a treatment room door; a controlled drug cupboard was found to be in a poor state of repair and was repl	A bid for funding to support the necessary environmental upgrading works across the Health Board has been submitted to Welsh Government as part of the capital planning process. work is being undertaken to identify opportunities to reshape services	Executive Nurse Director				Quality, Safety and Experience Committee - Prof Elizabeth Treasure		23 September 2014		No
18	3 November 2014	21 and 22/10/14	B1 UHW	Cardiology	Dignity and Essential Care Inspection	The immediate feedback was extremely positive although two areas which required immediate assurance were identified. These related to completion of Deprivation of Liberty paperwork on one patient; environmental issues related to the kitchen area on the wa		Executive Nurse Director		A comprehensive action plan has been submitted to address the areas of non-compliance.		Quality, Safety and Experience Committee - Prof Elizabeth Treasure		16 December 2014		Yes

AGENDA ITEM 4.1
Appendix

	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
2	Date of Report	Date of Visit/Review	Site/Location	Clinical Board/Directorate/ Specialty	Brief Description of reason for visit/Review	Summary of Findings/Recommendations	Management Response	Executive/Operational Lead	Due Date	Position as at 31 January 2015	Status (Ongoing/Complete)	Assurance Committee & Chair	If reported to another group state here	Date Reported to Assurance Committee	Date Next Scheduled Visit/Renewal of Licence/ Accreditation (if applicable)	Contained within CE Important Documents Log
19	Not received	12 November 2014	W1 UHL	General Medicine	Dignity and Essential Care Inspection	Immediate feedback was extremely positive. There were no areas that required immediate assurance. (Formal report not yet received)	No action required.	Executive Nurse Director				Quality, Safety and Experience Committee - Prof Elizabeth Treasure		16 December 2014		No
20	14 November 2014	6 November 2014	W3 Whitchurch	Mental Health	MH Act Monitoring Visit	MHA managed well. Increased OT and gym supervision provision necessary. Some Estates maintenance issues. Evidence of strong teamwork and empowering clinical leadership.		Executive Nurse Director	05 December 2014			Mental Health and Capacity Legislation Committee - Prof Marcus Longley				Yes
21	2 September 2014	11 June 2014	A4 UHW	General Medicine	Dignity and Essential Care Inspection	Overall patients felt the quality of their experience was high,staff aware of the need to protect the privacy&dignity of all patients & had measures in place to ensure that this happened. Lack of communication aids for those patients who may have some for	Detailed action plan produced.	Executive Nurse Director				Quality, Safety and Experience Committee - Prof Elizabeth Treasure				Yes

Ongoing
Complete



21

AUDIT ENQUIRIES TO THOSE CHARGED WITH GOVERNANCE AND MANAGEMENT
Name of Meeting : Audit Committee Meeting 24 April 2017

Executive Lead : Executive Director of Finance
Author : Deputy Director of Finance 029 20743555
Caring for People, Keeping People Well: Not Applicable
Financial impact: The responses provided to the enquiries made by the WAO give assurances that the financial statements should be free from material misstatement.
Quality, Safety, Patient Experience impact: This report supports robust financial reporting against the UHBs one year operational plan which supports improvements in quality, safety and patient / carer experience.
Health and Care Standard Number 1
CRAF Reference Number 6.7
Equality Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

- The response to the enquiries made by the Wales Audit Office.

The Audit Committee is asked to:

- **REVIEW** the draft response to the Wales Audit Office enquiries;
- **APPROVE** its submission to the Wales Audit office, subject to any agreed changes made by the Audit Committee and any further comments received form the Chair and Deputy Chair.

SITUATION

The WAO as part their Final Accounts Audit are responsible for obtaining reasonable assurances that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. The WAO have written to the UHB to gain responses on a number of risk, fraud and governance questions. These responses are required both from management and those charged with governance.

BACKGROUND

The WAO have sent the Health Board Finance Director a letter which formally seeks documented consideration and understanding on a number of governance areas that impact on their audit of our financial statements. These considerations are relevant to both the management of the Health Board and 'those charged with governance' (the Board).

The areas of governance on which views are being sought are summarized as:

- Management processes in relation to risk, fraud and ethical behaviour.
- Management's awareness of any actual or alleged instances of fraud.
- Management assurances that all relevant laws and regulations have been complied with.
- Potential litigation or claims that would affect the financial statements.
- Management's processes to consider areas of significant judgement and identification of any misstatements.

The letter received from the Wales Audit office is attached and a response to their questions has been requested by 30 April 2017.

ASSESSMENT

The draft response to the questions posed by the Wales Audit Office is attached and is detailed in the tables accompanying their letter. For information purposes, these tables also include the responses provided in 2015/16.

The Audit Committee, as part of its lead role in Final Accounts sign review and scrutiny, is asked to review the draft response, propose any changes to strengthen the response and support its submission to the Wales Audit Office within the timescales they have requested. To ensure good governance, this draft response has also been sent to the Chair and Deputy Chair for review and endorsement.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Wales Audit Office / Swyddfa Archwilio Cymru

24 Cathedral Road / 24 Heol y Gadeirlan
Cardiff / Caerdydd
CF11 9LJ
Tel / Ffôn: 029 2032 0500
Fax / Ffacs: 029 2032 0600
Textphone / Ffôn testun: 029 2032 0660
info@audit.wales / post@archwilio.cymru
www.audit.wales / www.archwilio.cymru

Mr Bob Chadwick
Director of Finance
Cardiff and Vale University Local Health Board
Headquarters
University Hospital of Wales
Heath Park
CARDIFF
CF14 4XW

Reference: CVUHB/MJ/NG

Date: 7 March 2017

Dear Bob

Cardiff and Vale University Local Health Board 2016/17 - Audit enquiries to those charged with governance and management

In my 2017 Audit Plan I indicate that I am responsible for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. I also set out the respective responsibilities of auditors, management and those charged with governance.

This letter formally seeks documented consideration and understanding on a number of governance areas that impact on my audit of your financial statements. These considerations are relevant to both the management of the Cardiff and Vale University Local Health Board (the UHB) and 'those charged with governance' (the Board).

I have set out below the areas of governance on which I am seeking views.

1. Management processes in relation to:

- undertaking an assessment of the risk that the financial statements may be materially misstated due to fraud;
- identifying and responding to risks of fraud in the organisation;
- communication to employees of views on business practice and ethical behaviour; and
- communication to those charged with governance the processes for identifying and responding to fraud.

1. Management's awareness of any actual or alleged instances of fraud.

2. How management gain assurance that all relevant laws and regulations have been complied with.

3. Whether there is any potential litigation or claims that would affect the financial statements.

4. Management's processes to identify any misstatements in significant judgment areas, such as accounting estimates, which could represent a risk of material misstatement due to fraud.

5. Management's processes to consider significant areas of judgment, such as accounting estimates, that consider identify, authorise, approve, account for and disclose related party transactions and relationships.

The information you provide will inform our understanding of the UHB and its business processes and support our work in providing an audit opinion on your 2016-17 financial statements.

I would be grateful if you could complete the attached table in Appendix 1. For information purposes this table also includes the responses provided in 2015-16. Although we have included last year's responses for your information, we would ask that you give full and renewed consideration to the arrangements in place for this financial year.

Your responses should be formally considered and communicated to us on behalf of both management and those charged with governance by 30 April 2017. In the meantime, if you have queries, please contact Mark Jones on 07748 181679 or by e-mail at mark.jones@audit.wales

Yours sincerely

John Herniman
Engagement Director

cc Chris Lewis, Deputy Director of Finance

Appendix 1

International Standard for Auditing (UK and Ireland) 240 – The auditor's responsibilities relating to fraud in an audit of financial statements

Background

Under the ISA, the primary responsibility for preventing and detecting fraud rests with both management and 'those charged with governance', which for the Commission is the Audit Committee. This includes fraud that could impact on the accuracy of the annual accounts. The ISA requires us, as external auditors, to obtain an understanding of how the Board exercises oversight of management's processes for identifying and responding to the risks of fraud and the internal controls established to mitigate them.

What is 'fraud' in the context of the ISA?

The ISA views fraud as either:

- the intentional misappropriation of the UHB's assets (cash, property, etc); or
- the intentional manipulation or misstatement of the financial statements.

What are we required to do?

We have to obtain evidence of how management and those charged with governance are discharging their responsibilities if we are to properly discharge our responsibilities under ISA240. We are therefore making requests from both management and the Audit Committee:

Enquiries of management		
Question	**2016-17 Response**	**2015-16 Response**
1. What is management's assessment of the risk that the financial statements may be materially misstated due to fraud and what are the principal reasons?	The assessed risk is extremely low as management are not aware of any fraud or potential fraud that would materially impact on the financial statements. This assessment is made on the basis of a robust and comprehensive counter fraud and internal audit services. Internal Audit also undertake a detailed annual review of the main financial systems from which the financial statements are prepared which has been reviewed as giving substantial assurance.	The assessed risk is minimal as management are not aware of any potential fraud that would materially impact on the financial statements. This assessment is made on the basis of a robust and comprehensive counter fraud and internal audit services. Internal Audit undertake a detailed annual review of the main financial systems from which the financial statements are prepared which has been reviewed as giving substantial assurance.

Enquiries of management		
Question	**2016-17 Response**	**2015-16 Response**
2. What are management's processes to identify any misstatements in significant judgment areas, such as accounting estimates, which could a risk of material misstatement due to fraud?	Major financial judgements and estimates are prepared and reviewed by senior finance staff and shared with the Audit Committee and Wales Audit Office for further review and scrutiny. In addition a detailed analytical analysis of income and expenditure is carried out to identify and explain any significant movements between financial years and this is also reviewed.	[WAO comment: please note that we did not ask this question last year.]
3. How can management assure the Board that it has not been inappropriately influenced by external pressures?	The Board has a good understanding of its statutory financial duties and accountabilities. Finance is a Board level responsibility and the Board is fully appraised of the financial position at every Board meeting and it receives Financial Reports that are consistent with the WG monitoring returns. Finance is considered alongside other performance metrics and is reported in an open, honest and consistent manner. This includes an assessment of Financial risk and the year-end forecast position. The Board has also set up a Finance Committee that meets monthly to have in-depth reviews of the in-year financial position, its forecast year end position and progress against financial targets.	The Board has a good understanding of its statutory financial duties and accountabilities. Finance is a Board level responsibility and the Board is fully appraised of the financial position at every Board meeting and it receives Financial Reports that are consistent with the WG monitoring returns. The Board has also had in-depth financial sessions to consider the financial plan as part of its development programme. Finance is considered alongside other performance metrics and is reported in an open, honest and consistent manner. This includes an assessment of Financial risk and the year-end forecast position.

Enquiries of management		
Question	**2016-17 Response**	**2015-16 Response**
4. Are management aware of any organisational pressure to meet revenue and capital budgets or other financial constraints?	The UHB did not have its three year IMTP approved in 2016/17. The organisation was then requested to submit a one year operational plan which it has done. The formation and sign off of these plans follows a rigorous scrutiny process, both internally and externally, where they are reviewed by both the Board and Welsh Government. The organisational accountabilities for meeting financial and non-financial targets are clear and the Executive Team have performance meetings with Welsh Government where this is discussed. In addition, the Chief Executive Officer and Chair have regular meeting with Welsh Government Chief Officers and Cabinet Secretary where performance is discussed and challenged. Finance is considered alongside other key tier 1 performance targets.	The organisation has clear financial duties and plans to deliver these as set out in the three year IMTP. The agreement of these plans follows a rigorous scrutiny process, both internally and externally, where both the Board and Welsh Government need to sign these off. The organisational accountabilities for meeting financial and non-financial targets are clear and the Executive Team have performance meetings with Welsh Government where this is discussed. In addition, the Chief Executive Officer and Chair have regular meeting with Welsh Government Chief Officers and Ministers where performance is discussed and challenged. The Health Board had its IMTP approved in August 2015 despite it not having a balanced financial plan. The Health Board has worked with the Welsh Government all year to work towards financial sustainability. Financial balance is considered alongside other key tier 1 targets.

Enquiries of management		
Question	**2016-17 Response**	**2015-16 Response**
5. What processes are employed to identify and respond to the risks of fraud more generally and specific risks of misstatement in the financial statements?	The Health Board has a year-end accounts closure process, including an analytical review which aims to mitigate against the risks of any financial misstatements. The Health Board's internal auditors also annually review the fundamental financial systems upon which the financial statements are based. This is also supported by a robust and well-resourced counter fraud programme. In addition, the Health Board has undertaken, through the Counter Fraud Department, a range of measures such as establishing a Post Payment Verification Panel which evaluates and monitor 'errors' with claims that have been submitted to Primary Care Services by the individual GP Practices and/or Opticians. All senior staff in the Finance Department must be professionally qualified accountants whose professional institutes have strong code of conducts and professional ethics. Any deliberate mis-statements would likely result in the individual being struck off from their professional body.	The Health Board has a year-end accounts closure process, including an analytical review which aims to mitigate against the risks of any financial misstatements. The Health Board's internal auditors also annually review the fundamental financial systems upon which the financial statements are based. This is also supported by a counter fraud programme which checks for such items as overpayments of salaries. In addition, the Health Board has undertaken, through the Counter Fraud Department, a range of measures such as establishing a Post Payment Verification Panel which evaluates and monitor 'errors' with claims that have been submitted to Primary Care Services by the individual GP Practices and/or Opticians. All senior staff in the Finance Department must be professionally qualified accountants whose professional institutes have strong code of conducts and professional ethics. Any deliberate mis-statements would likely result in the individual being struck off from their professional body

Enquiries of management		
Question	**2016-17 Response**	**2015-16 Response**
6. How has management communicated expectations of ethical governance and standards of conduct and behaviour to all relevant parties, and when?	All staff have access to the Standards of Behaviours Framework Policy via the Intra and Internet plus this is included upon recruitment and at induction. Consultant Medical and Dental Staff are reminded of the need to declare interests etc, when completing their job plans. This has been re-enforced throughout the year by the Assistant Medical Director – Workforce and the Clinical Boards, Board members are made aware of the policy on recruitment and are also prompted to complete a declaration on an annual basis. This requires them to confirm that they have read and understood the policy. 'Declarations of Interest' is also a standing item on the agenda of all Board and Committee meetings. The Review of Board and Committee working would also have acted as a reminder of the governance responsibilities of the Board. In addition, the Standards of Behaviours Framework policy has been circulated and also raised at the Health Systems	All staff have access to the Standards of Behaviours Framework Policy via the Intra and Internet plus this is included in recruitment and at induction. Consultant Medical and Dental Staff are reminded of the need to declare interests etc, when completing their job plans. This has been re-enforced throughout the year by the Assistant Medical Director – Workforce and the Clinical Boards, Board members are made aware of the policy on recruitment and are also prompted to complete a declaration on an annual basis. This requires them to confirm that they have read and understood the policy. 'Declarations of Interest' is also a standing item on the agenda of all Board and Committee meetings. The Review of the Board and Committee working, would also have acted as a reminder of the governance responsibilities of the Board. In addition, the Standards of Behaviours Framework policy has been circulated and also raised at the Health Systems

Enquiries of management		
Question	**2016-17 Response**	**2015-16 Response**
6. (cont'd ..) How has management communicated expectations of ethical governance and standards of conduct and behaviour to all relevant parties, and when?	Management Board to ensure that it is cascaded through Clinical Boards. This has been done to make sure that expectations of ethical governance and standards of conduct and behaviour are being communicated to all professional staff and not only to Medical and Dental staff.	Management Board to ensure that it is cascaded through Clinical Boards. This has been done to make sure that expectations of ethical governance and standards of conduct and behaviour are being communicated to all professional staff and not only to Medical and Dental staff.
7. What arrangements are in place to report about fraud to those charged with governance?	The Audit Committee agree a Counter Fraud Work Plan at the start of the year and then receives regular Counter Fraud progress reports at all of its normal business meetings. It also receives an annual counter fraud report which details the work that has been undertaken during the year, together with a Self-Risk Assessment that is required to be submitted to NHS Protect and which measures the Health Board's level of counter fraud work against a set of agreed National Standards for NHS Bodies in relation to fraud, bribery and corruption.	As part of the agreed Annual Counter Fraud Work-Plan, the Audit Committee receive regular Counter Fraud progress reports at all of their normal business meetings, an annual report which details the work that has been undertaken during the year, together with a Self-Risk Assessment that is required to be submitted to NHS Protect and which measures the Health Board's level of counter fraud work against a set of agreed National Standards for NHS Bodies in relation to fraud, bribery and corruption.

Enquiries of the Board		
Question	**2016-17 Response**	**2015-16 Response**
1. How does the Board, in its role as those charged with governance, exercise oversight of management's processes for identifying and responding to the risks of fraud within the UHB and the internal control that management has established to mitigate those risks?	The Board has delegated the review and monitoring of management processes for identifying and responding to fraud risks to the Audit Committee. This monitoring is supported by the work of the Audit Committee and the internal audit and counter fraud functions for which the Finance Director is the lead Executive. The Audit Committee receives regular reports on counter fraud matters and on the adequacy of internal control that exist within the Health Board and on the actions being taken to mitigate these risks. The Chair of the Audit Committee is an Independent Member of the Board and reports back to the Health Board on these matters and the minutes of both the public and private meetings of the Audit Committee are included in the meeting papers of the Board.	The Board has delegated the review and monitoring of management processes for identifying and responding to fraud risks to the Audit Committee. This monitoring is supported by the work and the internal audit and counter fraud functions for which the Finance Director is the Executive lead. The Audit Committee receives regular reports on counter fraud matters and on the adequacy of internal control that exist within the Health Board and on the actions being taken to mitigate these risks. The Chair of the Audit Committee is an Independent Member of the Board and reports back to the Health Board on these matters and the minutes of both the public and private meetings of the Audit Committee are included in the meeting papers of the Board.
2. Has the Board knowledge of any actual, suspected or alleged fraud since 1 April 2015?	As part of their private meetings, the Board receives minutes from the private meeting of the Audit Committee, which include reference and any significant points highlighted in the Counter Fraud Progress Reports.	As part of their private meetings, the Board receives minutes from the private meeting of the Audit Committee, which include reference and any significant points highlighted in the Counter Fraud Progress Reports.
3. Has the Board any suspicion that fraud may be occurring within the organisation?	Yes, but only what is reported as actual or suspected fraud as per the counter fraud reports to the Audit Committee for which the minutes and any key areas of concern are reported back to the Board.	Yes, but only what is reported as actual or suspected fraud as per the counter fraud reports to the Audit Committee for which the minutes and any key areas of concern are reported back to the Board.

Enquiries of the Board		
Question	**2016-17 Response**	**2015-16 Response**
4. Is the Board satisfied that internal controls, including segregation of duties, exist and work effectively? If 'yes', please provide details. If 'no' what are the risk areas?	Yes, the Health Board is satisfied that key internal controls work effectively. The Health Board has adopted the NHS Wales model Standing Orders and Standing Financial Instructions. It also has in place a detailed scheme of delegation and Financial Control Procedures and Policies. The adequacy of Internal Controls is reviewed on behalf of the Board by the Audit Committee and this is supported by the work of the Internal Audit and Counter Fraud Teams. The Board also agrees the Annual Governance Statement which sets out its review and opinion of internal controls. The Internal Audit review of the Health Boards Financial Systems was rated as substantial assurance.	Yes, the Health Board is satisfied that key internal controls work effectively. The Health Board has adopted the NHS Wales model Standing Orders and Standing Financial Instructions. It also has a detailed scheme of delegation to support these. There are also a number of Financial Control Procedures and Policies in place and a schedule for review of these is reported to the Audit Committee. The adequacy of Internal Controls is reviewed on behalf of the Board by the Audit Committee and this is supported by the work of the Internal Audit and Counter Fraud Teams. The Board also agrees the Annual Governance Statement which sets out its review and opinion of internal controls. The Internal Audit review of the Health Boards Financial Systems was rated as substantial assurance.
5. How do you encourage staff to report their concerns about fraud and what concerns about fraud are staff expected to report?	The Counter Fraud department has a regular annual programme of raising fraud awareness within the Health Board. Regular fraud awareness sessions are held with the various staff groups at which details on how and to who fraud is to be reported are outlined. In addition to this, a quarterly newsletter is produced that is available on the Health Board's Intranet website and all successful prosecutions' cases are also publicised to obtain the maximum deterrent.	As part of the ongoing programme of raising fraud awareness within the Health Board, regular fraud awareness sessions are held with the various staff groups at which details on how and to who fraud is to be reported are outlined. In addition to this, a quarterly newsletter is produced that is available on the Health Board's Intranet website and all successful prosecutions' cases are also publicised to obtain the maximum deterrent.

Enquiries of the Board		
Question	**2016-17 Response**	**2015-16 Response**
6. From a fraud and corruption perspective, what are considered by the Board to be high risk posts within the organisation and how are the risks relating to these posts identified, assessed and managed?	The highest risk functions are payroll, procurement, capital and estates, financial accounting and services, asset management and primary care contractor services. These areas are governed by Standing Orders and Standing Financial Instructions with supporting financial control procedures. Risks in these areas are covered within the internal audit, counter fraud and PPV work plans which are overseen by the Audit Committee on behalf of the Board.	The highest risk functions are payroll, procurement, capital and estates, financial accounting and services, asset management and primary care contractor services. These areas have governed by Standing Orders and Standing Financial Instructions with supporting financial control procedures. Risks in these areas are covered within the internal audit, counter fraud and PPV work plans which are overseen by the Audit Committee on behalf of the Board.
7. Is the Board aware of any related party relationships or transactions that could give rise to instances of fraud and how does the Audit Committee mitigate the risks associated with fraud related to related party relationships and transactions?	The Declarations of Interest Register is published and made available to the Board Secretary who is responsible for keeping the Chair appraised of any potential related party relationships or transactions that could give rise to fraud. There have been no known instances during the year.	The Declarations of Interest Register is published and made available to the Board Secretary who is responsible for keeping the Chair appraised of any potential related party relationships or transactions that could give rise to fraud. There have been no known instances during the year.
8. Is the Board aware of any entries made in the accounting records of the organisation that it believes or suspects are false or intentionally misleading?·	No. All major accounting judgements and estimates are reported to and discussed at the Audit Committee as part of the final accounts scrutiny process. These are thoroughly considered by a separate workshop which concentrates on reviewing and scrutinising the draft annual accounts.	No. All major accounting judgements and estimates are reported to and discussed at the Audit Committee as part of the final accounts scrutiny process. These are thoroughly considered at the annual accounts workshop.

Enquiries of the Board		
Question	**2016-17 Response**	**2015-16 Response**
9. Is the Board aware of any organisational, or management pressure to meet revenue and capital budgets or other financial constraints?	The UHB did not have its three year IMTP approved in 2016/17. The organisation was then requested to submit a one year operational plan which it has done. The formation and sign off of these plans follows a rigorous scrutiny process, both internally and externally, where they are reviewed by both the Board and Welsh Government. Organisational and Executive Director accountabilities for meeting financial and non-financial targets are clear and the Chief Executive Officer and Chair have regular meeting with Welsh Government Chief Officers and Cabinet Secretary where performance is discussed and challenged. Finance is considered alongside other key tier 1 performance targets.	The organisation has clear financial duties and plans to deliver these are set out in the three year IMTP. The agreement of these plans follows a rigorous scrutiny process both internally and externally where both the Board and Welsh Government need to sign these plans off. Organisational and Executive Director accountabilities for meeting financial and non-financial targets are clear and the Chief Executive Officer and Chair have regular meeting with Welsh Government Chief Officers and Ministers where performance is discussed and challenged. The Health Board had its IMTP approved in August 2015 despite it not having a balanced financial plan. The Health Board has worked with the Welsh Government all year to work towards financial sustainability. Financial balance is considered alongside other key tier 1 targets.

International Standard for Auditing (UK and Ireland) 250 – Consideration of laws and regulations in an audit of financial statements

Background

Under the ISA, in the UK and Ireland, the primary responsibility for ensuring that the entity's operations are conducted in accordance with laws and regulations and the responsibility for the prevention and detection of non-compliance rests with management and 'those charged with governance', which for the UHB is the Board. The ISA requires us, as external auditors, to obtain an understanding of how the Committee gains assurance that all relevant laws and regulations have been complied with.

What are we required to do?

We have to obtain evidence of how management and those charged with governance are discharging their responsibilities, if we are to properly discharge our responsibilities under ISA 250. We are therefore making requests from both management and the Board:

Enquiries of management		
Question	**2016-17 Response**	**2015-16 Response**
1. Is the Board aware of any non-compliance with relevant laws and regulations?	Discussed at appropriate Committees and where relevant linked to the Corporate Risk and Assurance Framework for the Health Board. Further training for Board members on legal requirements is also planned for a Board Development session in early 2017/18.	Discussed at appropriate Committees and where relevant linked to the Corporate Risk and Assurance Framework for the Health Board

Enquiries of management		
Question	**2016-17 Response**	**2015-16 Response**
2. If there have been instances of non-compliance what are they, and what oversight has the Board had to ensure that action taken by management to address and gaps in control?	Instances of non-compliance are: • Fire Safety Enforcement Notices where a plan of action has been agreed with Whitchurch Hospital the Fire and Rescue Authority. This is monitored via the Health and Safety Committee. • Breaches in 2016/17 of Welsh Government procurement rules, where action has been taken to correct processes. This is monitored by the Audit Committee. • Information Governance Breaches which are monitored by the People Performance and Delivery Committee (supported by the Information Governance sub group) which agree improvements plans. Through the Committees this is then reported to the Board • Health and Safety Executive (1 breach C.O.S.H. regulations) Action Plan delivered and compliance notice removed 6 Feb 2017 and was monitored by the Health and Safety Committee.	Instances of non-compliance are: • Fire Safety Enforcement Notices where a plan of action has been agreed with Whitchurch Hospital the Fire and Rescue Authority. This is monitored via the Health and Safety Committee. • Breaches in 2016/17 of Welsh Government procurement rules, where action has been taken to correct processes. This is monitored by the Audit Committee. • Information Governance Breaches which are monitored by the People Performance and Delivery Committee (supported by the Information Governance sub group) which agree improvements plans. Through the Committees this is then reported to the Board • Health and Safety Executive (1 breach C.O.S.H. regulations) Action Plan delivered and compliance notice removed 6 Feb 2017 and was monitored by the Health and Safety Committee.

International Standard for Auditing (UK and Ireland) 550 – Related parties

Background

The nature of related party relationships and transactions may, in some circumstances, give rise to higher risks of material misstatement of the financial statements than transactions with unrelated parties. For example:

- Related parties may operate through an extensive and complex range of relationships and structures, with a corresponding increase in the complexity of related party transactions.
- Information systems may be ineffective at identifying or summarising transactions and outstanding balances between an entity and its related parties.
- Related party transactions may not be conducted under normal market terms and conditions; for example, some related party transactions may be conducted with no exchange of consideration.

Because related parties are not independent of each other, many financial reporting frameworks establish specific accounting and disclosure requirements for related party relationships, transactions and balances to enable users of the financial statements to understand their nature and actual or potential effects on the financial statements. An understanding of the entity's related party relationships and transactions is relevant to the auditor's evaluation of whether one or more fraud risk factors are present as required by ISA (UK and Ireland) 240, because fraud may be more easily committed through related parties.

What are we required to do?

Where the applicable financial reporting framework establishes requirements for related parties, the auditor has a responsibility to perform audit procedures to identify, assess and respond to the risks of material misstatement arising from the entity's failure to appropriately account for or disclose related party relationships, transactions or balances in accordance with the requirements of the framework. We are therefore making requests from both management and the Board:

Enquiries of management		
Question	**2016-17 Response**	**2015-16 Response**
1. What controls are in place to identify, authorise, approve, account for and disclose related party transactions and relationships?	Staff are required to make declarations in accordance with the Standards of Behaviour Framework Policy, incorporating Gifts, Hospitality and Sponsorship. All Board members are asked to make a declaration on an annual basis, which is then recorded and published in the Declarations of Board Members' Interests. Where a Board Member's interests change during the year, they have a personal responsibility to declare this and inform the Board Secretary. These related party transactions are identified in the annual accounts and their materiality quantified. For all Committees and the Board we have a standing agenda item at the beginning of each meeting 'Declaration of Interest' in relation to items on the agenda.	Staff are required to make declarations in accordance with the Standards of Behaviour Framework Policy, incorporating Gifts, Hospitality and Sponsorship. All Board members are asked to make a declaration on an annual basis, which is then recorded and published in the Declarations of Board Members' Interests. Where a Board Member's interests change during the year, they have a personal responsibility to declare this and inform the Board Secretary. These related party transactions are identified in the annual accounts and their materiality quantified. For all Committees and the Board we have a standing agenda item at the beginning of each meeting 'Declaration of Interest' in relation to items on the agenda.
2. Confirm that you have: • disclosed to the auditor the identity of the entity's related parties and all the related party relationships and transactions of which you are aware; and • appropriately accounted for and disclosed such relationships and transactions in accordance with the requirements of the framework.	Yes	Yes

21

Enquiries of the Board		
Question	**2016-17 Response**	**2015-16 Response**
1. How does the Board, in its role as those charged with governance, exercise oversight of management's processes to identify, authorise, approve, account for and disclose related party transaction sand relationships?	Audit Committee receives bi-annual reports relating to compliance with the policy and the Gifts, Hospitality and Sponsorship Register. It also scrutinises the Annual Accounts which contain details of related party transactions.	Audit Committee receives bi-annual reports relating to compliance with the policy and the Gifts, Hospitality and Sponsorship Register. It also scrutinises the Annual Accounts which contain details of related party transactions.

CD&T Clinical Board
Radiology Treat-in-turn

FINAL INTERNAL AUDIT REPORT
2016/17

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

Review reference:	CUHB17.32
Report status:	Final
Fieldwork commencement:	February 2017
Fieldwork completion:	March 2017
Draft report issued:	March 2017
Management response received:	April 2017
Final report issued:	April 2017
Auditors:	Kimberley Rowe

Executive sign off:	Chief Operating Officer
Distribution:	Matthew Temby, Kathy Ikins, Samantha Morris
Committee:	Audit Committee

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

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, 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 the C&V University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

In accordance with the 2016/2017 internal audit plan, a review of the management of treat in turn within Radiology in the CD&T Clinical Board was undertaken.

The relevant lead Executive Director for the assignment is the Chief Operating Officer.

Treatment in Turn (TiT) requires that appointments reflect clinical priority and that patients are seen in Chronological Order depending on any adjustments which are permissible under the 'Rules'.

There are a number of justifiable reasons, which mean that patients would be treated out of turn, these include:

- A named referral could wait longer due to requirement to see a specific clinician rather than a pooled patient;
- Clinic slots available based on urgent/ routine ratio;
- Clinic times for certain specialities, e.g. two clinics per month;
- Theatre availability;
- Length of procedure and slots available;
- Complex cases v number patient that could be treated in the same time; and
- Number of urgent v routine patients.
- Waiting lists in UHW and UHL differ for same clinic and allocated by different teams.

2. Scope and Objectives

The objective of the audit is to evaluate and determine the adequacy of the systems and controls in place for the management of Radiology patients in order to provide reasonable assurance to the Health Board Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review is to provide assurance that patients in Radiology are treated in turn.

The main areas that the review will seek to provide assurance on are:

- Patients are treated in turn (chronological order), with exceptions being justified.

It should be noted that due to operational pressures in Radiology during the time of audit, testing wholly focussed on routine patients; therefore

the correct classification of patients as 'urgent' or 'priority' have not yet been tested at time of reporting.

3. Associated Risks

The potential risk considered in the review is as follows:

I. Inequitable treatment of patients.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with treat in turn within Radiology is **Substantial Assurance**.

RATING	INDICATOR	DEFINITION
Substantial Assurance		The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

Radiology have adequate systems in place in order to record and monitor the referral date, receipt date and subsequent appointment date of each patient, and ensure patients are treated in turn.

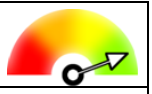
Each patient is initially classified as urgent or routine and subsequently vetted by a Radiologist to determine the set waiting time and list based on the diagnostic procedure and exam. The waiting lists can be cross-referenced to the RTT (Referral to Treatment) Warehouse to ensure there are no breaches.

Although the RADIS system and referral forms provide the opportunity to be annotated to document justifications of appointments offered, this facility is not always used.

23.1

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	*Inequitable treatment of patients.*				✓

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system control/design for treat-in-turn.

This is identified in the management action plan as (D).

Operation of System/Controls

The findings from the review have highlighted no issues that are classified as weakness in the operation of the designed system/control for treat-in-turn.

6. Summary of Audit Findings

The key findings are reported in the section below with full details in the Management Action Plan under Appendix A.

Risk: Inequitable treatment of patients.

The following areas of good practice were noted:

- Referrals are received into radiology, date stamped and then recorded into RADIS therefore it is easy to determine which patients should be first to receive appointments;
- Referrals are immediately classed as urgent or routine in order to determine which waiting list they are to be added to;
- Each of the referrals are subsequently vetted by a Radiologist to ensure they have been categorised correctly and are added to the clinically urgent list if necessary;
- Each of the referrals are put into categories based on the diagnostic procedure and exam to further breakdown the waiting lists;
- Periodically the waiting lists are uploaded into the RTT warehouse to determine the patients on this pathway, prioritising any breaches where necessary;

- A sample test of 40 pairs of patients was performed to determine whether they were treated in turn, or whether there is a justifiable explanation if not:
  - 23 patient pairs were deemed to be treated in turn (either in order or within a week of each other)
  - Of the remaining 17 patients, 10 had documented justifiable reasons as to why they were not treated in turn.

The following significant findings were noted:

- Of the 40 pairs tested, 7 did not have documented justifications for the patients not being treated-in-turn.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of Recommendations	**0**	**1**	**0**	**1**

Finding 1	Risk
Of the 40 pairs tested, 7 did not have documented justifications for the patients not being treated-in-turn. (D)	Inequitable treatment of patients
Recommendation 1	**Priority level**
Radiology administration staff should use the facility on RADIS or by writing on the scanned referral forms, notes as to the appointments offered the patients or justification as to any earlier appointments or delays.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**
The relevant staff have been reminded of the requirement to document on the referral and in RADIS the justification for patients not being treated in turn. As a consequence of this finding and recommendation the Directorate will undertake 3 monthly internal audits of this process.	Directorate Administrative Manager

23.1

CD&T CB – Radiology TiT

Cardiff & Vale University Health Board

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Core Financial Systems

FINAL INTERNAL AUDIT REPORT 2016/17

Cardiff and Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS Page

Review reference:	**CUHB_1617_09**
Report status:	**Final**
Fieldwork commencement:	**January 2017**
Fieldwork completion:	**March 2017**
Draft report issued:	**March 2017**
Management response received:	**March 2017**
Final report issued:	**April 2017**
Auditor/s:	**Jayne Gibbon Internal Audit Manager, Ross Hughes Internal Auditor**
Executive sign off :	**Bob Chadwick, Executive Director of Finance**
Distribution	Christopher Lewis Deputy Finance Director, Richard Hurton Assistant Finance Director
Committee	**Audit Committee**

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

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, 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 the Cardiff and Vale University Health Board and no responsibility is

taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

In accordance with the 2016/2017 internal audit plan, a review of the arrangements in place for the Core Financial Systems operating within Cardiff and Vale UHB has been undertaken.

The Financial Accounting Section of the Finance Department is responsible for the Financial Reporting of the organisation. This includes production of the Annual Accounts and the Monthly Financial Monitoring returns.

Accounts Receivable is part of the Financial Services Section of the Finance Department. Financial Services is responsible for managing the cash of the organisation as well as administering the debts incurred through the UHB's normal business.

The Health Board undertake a monthly cashflow forecast which is submitted to the Welsh Government, requesting their monthly funding.

The previous report in 2015/16 on financial systems (cuhb16.31) returned a rating of Substantial Assurance.

The outcome from this review can be linked / contribute assurance to section 6.7 Finance of the Board Assurance Framework and also Standard 1 Governance Leadership and Accountability of the NHS Wales Health and Care Standards.

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place for the management of the General Ledger, Accounts Receivable, Asset Register and Cash Management in order to provide reasonable assurance to the UHB Audit Committee that risks material to the achievement of systems objectives are managed appropriately.

The purpose of the audit was to provide assurance to the Audit Committee that:

- To ensure that the management of Accounts Receivable and Cash is adequate to ensure that all monies due are identified and collected on an accurate and timely basis with all income being correctly matched to its appropriate stream.
- To provide assurance as to whether the management of the UHB's Capital Asset Register was sufficient to ensure that all capital assets were identified and properly accounted for.
- To ensure that the General Ledger is accurate, up to date and accurately records all financial transactions.

3. Associated Risks

The potential risks considered in the review were as follows:

I. Loss of cash / inappropriate payments;
II. Income due to the UHB may not be received or properly accounted for;
III. The capital asset register may be inaccurate and assets may be incorrectly recorded or valued;
IV. Figures in the accounts may be incorrect;
V. Unauthorised data may be input to the ledger.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the Core Financial Systems is **Substantial** Assurance.

RATING	INDICATOR	DEFINITION
Substantial		The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

Overall the controls in place to manage the risks associated with the systems and processes tested within the review are of a high standard. Good practice was noted in processes concerning management of cash and the management of the capital asset register.

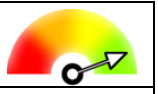
The audit however did identify a number of issues concerning monthly reconciliations and timeliness of requests for debtors, credit notes and

write offs. Improvements are also required around the monitoring of access to the Oracle System and also the PO hierarchy approval structure.

There were no high priority issues identified during this review.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	*Loss of cash / inappropriate payments*				✓
2	*Income due to the UHB may not be received or properly accounted for*				✓
3	*The capital asset register may be inaccurate and assets may be incorrectly recorded or valued*				✓
4	*Figures in the accounts may be incorrect*				✓
5	*Unauthorised data may be input to the ledger*			✓	

Design of Systems/Controls

The findings from the review have highlighted 2 issues that are classified as weakness in the system control/design for the management of the Core Financial Systems. This is identified in the action plan as (D).

Operation of System/Controls

The findings from the review have highlighted 4 issues that are classified as weakness in the operation of the designed system/control for the management of the Core Financial Systems. These are identified in the action plan as (O).

6. Summary of Audit Findings

The key findings are reported in the section below with full details in the management action plan.

Risk: Loss of cash / inappropriate payments.

23.2

The following areas of good practice were noted:

- There is guidance in place for the collection and receipting of monies received.
- Testing undertaken on a sample of monies received by the Cashiers departments found that the monies were banked in a timely manner and all monies intact.
- Monthly reconciliations are completed for the bank accounts.
- Monthly cash forecasts are prepared to ensure that the UHB has sufficient resources available to meet its obligations.

There were no significant findings under this risk.

Risk: Income due to the UHB may not be received or properly accounted for.

The following areas of good practice were noted:

- There is a Financial Control Procedure (FCP 14 Accounts Receivable) in place that details processes to be followed.
- Testing on a sample of 20 debtor requests found that all requests had appropriate authorisation and all data fields matched.
- Testing on a sample of 20 income transactions found that all monies had been receipted in a timely manner and allocated to the appropriate financial code or invoice
- Testing on a sample of 20 credit note requests noted that all requests had been processes in a timely manner, supporting documentation in place and reasons were appropriate.
- Bad debt write off is in line with the authorisation limits in place.
- There are good processes in place for debt management for all debts. With regards to NHS debts the Accounts Receivable Manager maintains a spreadsheet to monitor the level of debt to ensure that the necessary processes are followed for arbitration.
- The dunning process is performed monthly for all applicable overdue invoices.
- Aged debtor analysis is undertaken each month by the Accounts Receivable Manager.

There were no significant findings under this risk.

Risk: The capital asset register may be inaccurate and assets may be incorrectly recorded or valued.

The following areas of good practice were noted:

- Processes are in place within Finance to ensure all new assets are identified and recorded on the register.
- Procedures are in place to identify disposals of assets and remove from the register.
- Indexation and depreciation charges are accurately applied to UHB assets.
- An annual asset verification exercise is carried out by Finance whereby departments are required to confirm their assets.
- The asset verification process was verified by audit and a sample of 90 assets selected for verification across nine different departments, with 87% of the assets selected being found and verified. For the assets not verified (13%) audit was able to that all assets had been identified as disposals and were scheduled to be removed from the asset register by Finance at year end.

There were no significant findings under this risk.

Risk: Figures in the accounts may be incorrect

The following areas of good practice were noted:

- Suspense accounts are used to record expenditure which are yet to be assigned to a specific department.
- The accounts are reviewed on a monthly basis and expenditure assigned to the correct financial code when applicable. Where expenditure cannot be assigned to a department a reconciliation is completed.
- Month end reconciliations are completed for all balance sheet codes and reviewed and signed off by the Assistant Finance Director.
- Testing on a sample of monthly journal accruals found that all had appropriate supporting documentation.

There were no significant findings under this risk.

Risk: Unauthorised data may be input to the ledger

The following areas of good practice were noted:

- Access to the Oracle financial system is overseen by the E-Enablement team of NWSSP.
- Access is only granted on the receipt of approved NWSSP form which has been duly authorised.
- For staff requiring access to Oracle for procurement purposes the team will provide training to the staff member before live access is given.

- Testing on a sample of Oracle users found that access and responsibilities was appropriate.

There following significant findings were noted:

- Testing on a sample of staff leavers to determine if access to oracle had been removed noted the following:
  - 8 of 15 leavers were still registered as active users at the time of the audit
  - In addition for 2 of the 15 leavers there had been a considerable delay in removing user.
- There is currently no periodic review undertaken of staff access to determine if access and associated responsibilities are still appropriate.
- Testing on a sample of staff to ensure that the financial approval limits as per Oracle matched the Clinical Board's Scheme of Delegation noted that for 2 of the 6 staff selected the values differed.
- Currently no review is undertaken of the PO approval hierarchy to ensure that it matches the Scheme of Delegations within the Clinical Boards and Corporate Departments.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**2**	**4**	**6**

Finding 1: Debtor Requests	Risk
A sample of debtor requests was selected to test that all requests were authorised, that details on the UHB invoice matched the request and were processed in a timely manner. The testing undertaken noted the following: • For 4 of the 20 requests reviewed there was a delay in the originating department forwarding the request to the Accounts Receivable. (O)	Income due to the UHB may not be received or properly accounted for.
Recommendation 1	**Priority level**
Management should issue a reminder to all departments that debtor requests should be forwarded to the Accounts Receivable Department as soon as debt is identified.	**Low**
Management Response 1	**Responsible Officer/ Deadline**
The Financial Services Manager will write to All Heads of Finance emphasising the need for invoices to be raised on a timely basis.	Alun Williams/ April 2017
Finding 2: Credit Note Requests	**Risk**

23.2

Testing was undertaken on a sample of credit note requests to ensure that the requests were appropriate, authorised and processed in a timely manner. The testing noted the following issue: • 2/20 the same member of staff requested and authorised the credit note request. (O)	Income due to the UHB may not be received or properly accounted for.
Recommendation 2	**Priority level**
Management should issue a reminder that credit note requests should not be authorised by the same person that has requested the credit note.	**Low**
Management Response 2	**Responsible Officer/ Deadline**
The Financial Services Manager will write to All Heads of Finance emphasising the need for credit notes to have two designated signatories signing them.	Alun Williams/April 2017
Finding 3: Write Offs	**Risk**

23.2

Testing of a sample of write offs to ensure that the reasons were appropriate and had the appropriate level of authorisation noted the following: • 1 of 15 there was a delay in the debt being put forward for write off • 3 of 15 the supporting documentation was not fully completed (O)	Income due to the UHB may not be received or properly accounted for.
Recommendation 3	**Priority level**
Management should remind staff that all debts referred for write off should be submitted on a timely basis and that all supporting documentation should be fully completed.	**Low**
Management Response 3	**Responsible Officer/ Deadline**
The Financial Services Manager will write to All Heads of Finance emphasising the need for all requests for invoices to be written off to be accompanied with sufficient documentation	**Alun Williams/April 2017**

Finding 4: Reconciliations	**Risk**
Testing on a sample of monthly reconciliations to ensure that the reconciliations are completed in a timely manner, match the values in the financial ledger and are appropriately authorised noted the following: • 4 of the 20 reconciliations had a large number of outstanding transactions that relate to previous financial years (O)	Figures in the accounts may be incorrect.
Recommendation 4	**Priority level**

23.2

Management should review all reconciliations where there are a large number of outstanding transactions relating to previous financial years with a view to clearing said transactions.	**Low**
Management Response 4	**Responsible Officer/ Deadline**
Finding agreed and understood. The department has been one member of staff down for much of the year which has contributed to the situation. This vacancy is being filled from April 1st which will enable us to focus on clearing these balances.	**Richard Hurton/December 2017**

Finding 5: Oracle Access	**Risk**
Currently no review is undertaken of staff with access to oracle to determine if access and level of responsibility still required. Testing on a sample of staff leavers to determine if oracle access removed noted the following: • 8 of 15 staff access still active • 2 of 15 there had been a lengthy delay in removing staff as a user (D)	Unauthorised data may be input to the ledger
Recommendation 5	**Priority level**

23.2

Management should ensure that a review is undertaken for all staff that have access to Oracle to determine if access and associated responsibilities is still appropriate. It is noted that E-Enablement of NWSSP that have the responsibility for monitoring staff access are in communication with Health Board to discuss a way forward regarding the above.	**Medium**
Management Response 5	**Responsible Officer/ Deadline**
Discussions with the NWSSP E-enablement team have taken place to request the distribution of system administration reports on a monthly basis to managers/heads of department; so that they can review on behalf of their teams. This will commence in April 2017. In addition E-enablement will end date user accounts where users have not accessed the system for a period of 60 days or more.	**David Maddocks – April 2017**

Finding 6: PO Approval	**Risk**
Testing on a sample staff to ensure that approval levels within Oracle for Purchase Orders match the Clinical Board's Scheme of Delegation: • 2 of the 6 staff reviewed the financial limits did not match (D)	Unauthorised data may be input to the ledger.
Recommendation 6	**Priority level**

23.2

Management should ensure that a review is undertaken on the PO approval hierarchy within Oracle and cross referenced to Clinical Boards' Schemes of Delegation.	**Medium**
Management Response 6	**Responsible Officer/ Deadline**
A list of UHB authorised signatories is produced on a quarterly basis (last done January 2017) and distributed to The Heads of Finance for the Clinical Boards and the Executive departments. Accompanying the next distribution of this list will be a reminder that it is the Clinical Board/Executive Department's responsibility to ensure that approval hierarchies on Oracle reflect their current Scheme of Delegation.	**Paul Emmerson – April 2017.**

Core Financial Systems

Cardiff and Vale University Health Board

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

23.3

Dental – Medicines Management

FINAL INTERNAL AUDIT REPORT
2016/17

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

23.3

Review reference:	CUHB17.34
Report status:	Final
Fieldwork commencement:	December 2016
Fieldwork completion:	January 2017
Draft report issued:	February 2017
Management response received:	March 2017
Final report issued:	April 2017
Auditors:	Martyn Lewis, Stuart Bodman

Executive sign off:	Steve Curry, Chief Operating Officer
Distribution:	Hayley Dixon, Director of Operations - Dental Clinical Board
Committee:	Audit Committee

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

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, 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 the C&V University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The review of the management of Medicines within the Dental Clinical Board was completed in line with the Internal Audit Plan.

The relevant lead Executive for the assignment is the Chief Operating Officer.

2. Scope and Objectives

The overall objective of the review is to assess the adequacy of arrangements for the management of medicines within Dental Clinical Board in order to provide reasonable assurance to the UHB Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The scope of the review is to ensure that there are appropriate systems and processes are in place for the monitoring of the use of medicines, for reducing expenditure and ensuring appropriate use of medicines.

The main areas that the review will seek to provide assurance on are:

- There is a structure in place for Medicines Management within the Clinical Board.
- The use of medicines is subject to review within the Clinical Board.
- Plans are in place to reduce expenditure and increase efficiency of medicines use within the Clinical Board.

Five departments/clinics were sampled for testing during this review, namely;

- GA Theatres, University Dental Hospital
- Oral & Maxillofacial Surgery, University Dental Hospital
- Mountain Ash Outreach Clinic, Ysbyty Cwm Cynon
- Community Dental Service - North, Keir Hardie Health Park
- Community Dental Service - South, Sedation Suite, St. David's Hospital

3. Associated Risks

The potential risks considered in the review are as follows:

I. Patient harm due to inappropriate use of medicines.
II. Financial loss due to inadequate management of medicines.

23.3

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Medicines Management within the Dental Clinical Board is **Reasonable Assurance**.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Although there are operational processes in place for medicines management the Clinical Board does not have a formally documented structure or Group in place that oversees and coordinates the approach to Medicines Management, which leaves the process reliant on individuals. Additionally, there is no specific Clinical Board protocol for management of issues arising from medicines mismanagement.

Monthly financial information is submitted to budget holders outlining expenditure and variance analysis on drugs/medicines and any overspends, wastage or loss are actively managed and where appropriate escalated within the Clinical Board for discussion and action.

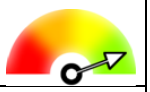
Dental Clinical Board has appropriate processes in place for the management and recording of controlled and non-controlled drugs and medicines across all departments/clinics tested. These processes also ensure the regular review of items held to ensure that expiration dates are not breached and items are disposed of in a safe and effective manner.

Testing did identify that a small number of Community Dental Service clinics undertaking regular checks on their emergency drug kits were not signing the checklist off upon completion and there are currently no local

procedures for the disposal and replacement of medicines used at any of the departments/clinics visited during the review.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Patient harm due to inappropriate use of medicines.			✓	
2	Financial loss due to inadequate management of medicines.				✓

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as weaknesses in the system control/design for the management of medicines within the Dental Clinical Board.

These are identified in the management action plan as (D).

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weakness in the operation of the designed system/control for the management of medicines within Dental Clinical Board.

These are identified in the management action plan as (O).

6. Summary of Audit Findings

Details of the key overall findings from the review that require corporate actions can be found in the Management Action Plan under Appendix A.

The main areas of good practice and significant findings noted under each objective heading are as follows:

Risk: Patient harm due to inappropriate use of medicines.

The following areas of good practice were noted:

- Management and recording of controlled drugs is undertaken in accordance with All Wales and UHB Medicines Policies.

- Issue, disposal and replacement of non-controlled drugs and medicines held at UDH and Community Dental clinics is undertaken appropriately with regular checks to ensure expiration dates are not breached.
- Emergency drugs boxes/pouches held at UDH and Community Dental clinics are subject to regular obsolescence checks and documented accordingly.

The following significant findings were noted:

- The Clinical Board does not have a formal structure supported by a group and protocol that oversees issues pertaining to the management of medicines.

Risk: Financial loss due to inadequate management of medicines.

The following areas of good practice were noted:

- Departmental/clinic budgetary reports outlining medicines expenditure are subject to regular review and wastage is being identified, reported to and acted upon at Clinical Board level.

No significant findings were noted relating to this risk.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of Recommendations	**1**	**0**	**2**	**3**

Finding 1	Risk
The Clinical Board does not have a formally documented structure and forum in place that oversees and coordinates its approach to Medicines Management. Currently this is managed at departmental level with no central oversight and issues/incidents would be reported and recorded through the UHB incident reporting process. Additionally, there is no specific Clinical Board protocol for management of issues that may arise from medicines mismanagement	Patient harm due to inappropriate use of medicines.
Recommendation 1	**Priority level**
A formal, structured approach to management of medicines should be implemented, supported by a forum that provides coordination and oversight with a protocol that underpins its operation and escalates key issues to the Clinical Board when deemed appropriate.	**High**
Management Response 1	**Responsible Officer/ Deadline**
• SOP to be developed and implemented throughout the Dental Clinical Board. • A quarterly report will be produced by the Dental Clinical Boards Finance Accountant. • Medicine Management to be added to the Q&S Agenda meetings.	Governance Manager/Dental Nurse Manager – 3 months Finance Accountant– 1 month Q&S Leads – 1 month

23.3

Finding 2	Risk
Whilst all sampled areas have documented processes in place for the review of emergency drug boxes/pouches; checklists for two clinics within CDS South (Llanishen and Ely) were not signed off by the dental nurses that undertook and recorded these checks. (O)	Patient harm due to inappropriate use of medicines.
Recommendation 2	**Priority level**
All clinics should be reminded to ensure that their emergency drug box checklists are completed and signed off by the dental nurse undertaking the review.	**Low**
Management Response 2	**Responsible Officer/ Deadline**
• Dental Nurse Manager to remind all nursing staff of the importance of signing the checklists • Checklist will be checked and compliance with signed monitored by the Senior Dental Nurse	Dental Nurse Manager - 1 month

Finding 3	Risk
None of the five sampled areas hold documented local procedures for the disposal and replacement of non-controlled drugs or medicines held/used. (O)	Patient harm due to inappropriate use of medicines.
Recommendation 3	**Priority level**
Local procedures/guidelines should be introduced to ensure that staff are conversant with processes for disposal and replacement of non-controlled drugs or medicines held/used.	**Low**
Management Response 3	**Responsible Officer/ Deadline**
• SOP to be developed and implemented throughout all areas of the Dental Clinical Board	Governance Manager/Dental Nurse Manager – 3 months

23.3

Dental – Medicines Management

Cardiff & Vale University Health Board

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Clinical Audit Follow Up

FINAL INTERNAL AUDIT REPORT 2016/17

Cardiff and Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

Clinical Audit Follow-Up

Cardiff and Vale University Health Board

CONTENTS

Error! Bookmark not defined.

Review reference:	CV17.13
Report status:	FINAL
Fieldwork commencement:	January 2017
Fieldwork completion:	March 2017
Draft report issued:	March 2017
Management response received:	March 2017
Final report issued:	March 2017
Auditor/s:	J Johns
Executive sign off :	Executive Medical Director
Distribution	Patient Safety and Quality Assurance Manager, Executive Medical Director
Committee	Audit Committee

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

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, 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 the Cardiff and Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. EXECUTIVE SUMMARY

This follow up review of Clinical Audit has been completed in line with the 2016/17 Internal Audit Plan. The review seeks to provide the Health Board with assurance that agreed actions from the previous review of Clinical Audit issued in November 2015 implemented appropriately.

The original Internal Audit report resulted in an overall assurance rating of Limited Assurance.

In following up the agreed actions the main areas that the review will seek to provide assurance on are:

- An appropriate structure is in place to ensure delivery of Clinical Audit work;
  - In the clinical audit department
  - Throughout the UHB
- Clinical Audit work is effectively planned, delivered and reported;
  - In the clinical audit department
  - Throughout the UHB
- An appropriate structure is in place to address clinical audit results.

The risk considered in the previous review was as follows:

i. The Clinical Audit Department does not deliver work aligned to the overall strategic objectives of the UHB;
ii. Clinical Audit does not effectively support quality assurance or requisite improvements;
iii. Breach of data protection / confidentiality;

Follow up work was undertaken to determine whether progress / full implementation had been made relating to the following actions from the agreed management responses:

2. CONCLUSION AND FINDINGS

The follow up review concluded that based upon discussions with relevant management, review of the evidence provided, along with the results of re-testing where appropriate, that good progress had been made with addressing agreed actions for each of the recommendations. In the case of each recommendation the actions have either been fully or partially implemented, or alternative actions have been taken forward.

As well as the progress with specifics from the recommendations additional actions have been taken forwarded to improve the Clinical Audit process, as well as looking to implement clinical audit software package to further enhance the process.

Therefore based on the findings of the follow up review the level of assurance that we are now able to provide is **REASONABLE** Assurance.

This increased assurance rating represents an improvement from the original review, with further details being given below.

The main issues highlighted through the follow up review can be summarised as follows:

- Clinical audit Leads have were issued guidance in the form of the HQIP guidance. A UHB Clinical Audit procedure is being developed and a guide on roles and responsibilities has been developed and circulated. Guidance on developing the clinical audit plan has been circulated with further targeted guidance being disseminated to clinical audit leads prior to the development of the 2017/18 clinical audit plans. There will be a further update to reflect the pending implementation of a Clinical Audit software package.

- The Clinical Audit software package is currently in the process of being developed for implementation and is designed to automate some of the clinical audit processes and allow for improved monitoring, recording and reporting of information. The software package has the potential to further improve the overall clinical audit process.

- A process was developed where by which Clinical Audit staff recorded their time for a period of time. This information was then analysed to look at the percentage of time spent on activities. This information supported the ongoing development within the audit team.

- A clinical audit plan setting out local clinical audits for each clinical board was prepared and was submitted to the Quality and Safety Committee for in April 2016. It is acknowledged that further work is still required to this process to ensure the depth and robustness of the plans and alignment to organisational priorities and risks. National audits on are added on top of this plan as they are issued later in year.

- A dashboard has been developed incorporating compliance with the national and local clinical audit and is used as the monitoring tool, to look at progress with audits, and is used to feed back to the Clinical Boards.

- A process exists for registering all clinical audit activity in the plan, although currently all audits are still not being registered through this process and further work is being undertaken to improve this.

- Improvements have been made in the reporting process for clinical audits with the central clinical audit team feeding outcomes back to the clinical boards and this information can be used to inform reporting to quality and safety meetings. Work has also been undertaken to improve the format of and information contained within the annual report.

- A proposal form is in place for local audits and these are submitted to Clinical audit team and this process allows for following up with leads if a proposal form has not been submitted.

- The clinical audit department undertake workshop sessions for staff across the UHB. These workshops cover the process and requirements for developing, delivering and reporting on clinical audits.

In terms of further action required it is recommended that the Clinical Audit team continue with the progress that has been made to ensure the further required enhancements are made.

Clinical Audit Follow-Up

Cardiff and Vale University Health Board

2016/17 Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

23.5

Leavers Management Follow Up

FIANL INTERNAL AUDIT REPORT 2016/17

Cardiff and Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

Review reference:	CV17.37
Report status:	Final
Fieldwork commencement:	February 2107
Fieldwork completion:	March 2017
Draft report issued:	March 2017
Final report issued:	April 2017
Auditor/s:	J Johns and L Jugessur
Executive sign off :	Executive Director of Workforce and Organisational Development
Distribution	Associate Director Workforce and Executive Director Workforce and Organisational Development
Committee	Audit Committee

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

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, 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 the Cardiff and Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Leavers Management Follow up

Cardiff and Vale University Health Board

1. Introduction and Scope

This follow up review of Leavers Management has been completed in line with the 2016/17 Internal Audit Plan. The review seeks to provide the Health Board with assurance that agreed actions from the previous review issued in June 2016 implemented appropriately.

The initial internal audit report highlighted a total of six recommendations which resulted in an overall assurance rating of Limited Assurance.

The purpose of the follow up review is to provide assurance that previously agreed management actions have been implemented ensuring that management are clear on their responsibilities to ensure leavers are properly recorded and removed from all UHB systems and processes.

The potential risks considered in the follow up review are as follows:

- Staff who have left the UHB still have access to UHB data, premises and processes.

Follow up work was undertaken to determine whether progress or full implementation had been made relating to the following actions from the agreed management responses.

They follow up review contained the following:

- A review of key documents and evidence to support actions taken to deliver agreed management responses.
- Test a sample of leavers across UHB to assess progress and organisational compliance.

2. CONCLUSION AND FINDINGS

The follow up review concluded that based upon discussions with relevant management, review of the evidence provided, ward and department discussions along with the results of re-testing where appropriate, that good progress had been made at a corporate level with the UHB by the Workforce Governance team across each of the recommendations.

However testing at ward and departmental level has still highlight awareness and compliance issues that will require further work to ensure an improved level of compliance with the new guidance is achieved across the organisation.

Therefore based on the findings of the follow up review the level of assurance that we are now able to provide is **REASONABLE** Assurance. 

This increased assurance rating represents an improvement from the original review, with further details bring given below.

- A "Leaver" checklist for managers had been introduced and following a trial in two directorates this was then disseminated across the UHB. The checklist was disseminated via administrator email, on CAV Web and has been placed on the Workforce and Organisational Development pages on the UHB Intranet.
- The checklist covers a range of matters for managers to consider when a member of staff leaves and includes reference to termination forms, IT access, Keys, ID badges, I.T. equipment, telecoms, uniforms and exit questionnaires.
- A leaving checklist for staff has also been developed, to highlight to staff issues for them to consider upon termination.
- The termination form now contains sections to highlight if staff had a IT NADEX user and access to ESR.
- The workforce governance team have also reiterated during the year via email and CAV Web the introduction of both checklists and also the requirement for the full and timely completion of the termination forms for payroll.
- As part of the review testing was undertaken of a sample of leavers since the checklist was introduced, with sample covering six wards and departments across the UHB.
- The outcome from the testing highlighted a mixed picture across the UHB with regards to awareness of the checklist and its usage.
- Some of the areas were aware of the checklist and had used it for the leavers in our sample; with others stating that they had become aware of it more recently. Others areas which were not aware of it were directed to the relevant sections of the intranet to review the guidance.

- The testing also highlighted inconsistencies in the areas visited with regard to the reclaiming of ID badges and the onward notification to security that the staff members had left. Guidance was being complied with in some cases but not in all, with some areas having reclaimed the badges and not informed security.

- Discussions at ward and department level indicated that formal exist interviews were not being carried out in all cases although in the majority of cases staff were being requested to complete the exist questionnaires and return to the workforce department.

In terms of further action required it is recommended that the Workforce Governance Team continue to reinforce the message for the need to manage staff leavers effectively and utilise the Leaver checklist. In addition this should also be regularly reinforced the message through the Clinical Board Workforce Teams.

2016/17 Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

23.6

Llanishen Stores Audit Follow Up

Final Report
2016/17

Cardiff and Vale UHB

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

23.6

CONTENTS Page

Please Note:

This audit brief has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, 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 the Cardiff and Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Executive Summary

This follow up review of Llanishen Stores has been completed in line with the 2016 /2017 Internal Audit Plan. The review seeks to provide the Health Board with assurance that agreed actions from the previous review of Llanishen Stores in May 2016 have been implemented appropriately.

The initial internal audit report was finalised in May 2016 and highlighted a total of eight issues which resulted in an overall assurance rating of No Assurance.

Llanishen is a joint NHS / Local Authority facility that provides a medical and care equipment rental service for users within the Cardiff and Vale area. The service operates out of two stores, these being West Point and Llanishen.

Both stores are run by the Joint Equipment Service, which is a joint enterprise between NHS and local authority, with a pooled budget and which is seen by the JES Board. The service uses council IT systems and ordering processes, with staff being a mix of both health board and council. The Llanishen site previously sat within the Council and is currently managed and ran by Council staff.

The risks considered in the previous review were as follows:

I. Stock is lost / damaged / stolen;
II. Too much stock is held resulting in inefficient use of finance;
III. Not enough stock resulting in delays to patient deliveries;
IV. Management is not aware of stock position;

Follow up work was undertaken to determine whether progress / full implementation had been made relating to the following actions from the agreed management responses:

- The JES Board will request that the JES undertake a full stock take and reset stock levels quantities to match stock level. (Finding1, High Priority)
- JES Board will request that the store manager implements a process to ensure all goods are verified prior to being disposed of. (Finding 2, High Priority)
- JES Board will recommend a discussion takes place in relation to this recommendation to ensure that there are adequate staffing levels at a senior level within the store to ensure a revised process is agreed implemented. (Finding 3, High Priority)

- JES Board will discuss and recommend that JES develops and implements an improved system for responding to requests for equipment or replacement of equipment. Also a system for closure of client files and formally writing off the system (CQUIP) (Finding 4, High Priority)
- JES Manager to confirm that audit trail is available on the JEs equipment system – Cquip. (Finding 5, Medium Priority)
- The JES Board should request that there is reconciliation between the amount that is being invoiced to West Point Stores and the amount of stock returned to Llanishen Stores. (Findings 6, Medium Priority)
- The JES Board will formerly request for the JES manager to review and agree in/max stock levels (Finding 7, Medium Priority)
- The JES Board should request that appropriate security is maintained over stock items. (Finding 8, Low Priority)

2. Conclusion and Findings

In summary, progress against the eight action contained in the management responses that required implementation were as follows;

Priority Rating	No of Management Responses to be implemented	Fully Actioned	Partially Actioned	Not Actioned
HIGH	4	4		
MEDIUM	3	3		
LOW	1	1		
TOTAL	**8**	**8**		

The follow up review concluded that based upon discussions with the relevant manager, review of the evidence provided and the results of re-testing where appropriate, that good progress has been made. Management have ensured that action has been taken against the agreed management responses in order to address the original control weaknesses identified.

Since the audit report Cardiff Council have employed a Project Manager who is responsible for ensuring that the recommendations from both UHB audit reports and their own Council audit reports are implemented. The project manager is hoping to outline to both organisations at the Strategic Leadership groups what the service is

23.6

at present and what it will look like, along with the likely expectations.

Cardiff Council are currently researching a new IT system, and have been given funding for this. At present the system has not been purchased as they are waiting to see how other organisations are using the system, with the Llanishen Stores Manager hoping to meet with these organisations to ensure that the system is fit for purpose. In addition the stores manager intends to meet with RCT to look at the new budget model that they have in place.

On the basis of this follow up, the level of assurance that could be given as to the effectiveness of the system of internal control in place to manage the risks associated with Llanishen Stores has improved to **Reasonable Assurance.**

Llanishen Stores have put controls in place to minimise the risks which were identified. The management actions completed to date can be summarised as follows:

- Stock take was carried out at the end of last year and showed that the variance was less than 10%.
- Ad hoc stock checks are carried out and authorised by the Store Manager.
- Stock adjustments are limited to the Stores Managers and the overall manager of Llanishen Stores.
- New or amended procedures have been presented to the JES board and distributed to staff members.
- A form has been introduced for items to be scrapped and is completed by the Store man, who identifies the equipment and the reason why it can no longer be used. This is then authorised by the Store Manager and updated on the system.
- Customers / district nurses have previously could come to the stores to pick up equipment but have not been asked to sign anything to confirm receipt. However, since the review, the client is asked to wait while the necessary paperwork is generated and asked to sign on receipt of the goods.
- There was previously no reconciliation between the amount that was invoiced to West Point Stores and the amount of stock returned to Llanishen. Consequently there is now regular correspondence between the stores managers in both locations who liaise about the stock items to ensure that the amount being paid is the amount they have received.

- Minimum and maximum holding levels have been introduced to the system along with new re-order levels, and these have all been reviewed to ensure they are appropriate
- CCTV has been installed at Llanishen and West Point Stores which covers all entrances / exists.

23.6

2016/17 Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

23.7

Medical Locums / Medacs Follow-Up

FINAL INTERNAL AUDIT REPORT 2016/2017

Cardiff and Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

23.7

Review reference:	CUHB1617.36
Report status:	Final
Fieldwork commencement:	20th March 2017
Fieldwork completion:	28th March 2017
Management Debrief Meeting:	28th March 2017
Draft report issued:	4th April 2017
Management response received:	10th April 2017
Final report issued:	11th April 2017

Auditor/s:	Ian Virgill, Johanna Butt
Executive sign off :	Graham Shortland, Medical Director
Distribution:	Graham Shortland, Medical Director Hilary Sharp, Senior Medical Workforce Manager
Committee:	Audit Committee

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

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, 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 the Cardiff and Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

23.7

1. EXECUTIVE SUMMARY

The follow up review of Medical Locums supplied by Medacs was completed in line with the Internal Audit Plan. The review sought to provide the Health Board with assurance that agreed actions from the previous review of Medacs Medical Locums have been implemented appropriately.

The initial internal audit report was finalised in March 2016 and highlighted a total of eight issues which resulted in an overall assurance rating of Limited Assurance.

The risks considered in the previous review were as follows:

- Inappropriate or unauthorised use of medical locums;
- Poor quality medical care provided by locums; and
- Financial loss to the UHB due to unnecessary or inappropriate expenditure on medical locums.

Follow up work was undertaken to determine whether progress/full implementation had been made relating to the following actions from the agreed management responses:

- The Wales Locum Guidance Document is currently under review by the BMA for the UHB. In addition to this Medacs and the Senior Medical Workforce Manager are writing a document that sets out who has the actual responsibility for undertaking the tasks i.e. either Medacs or the UHB as set out in the SLA and also how the process will work in the UHB in terms of monitoring approving etc.

  Medacs will issue an extension to the existing SLA until the 1st June 2017 whilst we amend the new SLA to meet the UHB requirements. Director for Medacs will meet the Medical Director on 24th March to discuss the new SLA. (Finding 1 – High Priority);
- Medacs to ensure that justification for booking is always recorded and will conduct a monthly audit to ensure compliance. Medacs will escalate any issues to the Clinical Boards (Finding 2 – Medium Priority);
- Medacs to contact Clinical Board Directors to request a list of approved personnel who are authorised to request locums and to obtain an escalation process when exceptional circumstances occur e.g. weekends, bank holidays etc (Finding 3 – Medium Priority);
- Medacs have been working with the UHB LED team to ensure that the Mandatory training undertaken via Medacs comply with the NHS Wales Mandatory training standards. All Medacs locums undertake Mandatory training, if for any reason this is not in place at the time of the locum booking then Medacs will contact the directorate to provide

23.7

an exception for the locum to work. Department specific locum induction to be arranged by the respective directorates (Finding 4 – Medium Priority);

- UHB will encourage the respective Directorates to complete the performance feedback forms and Medacs Healthcare will feedback into UHB where these are not forthcoming (Finding 5 – Medium Priority);
- Medacs Healthcare will produce monthly reporting to identify where invoices have not been submitted for hours worked (Finding 6 – Medium Priority);
- The locum process steps will identify whether a locum is paid via STAFFflow or via invoice in instances where they are not VAT efficient and so this will identify who holds the responsibility for payment and authorisation of that locum (Finding 7 – High Priority); and
- The Medical Director to raise the reporting of locum spend with the Finance Director to ensure appropriate mechanisms are in place for the Finance team to review and disseminate to appropriate groups (Finding 8 – Medium Priority).

2. CONCLUSION AND FINDINGS

In summary, progress against the eight actions contained in the management responses that required implementation was as follows;

Priority Rating	No of Management Responses to be implemented	Fully Actioned	Partially Actioned	Not Actioned
HIGH	2	-	1	1
MEDIUM	6	4	1	1
LOW	-	-	-	-
TOTAL	**8**	**4**	**2**	**2**

The follow up review concluded that based upon discussions with relevant management, review of the evidence provided and the results of re-testing where appropriate, reasonable progress has been. There are a number of agreed management actions that need to be further progressed in order to fully address the original control weaknesses identified.

On the basis of this follow up, the level of assurance that could be given as to the effectiveness of the system of internal control in place to manage the risks associated with (Medacs) Medical Locums has improved to **Reasonable Assurance**.

23.7

The Medical Workforce Department, alongside the Medacs Client Relationship Manager, have put processes in place to address a number of the issues highlighted from the original review; including the justification of locum requests, the completion of accruals for non-invoiced sessions and the submission of management information. However, further work is required to produce a policy and an up to date SLA. The issues around confirming authorising staff details, monitoring locum performance and ensuring prompt payment of invoices also require further work.

The management actions completed to date can be summarised as follows:

- The Medacs Client Relationship Manager receives an 'unspecifieds' report from the Medacs Analysts on a monthly basis. This report lists any instances on Frostnet where the reason code for locum usage is unspecified. The Medacs Client Relationship Manager contacts the relevant departments to confirm the reason for the locum and updates Frostnet as appropriate. Sample Testing of 10 locums did not identify any instances whereby the reason for locum usage was not detailed (Finding 1 – Fully Actioned);
- The Medacs Client Relationship Manager has been in communication with the Learning Education & Development Manager for the Health Board to ensure that the on-line training completed by the Locums provided by Medacs is comparable and meets the learning objectives set out in the Health Boards Induction. Review of Frostnet for 10 of the Locums sample tested confirmed that all had completed on-line induction (Finding 4 – Partially Actioned);
- The Medacs Client Relationship Manager sends an accruals report to the C&V UHB Shared Financial Information Manager on a monthly basis. The report details the hours worked by the Locums and the costs of the hours worked that have not yet been invoiced (finding 6 – Fully Actioned); and
- The Medacs Client Relationship Manager e-mails Monthly Management Information reports to both the Head of Finance and the Head of Workforce and OD for each of the Clinical Boards (Finding 8 – Fully Actioned).

The main issues highlighted through the follow up review can be summarised as follows:

- At the time of the audit the 'All Wales' Locum Guidance Document was still under review by the BMA and as such the 'Recruitment of Locum Doctors and Dentist Operational Procedure' had not been

23.7

updated. However, the Senior Medical Workforce Manager has enquire whether it would be possible to work collaboratively on a shorter more succinct local document. As the SMPM is conscious that the Wales document is taking too long to approve. The SMPM is awaiting a date to meet with the BMA in April.

An extension letter to the SLA was issued in March 2016, however, at the time of the audit the Health Board had not signed the SLA extension letter. The initial reason stated for not signing the extension was a lack of response from UHB Finance teams. More recently issues have been identified within the body of the SLA where cross references to other paragraphs are highlighted as 'Error! Reference source not found'. This is in the process of being rectified (finding 1 – Partially Actioned);

- An e-mail request was sent out by the Medacs Client Relationship Manager in March 2016 to each Clinical Board to obtain a list of approved personnel. However, only three of the Clinical Boards – (Surgery, Mental Health and Dental) responded with a list of authorised personnel. Sample Testing of 10 Locums identified that for 6 the details of who had requested the Locum was not available and was not recorded on Frostnet. The Medacs Client Relationship Manager confirmed that the name of the person verbally requesting a Locum is not recorded on Frostnet. Locum Request information was available for the other 4 Locums - all vacancies were on-going requests i.e. to cover constant shortages within departments (Finding 3 – Partially Actioned);
- At the time of the audit there was no process in place with Medacs for monitoring whether Performance feedback forms had been received for Locums. Sample testing of 10 Locums confirmed that no Performance Feedback forms had been received for any of the Locums (Finding 5 – Not Actioned); and
- Sample Testing of 12 Medacs Invoices (for 4 Non StaffFlow Locums) confirmed that only 4/12 had been authorised and paid at the time of the audit. Of the 8 invoices that had not been authorised or paid, three were from January 2017; one was from November 2016; one was from August 2016 and three were from July 2016 (Finding 7 – Not Actioned).

2016/17 Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

23.8

Mental Health Clinical Board
Continuing Health Care / Out of Area Patients (CHC / OOA)

FINAL INTERNAL AUDIT REPORT
2016/17

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

Review reference:	CUHB17.52
Report status:	Final
Fieldwork commencement:	September 2016
Fieldwork completion:	December 2016
Draft report issued:	January 2017
Management response received:	March 2017
Final report issued:	April 2017
Auditors:	Martyn Lewis, Caroline Stephens

Executive sign off: Chief Operating Officer
Distribution:
Committee: Audit Committee

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

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, 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 the C&V University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

23.8

1. Introduction and Background

In accordance with the 2016/2017 internal audit plan, a review of the management of Continuing Health care and of Out of Area Patients within Mental Health Clinical Board was undertaken and this report combines the two assignments. The OOA aspect originates from the internal audit plan and the CHC was as a result of a request from the Director of Finance.

The relevant lead Executive Director for the assignment is the Chief Operating Officer.

NHS continuing healthcare is the name given to a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital and have been assessed as having a "primary health need". Many of these placements are in non NHS settings, some of which are out of the local area. For Mental Health there is also a tranche of patients who are not CHC, but are out of area as they are subject to section 117 aftercare.

2. Scope and Objectives

The objective of the audit is to evaluate and determine the adequacy of the systems and controls in place for the management of CHC and OOA in Mental Health, in order to provide reasonable assurance to the Health Board Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review is to provide assurance that there are appropriate systems and processes in place for the assessment of CHC patients along with the commissioning of placements and approval of these, together with the commissioning of placements in out of area (non NHS facilities) to ensure the safety of, and quality of care provided to, vulnerable individuals.

The main areas that the review will seek to provide assurance on are:

- There is a formally documented procedure in place for assessment, decision making and commissioning processes for CHC and out of area placements.
- Mental Health has adequate processes in place to ensure timely appropriate commissioning of placements.
- All CHC placements are appropriately approved within the relevant timescales and are based on an appropriate assessment process.
- The UHB has adequate processes in place to ensure appropriate commissioning of placements which include joint working with other agencies.

- Contracts are in place for the provision of care, which include KPIs.
- There are appropriate processes in place for contract management.
- The quality of care provision is monitored.
- Periodic reports on out of area care and the associated costs are produced and submitted to appropriate management groups for review and action.

3. Associated Risks

The potential risks considered in the review are as follows:

I. Impact of placement delays on patient care / Poor Care Provision;
II. Financial loss due to inadequate performance management of providers;
III. Financial loss due to inadequate management of CHC process or OOA patients.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with CHC / OOA is **Reasonable Assurance**.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Overall the level of assurance given is reasonable. There is guidance in place at an All Wales, UHB and Clinical Board level for the assessment, quality assurance and approval of CHC and Out of Area placements. Testing showed that the processes were working appropriately with patients being appropriately assessed and subject to quality assurance. Whilst there were occasions where the timeliness of the process was not

compliant with standards, it was noted that more recent cases show evidence of a better process flow and timeliness.

Patients were also subject to ongoing management / contact with evidence of regular care plan reviews.

Issues were identified with non-compliance with process; with not all patients having a contract on file and a small number of patients not having care plan reviews / contact.

It was also noted that historically there was no consistent process for reviewing provider sites, however the introduction of a new framework contract now provides a mechanism to resolve this.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	*Impact of placement delays on patient care / Poor Care Provision*			✓	
2	*Financial loss due to inadequate performance management of providers*			✓	
3	*Financial loss due to inadequate management of CHC process or OOA patients.*			✓	

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as weaknesses in the system control/design for CHC / OOA.

This is identified in the management action plan as (D).

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weakness in the operation of the designed system/control for CHC / OOA.

These are identified in the management action plan as (O).

6. Summary of Audit Findings

The key findings are reported in the section below with full details in the Management Action Plan under Appendix A.

Risk: Impact of placement delays on patient care / Poor Care Provision.

The following areas of good practice were noted:

- There is a UHB protocol for CHC governance.
- There is a UHB protocol and process for quality assurance of CHC assessments.
- There is a decision support tool in place.
- There is guidance for Mental Health Clinical Board CHC process and quality assurance.
- There are draft section 117 procedures and toolkit in place.
- Process in place to provide quality assurance to CHC panel.
- A review of the commissioning process found that:
  - All were assessed by MDT for decision;
  - All had QA assessment where relevant;
  -The QAs done are rigorous, with evidence of challenge and recommendations;
  - All CHC placements were after the QA / assessment except one which was approved outside panel as an emergency;
  - All approved by right level at panel;
  - All had care plans.
- In general the new patients possibly have a better flow with assessment / quality assurance / panel / placement / agreement being appropriately timed and documented.

The following significant findings were noted:

- Testing of the commissioning and placement process indicated the following issues:
  -placements which were before panel date and were not emergencies;
  -no panel information on file;
  -placements taking over the 10 weeks stated within the guidance;
  -no contract / placement agreement on file.

- Testing of the monitoring process highlighted the following issues:
  -patients had no contract on file.
  -patients had not had a care plan review in the last 12 months.
  -There were no explicit reviews of the provider / site on file.
  -1 patient had no recent contact.

23.8

RISK: Financial loss due to inadequate performance management of providers.

The following area of good practice was noted:

- Generally, all patients have been seen recently by a C&V health professional.

The following significant finding was noted:

- As part of the new framework process all providers were reviewed and provided with an improvement plan if appropriate. However testing showed that 7 of 11 provider sites had no evidence of review for CHC and 7 of 13 for OOA.

RISK: Financial loss due to inadequate management of CHC process or OOA patients.

The following areas of good practice were noted:

- There is a new framework contract in place for non nhs placements;
- There is a clear quality assurance and approval processes in place within Mental Health.

The following significant finding was noted:

- There is no forum within Mental Health clinical board for monitoring and reporting on CHC. In addition the KPI target within the UHB report excludes Mental Health and Learning Difficulty patients. As such there is no formal monitoring of KPIs for MH CHC.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of Recommendations	**0**	**4**	**0**	**4**

Finding 1	Risk
Testing of the commissioning and placement process indicated the following issues: CHC - 5 placements were before panel date and were not emergencies; - 1 patient had no panel information on file; - 5 took over the 10 weeks stated within the guidance; - 7 had no contract / placement agreement on file. Audit notes that under the old framework the intent was to do SLAs but this wasn't always completed due to resource constraints. OOA Testing of the commissioning and placement process indicated the following issues: - 1 placement was after panel date and was not an emergency; - 5 had no contract / placement agreement on file. (O)	Impact of placement delays on patient care / Poor Care Provision.
Recommendation 1	**Priority level**
All new placements should have a placement agreement in place and be processed within the timescales required by guidance, with panel approval prior to placement.	**Medium**
Management Response 1	**Responsible Officer/ Deadline**

➢ All Nursing Home placements will continue to go to PCIC approval panel with immediate effect ➢ A new process has been established for urgent cases that are not able to wait for the next Mental Health approval CHC panel. Authorization by at least 2 clinical board members including the Director of Nursing. This is with immediate effect. ➢ For emergency CHC placement approvals placements to be signed off by the Director of Nursing with immediate effect.	Jayne Tottle – Director of Nursing Ian Wile – Director of Ops Julia West - Complex Clinical Commissioning Team Manager Fiona Bunce – Head of Finance. April 2017
Finding 2	**Risk**
Testing of the monitoring process highlighted the following issues: CHC - 11 patients had no contract on file. (this was due to being under old framework). - 1 patient had not had a care plan review in the last 12 months. - There were no explicit reviews of the provider / site on file. OOA - 5 patients had no contract on file. (this was due to being under old framework) - 2 patients had not had a care plan review in the last 12 months. - 1 patient had no recent contact. - There were no explicit reviews of the provider / site on file.	Impact of placement delays on patient care / Poor Care Provision.

(O)	
Recommendation 2	**Priority level**
MH should ensure that for all new CHC placements under the new framework, a copy of the placement agreement is held on file. All patients should have a care plan review at least every 12 months.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
➢ An electronic process has been established to ensure the Care Co-ordinator is prompted when annual review is undertaken – this has commenced. ➢ The lead manager for the CCCT team has this responsibility and is now able to be released following additional capacity within the team from June 17 onwards ➢ The all Wales commissioning framework is being extended into high relational support and for procuring nursing home placements, with an unforeseen delay in the procurement of those contracts. For new placements individual SLAs will be issued.	Jayne Tottle – Director of Nursing Ian Wile – Director of Operations Julia West – Team Leader – Complex Clinical Commissioning Team Clare Salisbury – UHB Procurement Team. April 2017
Finding 3	**Risk**

As part of the new framework process all providers were reviewed and provided with an improvement plan if appropriate. However testing showed that 7 of 11 provider sites had no evidence of review for CHC and 7 o f13 for OOA. (O)	Impact of placement delays on patient care / Poor Care Provision.
Recommendation 3	**Priority level**
All provider sites should be reviewed to ensure the site can provide appropriate, safe care.	**Medium**
Management Response 3	**Responsible Officer/ Deadline**
➢ The national procurement team currently hold the improvement plans issued for all providers on the NHS Wales National Framework. ➢ For all other placement sites, the Local CCCTeam will undertake annual monitoring visits to the sites. Any concerns are escalated to the MHCB. Thus is with immediate effect.	Shane Mills – Head of National Procurement team Jayne Tottle – Director of Nursing Ian Wile – Director of Operations Julia West – Team Leader – Complex Clinical Commissioning Team April 2017

23.8

Finding 4	Risk
There is no forum within Mental Health clinical board for monitoring and reporting on CHC. In addition the kpi target within the UHB report excludes Mental Health and Learning Difficulty patients. As such there is no formal monitoring of KPIs for MH CHC. (D)	Financial loss due to inadequate management of CHC process or OOA patients.
Recommendation 4	**Priority level**
Mental Health should ensure that an appropriate monitoring / oversight process is developed for MH CHC. This should include KPIs and feed into the UHB process.	**Medium**
Management Response 4	**Responsible Officer/ Deadline**
➢ Mental Health Clinical Board to establish a Clinical Commissioning Team performance meeting to monitor, care plan compliance under part 2 of the mental health measure, care coordinator annual reviews, DTOCs in placement, placement contract reviews & medium secure step downs awaiting. First meeting in April 2017	Jayne Tottle – Director of Nursing Ian Wile – Director of Operations Julia West – Complex Clinical Commissioning Team Leader. April 2017

23.8

Mental Health CB – CHC / OOA

Cardiff & Vale University Health Board

23.8

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Type	Practice Code	LHB	Head of Practice	Practice Address	Visit Type	Visit Year	Visit Date	
GMS	W97049	CDF	M Thomas (O'Sullivan)	Llanrumney Medical Group	Routine	2017/2018	Jun-17	Q1
GMS	W97007	CDF	D Cocks (J Foy)	Cloughmore Medical Centre	Routine	2017/2018	May-17	Q1
GMS	W97291	CDF	KP Saunders	Butetown Medical Practice	Extended - Minor Surgery	2017/2018	Jun-17	Q1
GMS	W97069	CDF	A Disley	Willowbrook Surgery	Routine	2017/2018	Jul-17	Q2
GMS	W97044	CDF	M A Naseem	Cardiff Bay Surgery	Routine	2017/2018	Aug-17	Q2
GMS	W97002	CDF	A Dearden (SK Kamath)	Roathwell Surgery	Extended - Minor Surgery, Wound Care, NPT & MMR	2017/2018	May-17	
GMS	W97009	CDF	NK Brown	Cathays Surgery	Routine	2017/2018	Sep-17	
GMS	W97013	CDF	DR Jenkins (EH Williams)	Llanishen Court Surgery	Routine	2017/2018	Oct-17	
GMS	W97036	CDF	A Davies (P Matthews)	Danescourt Surgery	Routine	2017/2018	Sep-17	
GMS	W97025	CDF	E Wiltshire (DE Ward)	Whitchurch Road Surgery	Routine	2017/2018	Feb-18	
GMS	W97028	CDF	G Lewis	Bishops Road Medical Centre	Routine	2017/2018	Mar-18	
GMS	W97029	CDF	AC Jones (S Short)	Saltmead Medical Centre	Routine	2017/2018	Nov-17	
GMS	W97034	CDF	J Westlake (L Jones-Tapper)	Roath House Surgery	Routine	2017/2018	Jul-17	
GMS	W97061	CDF	S Sinha (SG Lush)	Grange Medical Practice	Routine	2017/2018	Nov-17	
GMS	W97017	CDF	J Lewis (SM Wood)	Westway Surgery	Routine	2017/2018	Aug-17	
GMS	W97616	CDF	R Tiwari	Grangetown Health Centre	Routine	2017/2018	Apr-17	
GOS	371	CDF	Eye Centre	Llanrumney	Routine	2017/2018	Jul-17	Q2
GOS	352	CDF	Specsavers	Queen Street	Routine	2017/2018	May-17	
GOS	582	CDF	Specsavers	Llanishen	Routine	2017/2018	Jun-17	
GOS	573	CDF	Costco	Leckwith Rd	Routine	2017/2018	Aug-17	
GOS	515	CDF	Pearce & Buckmaster (Eyecare at St Davids)	St Davids	Routine	2017/2018	Aug-17	
GOS	326	CDF	S Greenberg	Llandaff	Routine	2017/2018	Sep-17	
GOS	468	CDF	Optimise Opticians	Gabalfa	Routine	2017/2018	Oct-17	
GOS	343	CDF	Parish Opticians	Birchgrove	Routine	2017/2018	Nov-17	
GOS	348	CDF	R N Roberts	Gabalfa	Routine	2017/2018	Feb-18	
GOS	513	CDF	Soulsby Opticians	Llanishen	Routine	2017/2018	Feb-18	
GOS	393	CDF	S Greenberg	Whitchurch	Routine	2017/2018	Mar-18	
GOS	424	CDF	Asda Opticians	Coryton	Routine	2017/2018	Dec-17	
GOS	420	CDF	Optical Health Limited	Cathedral Road	Routine	2017/2018	Jul-17	
GOS	437	CDF	Specsavers	Roath	Routine	2017/2018	Mar-18	
GOS	479	CDF	JR Lane	Llandaff North	Routine	2017/2018	Jun-17	
GOS	501	CDF	Darlingtons	Canton	Routine	2017/2018	Feb-18	
GOS	504	CDF	Direct Eyecare (Value Vision)	Splott	Routine	2017/2018	Sep-17	
GOS	500	CDF	Darlingtons	Grangetown	Routine	2017/2018	Jan-18	
GPS	602807B	CDF	Lloyds Pharmacy	Rhiwbina	Routine	2017/2018	Apr-17	
GPS	602853H	CDF	Well Pharmacy	Rhiwbina	Routine	2017/2018	Apr-17	
GPS	602545L	CDF	M W Phillips	Splott Road	Routine	2017/2018	Aug-17	
GPS	602816M	CDF	Boots UK Ltd	36 Queens Street	Routine	2017/2018	Aug-17	
GPS	602807K	CDF	Lloyds Pharmacy	Merthyr Road	Routine	2017/2018	Sep-17	
GPS	602870M	CDF	Tesco Stores Ltd	Western Avenue	Routine	2017/2018	Sep-17	
GPS	602807C	CDF	Lloyds Pharmacy	Park Road	Routine	2017/2018	May-17	
GPS	602806F	CDF	Asda Pharmacy	Coryton	Routine	2017/2018	May-17	
GPS	602806A	CDF	Asda Pharmacy	Pontprennau	Routine	2017/2018	Jan-18	
GPS	602816K	CDF	Boots UK Ltd	Countisbury Avenue	Routine	2017/2018	Jan-18	
GPS	602139B	CDF	Clifton Pharmacy	Clifton Street	Routine	2017/2018	Jul-17	

Month	Amount of visits
Apr-17	8
May-17	8
Jun-17	8
Jul-17	8
Aug-17	8
Sep-17	8
Oct-17	5
Nov-17	6
Dec-17	5
Jan-18	6
Feb-18	8
Mar-18	4

Type	Practice Code	LHB	Head of Practice	Practice Address	Visit Type	Visit Year	Visit Date
GPS	602856L	CDF	Well Pharmacy	Upper Clifton Street	Routine	2017/2018	Jul-17
GPS	602816H	CDF	Boots UK Ltd	Albany Road	Routine	2017/2018	May-17
GPS	602004B	CDF	Central Pharmacy (Aggarwal)	Wellfield Road	Routine	2017/2018	May-17
GPS	602807B	CDF	Lloyds Pharmacy	Rhiwbina	Routine	2017/2018	Jan-18
GPS	602853E	CDF	Well Pharmacy	Pentwyn	Routine	2017/2018	Jan-18
GPS	602030A	CDF	G S Bhogal Pharmacy	Barmouth Road	Routine	2017/2018	Oct-17
GPS	602807J	CDF	Lloyds Pharmacy	Ball Road	Routine	2017/2018	Oct-17
GPS	602807D	CDF	Lloyds Pharmacy	St Mellons	Routine	2017/2018	Feb-18
GPS	602856N	CDF	Well Pharmacy	Wentloog Road	Routine	2017/2018	Feb-18
GPS	602816J	CDF	Boots UK Ltd	213-215 Cowbridge Road	Routine	2017/2018	Jun-17
GPS	602855M	CDF	Well Pharmacy	Bute Street	Routine	2017/2018	Jun-17
GPS	602597A	CDF	North Road Pharmacy	North Road	Routine	2017/2018	Feb-18
GPS	602852H	CDF	Well Pharmacy	180 City Road	Routine	2017/2018	Feb-18
GPS	602870D	CDF	Tesco Stores Ltd	Culverhouse Cross	Routine	2017/2018	Jun-17
GPS	602818G	CDF	Boots UK Ltd	Cardiff Bay	Routine	2017/2018	Jun-17
GMS	W97003	VOG	MC Davies (PRW Lewis)	Redlands Surgery	Routine	2017/2018	Jul-17
GMS	W97614	VOG	A Baig	Vale Family Practice	Routine	2017/2018	Apr-17
GMS	W97055	VOG	A Cherry/S Thomas	Dinas Powys Medical Centre	Routine	2017/2018	Dec-17
GMS	W97046	VOG	B Roper	Ravenscourt Surgery	Routine	2017/2018	Apr-17
GMS	W97001	VOG	SK Holgate	West Quay Medical Centre	Routine	2017/2018	Mar-18
GMS	W97045	VOG	GJ Crimmins	Eryl Surgery	Routine	2017/2018	Jan-18
GOS	545	VOG	Asda Opticians	Barry	Routine	2017/2018	Jul-17
GOS	418	VOG	Specsavers	Barry	Routine	2017/2018	Apr-17
GOS	401	VOG	Chris Williams	Llantwit Major	Routine	2017/2018	Oct-17
GOS	300	VOG	Arbuthnot Opticians	Barry	Routine	2017/2018	May-17
GOS	398	VOG	D O'Sullivan	Barry	Routine	2017/2018	Dec-17
GOS	448	VOG	Nina Davies	Llantwit Major	Routine	2017/2018	Nov-17
GPS	602816I	VOG	Boots UK Ltd	121-125 Holton Road	Routine	2017/2018	Nov-17
GPS	602850E	VOG	Lloyds Pharmacy	99-101 Holton Road	Routine	2017/2018	Nov-17
GPS	602816L	VOG	Boots UK Ltd	Penarth	Routine	2017/2018	Apr-17
GPS	602422C	VOG	Mayberry Pharmacy	Penarth	Routine	2017/2018	Apr-17
GPS	602807E	VOG	Lloyds Pharmacy	Stirling Road	Routine	2017/2018	Aug-17
GPS	602755C	VOG	Sylvia Williams Chemist	Cowbridge	Routine	2017/2018	Aug-17
GPS	602808G	VOG	Lloyds Pharmacy	Court Road	Routine	2017/2018	Sep-17
GPS	602381B	VOG	TH & L Jones	Dinas Powys	Routine	2017/2018	Sep-17
GPS	602123A	VOG	Washington Pharmacy	Penarth	Routine	2017/2018	Dec-17
GPS	602514C	VOG	Pearns Pharmacy	Penarth	Routine	2017/2018	Dec-17

Type	Practice Code	LHB	Head of Practice	Practice Address	Visit Type	Visit Year	Visit Date	
GMS	W97047	CDF	M Harrison	Fairwater	Revisit	2017/2018	Aug-17	
GMS	W97057	VOG	S Thomas	Penarth	Revisit	2017/2018	Dec-17	
GOS	355	CDF	Cardiff Uni Eye Clinic	Cardiff	Revisit	2017/2018	Apr-17	
GOS	349	CDF	R N Roberts	Whitchurch	Revisit	2017/2018	Nov-17	
GOS	472	CDF	Radyr Eyecare	Radyr	Revisit	2017/2018	Sep-17	
GOS	333	CDF	Page Hughes	Rumney	Revisit	2017/2018	Dec-17	Practice closed - PPV can't attend
GOS	353	CDF	Specs 4 Less	Central	Revisit	2017/2018	Jan-18	
GOS	336	VOG	RE Lloyd	Cowbridge	Revisit	2017/2018	Jun-17	brought forward due to potential closure
GOS	471	VOG	Specsavers	Penarth	Revisit	2017/2018	May-17	
GOS	316	VOG	Osmond Drake	Penarth	Revisit	2017/2018	Jan-18	

24