Bundle Audit and Assurance Committee 30 September 2019

Agenda attachments

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John Union

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John Union

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John Union

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5 Action log following meetings held on 23 and 30 May 2019
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John Union

7 ITEMS FOR REVIEW AND ASSURANCE

7.1 Brexit Update
Abigail Harris

7.2 Internal Audit Progress and Tracking Report
Ian Virgill
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7.3 Wales Audit Office progress Report
Wales Audit Office
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7.5 Wales Audit Office Report - Clinical Coding
David Thomas
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7.6 Post Payment Verification Report
Scott Lavendar
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7.7 Wales Audit Office Tracking Report
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7.8 Internal Audit Tracking Report
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7.9 Regulatory Bodies Tracking Report
Nicola Foreman
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7.10 Declarations of Interest Report

Nicola Foreman

7.10 - Declarations of Interest, Gifts, Hospitality & Sponsorship - Report for Audit & Assurance 30.09.docx

8 ITEMS FOR APPROVAL / RATIFICATION

8.1 No items to report

9 ITEMS FOR NOTING AND INFORMATION

9.1 Internal Audit Reports

Ian Virgill

9.1.1 MHRA Compliance

9.1.1 - CUHB1819.22 MHRA Compliance Final report.pdf

9.1.2 E-Advice Project

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9.1.3 UHB Transformation Process

9.1.3 - CV1819.12 UHB Transformation Final Report.pdf

9.1.4 Standards of Behaviour Follow-up

9.1.4 - CUHB1920.06 Standards of Business Conduct Follow-up Final.pdf

9.1.5 Annual Quality Statement

9.1.5 - CUHB1920.19 AQS Final report.pdf

9.1.6 Carbon Reduction Commitment

9.1.6 - CUHB1920.45 CRC Final report.pdf

9.1.7 Mental Health Clinical Board - Sickness Management Follow up

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9.1.8 Sustainability Reporting

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9.1.9 Specialist Clinical Board - Rosterpro

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9.1.10 Legislative / Regulatory Compliance Follow up

9.1.10 - CUHB1920.05 Legislative Compliance Follow-Up Final.pdf

10 Items to bring to the attention of the Board / Committee

11 REVIEW OF THE MEETING

12 To note the date, time and venue of the next Committee meeting:

Tuesday, 3 December 2019 at 9.00am
Coed y Bwl Room, Ground Floor, Woodland House, Heath Cardiff, CF14 4HH

AUDIT AND ASSURANCE COMMITTEE

Monday, 30 September 2019 at 9.00am
Coed y Bwl, Ground Floor
Woodland House, Maes y Coed Road,
Heath, Cardiff, CF14 4HH

AGENDA

1.	Welcome & Introductions	John Union
2.	Apologies for Absence	John Union
3.	Declarations of Interest	John Union
4.	Minutes of the Committee Meeting held on 23 and 30 May 2019	John Union
5.	Action Log – 23 and 30 May 2019	John Union
6.	Chairs Action taken since last meeting	John Union
7.	**Items for Review and Assurance**	
7.1	Brexit Update	Abigail Harris
7.2	Internal Audit Progress and Tracking Report	Ian Virgill
7.3	Wales Audit Office Progress Report	WAO
7.4	Audit of Financial Statements report addendum – Recommendations	WAO
7.5	Wales Audit Office Report – Clinical Coding	David Thomas
7.6	Post Payment Verification Report	Scott Lavendar
7.7	Wales Audit Office Tracking Report	Nicola Foreman
7.8	Internal Audit Tracking Report	Nicola Foreman
7.9	Regulatory Bodies Tracking Report	Nicola Foreman
7.10	Declarations of Interest Report	Nicola Foreman
7.11	Clinical Audit Progress Reports	Stuart Walker
8.	**Items for Approval/Ratification**	
8.1	No items to report	
9	**Items for Noting and Information**	
9.1	**Internal Audit Reports** **Assignment** — **Assurance Rating** 1. Annual Quality Statement — Substantial 2. MH CB Sickness Management Follow up — Reasonable 3. Sustainability Reporting — Reasonable 4. Carbon Reduction Commitment — Substantial 5. Standards of Behaviour (DoI & G&H) Follow up — Substantial 6. Specialist CB Rosterpro — Reasonable 7. Legislative / Regulatory Compliance Follow up — Reasonable 8. MHRA Compliance — Reasonable 9. E-Advice Project — Reasonable 10. UHB Transformation Process — Reasonable	Ian Virgill

10	**Items to bring to the attention of the Board/Committee**	
11	**Review of the Meeting**	
12	**Date and time of Committee meeting:** Tuesday, 3 December 2019, at 9.00am Coed y Bwl Room, Ground Floor, Woodland House, Heath, Cardiff CF14 4HH	

UNCONFIRMED MINUTES OF THE AUDIT AND ASSURANCE COMMITTEE HELD ON 23 MAY 2019
EXECUTIVE MEETING ROOM, WOODLANDS HOUSE

Present:

John Union	Chair – Audit & Assurance Committee
Dawn Ward	Independent Member, Trade Union

In Attendance:

Robert Chadwick	Executive Director of Finance
Simon Cookson	Director of Audit and Assurance, NWSSP
Nicola Foreman	Director of Corporate Governance
Sharon Hopkins	Deputy Chief Executive/Director of Transformation and Informatics (for Cyber Security item)
Richard Hurton	Assistant Director of Finance
Mark Jones	Wales Audit Office
Christopher Lewis	Deputy Director of Finance
Mike Usher	Wales Audit Office
Ian Virgil	Deputy Head of Internal Audit

Secretariat:

Glynis Mulford	Corporate Governance Officer

Apologies:

Eileen Brandreth	Independent Member - ICT
Craig Greenstock	Counter Fraud Manager
Charles Janczewski	UHB Vice Chair

AC: 19/05/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting and confirmed that it was quorate.	**ACTION**
AC: 19/05/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
AC: 19/05/003	**DECLARATIONS OF INTEREST** There were no declarations of interest made.	
AC: 19/05/004	**UNCONFIRMED MINUTES OF THE MEETING HELD ON 23 APRIL 2019** The Committee reviewed the Minutes of the meeting held on 23 April 2019.	

	The Committee Resolved that: a) the minutes of the meeting held on 23 April 2019 be approved as a true and accurate record.	
AC: 19/05/005	**COMMITTEE ACTION LOG** The Committee reviewed the action log and noted the following: • **AC 19/04/012: Tracking Report from Recommendations from Regulatory Bodies:** The log had been viewed at a meeting of Management Executives. Another session would be held with the executive team and rolled out thereafter. • **AC 19/04/011: Declarations of Interest and Gifts of Hospitality:** work was ongoing to implement the recommendations made by Internal Audit and the Standards of Behaviour audit would be subject to re-audit in a couple of months. • **AC18/071: Wales Audit Report on Medical Equipment:** An update would be brought to the September meeting. • **AC 19/02/019: Limited Assurance Report on Medicine Clinical Board Internal Medicine Follow-up:** As the Interim Medical Director was on annual leave a report would be brought back to the Committee in September 2019. **The Committee resolved that:** a) the action log be noted.	NF IA FJ PD
AC: 19/05/006	**CHAIR'S ACTION TAKEN SINCE LAST MEETING** It was confirmed that there had been no Chair's Action taken since the last meeting.	
AC: 19/05/007	**INTERNAL AUDIT PROGRESS REPORT** The Interim Head of Internal Audit provided the Committee with an update on progress against the Internal Audit plan for 2018/19. It was confirmed that: • six audits had been finalised since the Committee's last meeting and a further three audits had reached draft	

	report stage. • Finalisation of four of the audits had been delayed. It was confirmed that these reports would now come to the September meeting. • The start of the review of *Performance Reporting Data Quality – RTT* had been delayed due to issues with audit resources. It was noted that this review would be moved to next year's plan. ***Cyber Security – Limited Assurance*:** The Interim Head of Internal Audit introduced the report on Cyber Security and advised that the review had resulted in a '*limited assurance*' rating. The following was highlighted: • in October 2017, Stratia Consulting were commissioned by Velindre Trust, on behalf of NHS Wales, to carry out external cyber security assessments for its organisations. For each organisation, a cyber-security assessment report and security improvement plan (SIP) was produced. • the review focused on the governance and visibility of the Stratia assessment report and SIP. • in the main the actions contained within the Stratia report had not been progressed; leading to vulnerabilities not being addressed, in particular related to the use of old software and patching delays. This together with the lack of any active monitoring or vulnerability scanning meant that the UHB was potentially unaware of its security position. The Committee Chair thanked the Deputy Chief Executive/Director of Transformation and Informatics for attending the meeting. In presenting the response to the report the Deputy Chief Executive/Director of Transformation and Informatics: • acknowledged that the report was not an easy read and confirmed that there had been discussions at a committee level for some time regarding the work which was needed. • confirmed that significant restructuring within the IT department was ongoing. The consultation on the restructure would run for three weeks and recruitment to new posts would start in July 2019. It was noted that funding had been received from Welsh Government to	IA IA

	support the Cyber agenda. • confirmed that interim work was being undertaken to address some of the issues while recruitment was being taken forward. • advised that some of the equipment and software needed to improve the management of security incidents and to scan for vulnerabilities was being introduced. • noted that the team currently managing Cyber security had advised that the risks were not as acute as previously considered. It was confirmed that an internal review completed in relation to the software and hardware used in relation to patching, had helped to prioritise action. • reported that incidents were responded to in a timely manner, but acknowledged that there were issues to be addressed. • confirmed that preliminary work had been undertaken to ensure the UHB was safe and the UHB's IT and IG departments were working well with NWIS and other Health Boards. • highlighted that the cyber security issues were not unique to Cardiff and Vale UHB. It was confirmed that discussions regarding priorities were taking place at an all Wales level. • Advised that time was needed to allow the additional resources to be put in place and the action plan to be delivered. It was noted that the Cyber industry was a young one and individuals with the required knowledge and technical expertise were sought after and other Health Boards were recruiting to the same roles. As part of discussions in relation to this point it was suggested that the UHB link with Cardiff University's IT department. • emphasised that recruitment commenced in July 2019 and work would commence in September 2019. The Interim Head of internal Audit confirmed that a 'follow-up' review would take place in 2019/20. **The Committee Resolved that:** a) the Internal Audit Progress Report be noted.	IA

AC: 19/05/008	**REPORT OF THE LOSSES AND SPECIAL PAYMENTS PANEL** The Deputy Director of Finance introduced the report and noted that: • the Losses and Special Payments Panel met twice in 2018/19 to review items that that fell into the categories of a loss or special payment. • the assessment section of the report prepared for the Committee set out the items that were being recommended to the Committee for write off. It was confirmed as part of these discussions that: - the UHB's clinical negligence costs in 2018/19 were lower than in the previous year. - the obsolete or lost/damaged stock figure had increased in 2018/19, the main factor was the need to write off clinical monitoring equipment used across the UHB as the manufacturer had stopped supporting the software used. **The Committee Resolved that:** a) the report of the Losses and Special Payment Panel be noted b) the write offs outlined in the assessments section of the Report be approved.	
AC: 19/05/009	**ITEMS FOR INFORMATION** The Committee received the following Internal Audit reports for information: • Strategic Planning and IMTP • Core Financial Systems • Estates Statutory Compliance • Water • Health and Care Standards It was noted that the reports on E-Advice, UHB Transformation and MHRA compliance had not been finalised in time for the meeting. These audits had been given a 'reasonable assurance' rating and would be presented at the September meeting of the Committee.	IA

	The Committee Resolved that: a) the reports provided for information be noted. b) The 2018/19 internal audit reports still to be finalised would be considered at the September meeting of the Committee.	IA
AC: 19/05/010	**ITEMS TO BE REFERRED TO THE BOARD OR A COMMITTEE** The Committee agreed that there were no items to be referred to the Board or one of its Committees. It was noted that a summary of the meeting would be provided in the Chair's report to Board.	
AC: 19/05/011	**URGENT BUSINESS** There was no other urgent business.	
AC: 19/05/012	**DATE OF THE NEXT MEETING OF THE COMMITTEE** It was confirmed that the next Audit and Assurance Committee meeting was scheduled to take place at 9.00am on Tuesday, 30 May 2019, Executive Meeting Room, Woodland House, Heath, Cardiff CF14 4TT	

UNCONFIRMED MINUTES OF THE AUDIT AND ASSURANCE COMMITTEE HELD ON 30 MAY 2019
EXECUTIVE MEETING ROOM, WOODLAND HOUSE

Present:

John Union	Chair – Audit and Assurance Committee
Eileen Brandreth	Independent Member, ICT
Charles Janczewski	UHB Vice Chair
Dawn Ward	Independent Member, Trade Union

In Attendance:

Robert Chadwick	Executive Director of Finance
Nicola Foreman	Director of Corporate Governance
Craig Greenstock	Counterfraud Manager
Richard Hurton	Assistant Finance Director
Mark Jones	Wales Audit Office
Christopher Lewis	Deputy Director of Finance
Mike Usher	Wales Audit Office
Ian Virgil	Deputy Head of Internal Audit

Secretariat:

Glynis Mulford	Corporate Governance Officer

AC: 19/05/013	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting and confirmed it was quorate.	**ACTION**
AC: 19/05/014	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
AC: 19/05/015	**DECLARATIONS OF INTEREST** There were no declarations of interest made.	
AC: 19/05/016	**THE COUNTER FRAUD ANNUAL REPORT FOR 2018/19** The UHB's Counter Fraud Manager provided the Committee with an overview of the Counter Fraud Annual Report and highlighted: • during 2018/19 there had been 31 new investigations. Three cases were with the Crown Prosecution Service (CPS) awaiting a decision regarding next steps.	

	• the outcome of an industrial tribunal case had resulted in the recovery of £9,300. This amount may not meet the full cost of investigation but action was a deterrent as it demonstrated that the UHB would take action. • 22 fraud awareness sessions were delivered during the year to over 450 staff. • the Counter Fraud team was required to undertake an annual self-assessment of its capacity and capability against a set of criteria and standards set by the NHS Counter Fraud Authority. This self-assessment was submitted to the NHS Counter Fraud Authority in May 2019, following ratification by the Chair of the Audit and Assurance Committee and sign-off by the Executive Director of Finance. • the Counter Fraud Policy would be reviewed during 2019-20, to ensure compliance with the GDPR Regulation. • a Medical Induction Programme had been implemented. and a staff newsletter and video was available on the intranet. • the CPS had decided not to prosecute in three cases referred to it by the Counter Fraud team for consideration. A key factor contributing to the decision not to prosecute had been the lack of robust job plans. As part of discussions in relation to this point Committee Members asked that the reasons behind decisions not to prosecute be set out in future reports. The Committee also raised concerns in relation to the status of jobs plans and it was suggested that consideration be given to introducing an approach that meant that job plans were agreed and signed-off as part of the PADR process. • the 'follow-up' internal audit review of Job Planning had been deferred to 2019/2020. Committee Members stressed the importance of the Management Executive Team ensuring that the findings and recommendations set out in the original Job Planning Internal Audit Report were addressed, and asked that the report be taken to the Management Executive for further consideration. • staffing issues had occurred within the Counter Fraud team and one team member had moved to the regional team; this post was recruited to in February 2019. It was noted that the band 4 post had been advertised and the team would be back to full strength by July. The new	CG PD/NF

	member of staff would arrange fraud awareness sessions. The Committee asked if the UHB was receiving value for money from the Counter Fraud Service and queried whether the teams staffing and allocated days were adequate. In response it was confirmed that once the Band 4 post had been filled, the staff numbers would be would sufficient to deliver planned work but the number of referrals which could impact on staffing was unknown. It was confirmed that the regional team provided support where they could. **The Committee resolved that**: • the Counter Fraud Annual Report be noted.	
AC: 19/05/017	**A REPORT ON THE ANNUAL ACCOUNTS OF THE UHB 2018/19** The Deputy Director of Finance provided the Committee with an overview of the 2018/19 Annual Accounts. It was confirmed that the Audit and Assurance Committee's role was to review the Accounts and associated documentation and make a recommendation to the Board in relation to their approval. The following points were noted: • the draft accounts, Accountability Report and associated documentation had been reviewed in detail at the Workshop held on 23 May 2019. It was noted that the changes recommended by the Committee were highlighted in the report of the Workshop and confirmed that the Financial Performance Report remained the same as that considered by the Committee on 23 May 2019. • there were two breaches during 2018-19; the £65.968 million revenue overspend; and the lack of an integrated medium-term plan (IMTP) for 2018-19 to 2020-21 that the Welsh Government had approved. • in relation to the Capital Resource Limit the UHB broke even over the three year period and met its financial duties. • the work undertaken by the Audit and Assurance Committee throughout the year and the Annual Report of the Interim Head of Internal Audit supported the content of the Annual Accountability Statement. • one recommendation had been omitted from the report circulated to the Committee, and so the report would be	

	updated and Website with an additional recommendation. **The Committee resolved that:** a) the reported financial performance contained within the Annual Accounts and the fact that the UHB had breached its statutory financial duties in respect of revenue expenditure be noted. b) the changes made to the Draft Annual Accounts be noted; c) the ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation, the response to the audit enquiries to those charged with governance and management be noted; d) the Annual Accountability Report for 2018/19 including the Annual Accounts and financial statements be recommended to the Board for approval.	
AC: 19/05/018	**WALES AUDIT OFFICE (WAO) ISA 260 REPORT** Mark Jones, WAO presented the ISA 260 report, highlighting that: • The report reflected how well the audit had proceeded and there had been excellent engagement with staff across the UHB. • the accounts were provided with an unqualified opinion. • a qualified opinion had been issued in respect of regularity because the UHB had breached its revenue resource-limit by spending £65.968 million over its authorised limit of £2,693 million for the three-year period 2016-17 to 2018-19. • no material weakness in internal controls were identified, however some weaknesses had been identified and these would be reported separately. • following audit certification by the Auditor General a separate report setting out the UHB's actions against last year's recommendations; audit observations and recommendations from this year's audit, together with senior officers' responses and intended actions would be provided to the Committee. • The Letter of Representation would be signed by the UHB Chair and CEO after the Board meeting scheduled	WAO

	for 30 May 2019. The Executive Director of Finance confirmed that a workshop would be held to discuss the uncorrected misstatements and explore how such misstatements could be avoided going forward. Mike Usher noted that it had been his first year as the WAO's Engagement Lead for the UHB and confirmed that he had been impressed with the quality of the draft accounts and the way the finance team worked with the WAO. It was confirmed that the Auditor General would sign the Audit Certificate on 11 June 2019 and it would be laid before the National Assembly on 12 June. Committee Members were pleased to note the positive way in which the UHB's finance staff had worked with the WAO's audit team to finalise the 2018-19 accounts. **The Committee Resolved that:** a) the WAO ISA 260 Report be noted.	
AC: 19/05/019	**THE HEAD OF INTERNAL AUDIT ANNUAL REPORT 2018/19** The Interim Head of Internal Audit presented the Head of Internal Audit's Annual Report and noted that: • no changes had been made to the content of the report since it was discussed at the Committee workshop held on 23 May 2019. • the overall opinion was positive and for 2018/19 a 'reasonable assurance' rating had been confirmed. • seven out of 45 audits undertaken had resulted in a limited assurance report. • the Committee had agreed to defer nine audits from 2018/19 to 2019/20. • where reports related to 'follow-up' work the updates from these were not taken into account when formulating the overall Head of Internal Audit opinion. The Committee Chair advised that a focused piece of work in relation to Job Planning was needed by the Management Executive to ensure that all recommendations were dealt with appropriately and in a timely manner. Committee Members asked whether any Health Boards had	IA

	achieved an end of year opinion of 'substantial assurance'. Members noted their concern that given the complexity and size of the UHB a 'substantial assurance' rating would never be achieved. In response, the Interim Head of Internal Audit advised that the Annual Internal Audit Plan was risk based and so it was inevitable that some audits would result in a 'limited assurance' rating. *[The meeting Interrupted by a fire alarm at 11.00am – Mike Usher left the meeting at this time]* *[the meeting reconvened]* **The Committee resolved that:** a) the Annual Report of the Head of Internal Audit be noted.	
AC: 19/05/020	**THE LETTER OF REPRESENTATION; RESPONSE TO THE AUDIT ENQUIRIES TO THOSE CHARGED WITH GOVERNANCE AND MANAGEMENT AND THE ANNUAL ACCOUNTABILITY REPORT INCLUDING THE FINANCIAL STATEMENTS.** The Committee reviewed and discussed the following documents: • the Letter of Representation included within the ISA 260 Report; • the Response to the audit enquiries and those charged with governance and management; and • the Annual Accountability Report including the Financial Statements. It was confirmed that these documents had been previously considered at the Workshop held on 23 May 2019, where Committee Members had provided feedback. Those involved in their preparation were commended for their hard work. **The Committee resolved that**: a) it be recommend that the Board agree and endorse the ISA 260, the Annual Report of the Head of Internal Audit, the Letter of Representation and responses of those charged with governance and management	

	b) it be recommend to the Board that it approve the Annual Accountability Report for 2018-19, including the Annual Accounts and Financial Statements	
AC: 19/05/021	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD** It was agreed that at the Board meeting scheduled for the afternoon of 30 May 2019, the Committee Chair would, on behalf of the Audit and Assurance Committee, recommend that the Board: ▪ agree and endorse the ISA 260, the Annual Report of the Head of Internal Audit; the Letter of Representation and the responses of those charged with governance and management ▪ approve the Annual Accountability Report of 2018-19 including the Annual Accounts and Financial Statements	
AC: 19/05/022	**DATE OF THE NEXT MEETING OF THE COMMITTEE** It was confirmed that the next Audit and Assurance Committee meeting was scheduled to take place at 9.00am on Tuesday, 30 May 2019, Executive Meeting Room, Woodland House, Heath, Cardiff CF14 4TT	

ACTION LOG
FOLLOWING AUDIT COMMITTEE MEETINGS
23 & 30 MAY 2019

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	|STATUS/COMMENTS
Completed Actions					
AC 19/05/016	Counter Fraud Annual Report for 2018/19	For decisions not to prosecute to be set out in future reports For the follow-up internal audit review on Job Planning which had been deferred to the 2019/20 plan to be considered at Management Executive meeting	C Greenstock		**COMPLETED.** This has been noted for future reporting. **COMPLETED.** Agreed at Management Execs that this could be deferred
AC 19/05/019	The Head of Internal Audit Annual Report 2018/19	The committee agreed to defer 9 audits from 2018/19 – 2019/20	I Virgil		**COMPLETED.** All items on 2019/20 Internal Audit Plan
AC 19/04/007	Internal Audit Progress & Tracking Report	Final Internal Audit Annual Report to be presented at May meeting	I Virgil	24.09.19	**COMPLETED**
AC 19/04/011	Declarations of Interest and Gifts of Hospitality	To publish Declarations of Interest on UHB website	N Foreman	1.09.19	**COMPLETED.** Declarations published from 1 September onwards.
Actions in Progress					
AC 19/05/018	Wales Audit Office (WAO) ISA 260 Report	A separate report setting out UHBs actions against last year's recommendations to be provided to the Committee	WAO		The Audit of Financial Statements Report Addendum – Recommendations: Item on agenda for September meeting. *(Agenda Item 7.4)*
AC 19/05/007	Internal Audit Progress Report	Three audit reports to come to September meeting	I Virgil	24.09.19	Delayed reports to be brought to September meeting

		The review of Performance Reporting Data Quality – RTT would be moved to the 2019/20 plan	I Virgil		*(Agenda Item 7.1)* To be brought to February 2020 meeting
AC 19/05/007	Internal Audit Progress Report: Cyber Security – Limited Assurance	Follow-up review was on the 2019/20 plan	I Virgil		To be brought to a February 2020 meeting
AC 19/05/009	Items for information	A number of reports to be finalised to be presented at the next Committee meeting	I Virgil	24.09.19	See Action AC 19/05/007 *(Agenda Item 9.1)*
AC 19/04/012	Tracking Report from Recommendations from Regulatory Bodies	A high level dashboard to be presented in September. A project plan on the dashboard would be taken to Management Executives and HSMB for consultation and approval	N Foreman N Foreman	24.09.19	On agenda for September 2019 meeting. *(Agenda Item 7.12)* Plan agreed to roll out high level dashboard to Corporate Governance next …….
AC 19/04/011	Declarations of Interest and Gifts of Hospitality	This action was discussed in May meeting and will be subject to re-audit in a few months' time.	I Virgil		Re-Audit due to be completed in August and report brought to September 2019 meeting *(Agenda Item 9.1)*
AC 19/04/009	Post Payment Verification Report	To provide an update on error and claim rates.	S Lavendar	24.09.19	Item deferred from May to September meeting. *(Agenda Item 7.7)*
AC 18/071	Wales Audit Report on Medical Equipment	Investigate how other Health Boards deal with equipment <£5k inventory. This was discussed at the May meeting and deferred to September meeting.	F Jenkins	24.09.19	The data would be formatted to provide more information. A report to be provided to the September meeting *(Agenda Item 7.14)*
AC 19/02/19	Limited Assurance Reports: Medicine Clinical Board – Internal Medicine Follow up	For the Medical Director to provide an update on Job Planning.	S Walker	23.04.19 24.09.19	This item was deferred from May to the September meeting due to the Interim Medical Director being on annual leave *(Agenda Item 7.5)*
Actions referred to other Committees/Board					

REPORT TITLE:	Internal Audit Progress Report								
MEETING:	Audit Committee						**MEETING DATE:**	30.09.19	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**	**x**	**For Information**		
LEAD EXECUTIVE:	Director of Governance								
REPORT AUTHOR (TITLE):	Acting Head of Internal Audit								

PURPOSE OF REPORT:

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.

REPORT:

BACKGROUND:

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

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

The progress report provides the Audit 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 Reasonable or Substantial assurance are summarised in the progress report with the reports given Limited or No Assurance included in full. There are no reports that have been given a No Assurance rating during the current period.

Appendix A of the progress report sets out the Internal Audit plan as agreed by the committee, including details of postponed audits, commentary as to progress with the delivery of assignments and outcomes from completed audits.

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

RECOMMENDATION:

The Audit Committee is asked to:

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

Approve the proposed amendments to the Internal Audit Plan for 2019/20.

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

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	Prevention		Long term	x	Integration	x	Collaboration	x	Involvement		

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable

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

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit Committee September 2019

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

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 2019/20 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 2019/20 was agreed by the Audit Committee in April 2019 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. ASSIGNMENTS WITH DELAYED DELIVERY

2.1. Full details of the current year's audit plan along with progress with delivery and commentary against individual assignments regarding their status is included at Appendix A. The assignments noted in the table below are those which had been planned to be reported to the September Audit Committee but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
Deprivation of Liberties Safeguards	WiP	/	Delay in completion of fieldwork due to availability of Internal Audit resources
Safeguarding Adults & Children	WiP	/	Delay in completion of fieldwork due to availability of Internal Audit resources
Private and Overseas Patient	Draft	Reasonable	Delay in completion of fieldwork due to availability of Internal Audit resources
MH CB – Third Sector Contracts	Draft	Reasonable	Delay in completion of fieldwork due to availability of department staff
Surgery CB – Medical Staff Governance Follow-up	Draft	Reasonable	Delay in commencing fieldwork due to availability of management

3. OUTCOMES FROM COMPLETED AUDIT REVIEWS

3.1. 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.

3.2. The three remaining reports from 2018/19 that hadn't been reported to the audit committee in May have been finalised and reported below.

3.3. A summary of the key points from the assignments with Reasonable and Substantial assurance are reported in Section five. The reports with a Limited Assurance rating are included as a full version of the report at Appendix F.

FINALISED AUDIT REPORTS (2018/19 Opinion)	ASSURANCE RATING	
MHRA Compliance	Reasonable	
e-Advice Project		
UHB Transformation Process		

FINALISED AUDIT REPORTS (2019/20 Plan)	ASSURANCE RATING	
Standards of Behaviour Follow-up	Substantial	
Annual Quality Statement		
Carbon Reduction Commitment		
MH CB – Sickness Management Follow-up	Reasonable	
Sustainability Reporting		
Specialist CB – Rosterpro		
Legislative / Regulatory Compliance Follow-up		
	Limited	
	No	

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1. From the table in section three above it can be seen that ten audits have been finalised since the Committee met last.

Three of the finalised audits are from the 2018/19 Internal Audit plan and the draft outcomes were included within the previous year's Head of Internal Audit Opinion.

In addition, there are a further three audits that have reached draft report stage.

4.2. All of the audits that have reached reporting stage for the current year have concluded positively with ratings of reasonable or substantial assurance.

Three follow-ups have been undertaken for audits that were given Limited assurance ratings in the previous year.

The Standards of Behaviour Follow-up has identified that all agreed management actions have been implemented and the rating has therefore improved to Significant Assurance.

The Follow-ups for Legislative / Regulatory Compliance and MH CB – Sickness Management have both identified that good progress is being made towards implementing the agreed actions and the ratings have therefore increased to Reasonable Assurance.

With the current year audits that have reached reporting stage in the first part of the year concluding positively, along with good progress with the three follow-up audits, this puts the Health Board in a good position going forward. However, with the number of audits in the plan to be delivered, this could obviously change between now and the year-end. Appendix B shows the assurance summary by domain.

The audit assignment schedule at Appendix A gives specific details as to the status of the planned work.

4.3. <u>Adjustments to the 19/20 plan.</u>

The following audits have been identified for potential deferral or removal from the plan:

- Management of LTAs – The Director of Finance has requested removal as there are no issues and he is happy with the current internal assurance arrangements.

The scope and / or timescale of the following audits has changed:

- IT Strategy – Scope changed to Use of Digital Tech at request of Director, resulting in a move from Q1 to Q3.

- Medicine CB Specialling – Scope changed to QSE Governance at request of Clinical Board and agreed by COO.
- CHC – Moved from Q1 to Q2 due to availability of resources.
- Risk Management / BAF – Moved from Q3 to Q4 due to use of South East team auditors.
- Management of Health Board Policies – Moved from Q3 to Q4 at request of Dir of Governance.
- Engagement around Service Planning – Moved from Q2 to Q4 due to availability of resources.
- Service Improvement Team – Moved from Q2 to Q3 due to availability of resources.

The following audits have been identified for addition to the plan:

- Cyber Security Follow-up – original report finalised as Limited after agreement of the 19/20 plan.
- Keir Prompt Payments – Review of compliance with the 'Fair Payment' Charter by Supply Chain Partners on the Neonatal project.

The detail of the allocation of the completed audits across the assurance domains, along with those still to be undertaken and those deferred, is recorded within Appendix B.

4.4. Appendix C highlights the times for responding to Internal Audit reports. Appendix D shows the Audit & Assurance Key Performance Indicators. Both of these highlight the need for the Health Board to improve its timeliness in responding and signing off Internal Audit reports.

5. FINAL REPORT SUMMARIES

5.1 Standards of Behaviour Follow-up

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.

The Corporate Governance Team has made significant improvements to enhance the systems and controls in place for Standards of Behaviour within the organisation.

The out of date policy has been revised and shared at the appropriate groups and will be presented at Audit Committee in September 2019. They have an extensive improvement plan in place to help address the awareness of the policies and procedures, which has already had an impact on the responses received.

A new DoI Register has been created and both the DoI and GH&S forms have been updated to ensure that all the required information is captured and is in line with the policy. Links to the Intranet page have also been incorporated into the policy and to the revised forms.

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Standards of Business Conduct has significantly improved to **Substantial Assurance**.

5.2 Annual Quality Statement

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.

The UHB continues to have robust processes in place to produce and publish the Annual Quality Statement (AQS) in line with the set timetable. Even though the Health Board had to work to a much tighter deadline this year, at the time of review they were on track to publish the document by the required date of 31st May 2019.

The statement is presented in a clear and user friendly format that should be easily understood by its audience. The AQS provides a clear assessment of how well the Health Board is doing, identifies areas that require improvements and reports on the progress it has made year on year.

This is communicated through the key themes that are in line with the Health and Care Standards for Wales and the Health Boards Quality Safety and Improvements (IQS) Framework.

5.3 Carbon Reduction Commitment

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.

Our review has confirmed that the Health Board had appropriate processes in place for calculating the data for inclusion within its CRC report for 2018/19, the final year of the CRC scheme.

The Health Board identified issues with the data calculated via the Bureau database which lead to a change in the process for calculating the CRC data. A prudent approach was however adopted utilising a combination of British Gas statements and last year's data to ensure that appropriate usage figures were recorded.

The Health Board has retained an appropriate evidence pack to support the CRC report and this provides an adequate audit trail.

The CRC report and associated data was formally submitted by the Health Board before the required deadline of 31st July 2019.

Following surrender of the required allowances for 2018/19, the Health Board will be left with a potential surplus of allowances. A plan for selling the surplus allowances will need to be agreed and actioned as soon as possible to ensure that the Health Board maximises the potential income.

5.4 MH CB – Sickness Management Follow-up

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.

It is evident that the Clinical Board has made progress towards implementing the agreed management actions from the original review. This has led to an increased knowledge of the NHS Wales Managing Attendance at Work Policy and the associated processes for managing sickness absence.

The sampled wards tested during the original review and the current follow-up have shown considerable improvement in sickness management. The results of the current testing identified that all sampled sickness absence was appropriately managed within Cedar ward. Within the other three wards, whilst some issues of non-compliance were identified, the levels were lower than within the original audit.

As detailed within section 5 below, the follow-up has concluded that two of the management responses have been fully actioned (1 high & 1 Low) and 2 have been partially actioned (1 High & 1 Low).

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Mental Health Clinical Board – Sickness Management has improved to **Reasonable Assurance**. Management will however need to ensure that the outstanding actions are fully implemented and all future sickness absence is consistently managed in accordance with the All Wales Managing Attendance at Work policy.

5.5 Sustainability Reporting

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.

Our audit has confirmed that the format and content of the 2018/19 Sustainability Development Report complies with guidance issued by the Welsh Government and fairly represents the organisations sustainability position and performance. There was documented guidance in place setting out roles and responsibilities for producing the report which was presented in a clear and user friendly format, and there were adequate arrangements in place for producing the report.

However the process for producing the report has evolved and changed over the last few years. Consequently the process documentation could be improved by updating the roles and responsibilities of staff involved in preparing the report and supplementing the guidance with the methodology used to complete the three mandatory tables. The current process, which now takes place within a reduced timescale, has also resulted in the approval and report sign-off taking place after the report is published, although to date this has not been evidenced by audit. The process could also be improved by drawing up a timetable each year to help ensure the report is checked and published within the required deadline.

5.6 Specialist CB - Rosterpro

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.

We identified that there are multiple interdependent systems operating within Critical Care for the monitoring of rosters and individuals working hours, a reconciliation exercise has shown that the systems are generally accurate over our sample period (January – March 2019);

The review highlighted one high priority finding relating to staff members accumulating large amounts of negative hours (greater than 12 hours) over our sample period; whilst employing bank and agency staff to work shifts.

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.

5.7 Legislative / Regulatory Compliance Follow-up

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.

Since our previous review the Corporate Governance Team has made good initial progress towards improving the process for the management of legislative and regulatory compliance. An effective policy has been developed that includes appropriate appendices to support and assist the process. An overhaul of the existing Tracker Report has taken place, which involved a considerable amount of work and a complete new format was agreed upon and introduced.

The Corporate Governance Team have received from the Clinical Boards a list of all the Regulatory Bodies that they are responsible for, the standards that they are inspected against and who the Executives leads are. The collation of most of this information and the updating of information within the Tracker Report took place whilst the follow-up audit was being carried out, so we were unable to test against it.

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Standards of Business Conduct has improved to **Reasonable Assurance**.

CARDIFF AND VALE UHB INTERNAL AUDIT ASSIGNMENT STATUS SCHEDULE

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Annual Quality Statement	18		Nursing	Q1	Final – Issued May 19	Substantial	Sept
MH CB – Sickness Management Follow-up	36		COO/Clinical Board	Q1	Final – Issued July 19	Reasonable	Sept
Sustainability Reporting	44		Planning	Q1	Final – Issued August 19	Reasonable	Sept
Carbon Reduction Commitment	45		Planning	Q1	Final – Issued August 19	Substantial	Sept
Standards of Behaviour (DoI & G&H) Follow-up	06		Governance	Q1	Final – Issued September 19	Substantial	Sept
Specialist CB – Rosterpro	34		COO	Q1	Final – Issued September 19	Reasonable	Sept
Legislative / Regulatory Compliance Follow-up	05		Governance	Q1	Final - Issued September 19	Reasonable	Sept
Private and Overseas Patients	17		Medical	Q1	Draft – Issued September 19	Draft Reasonable	Sept
MH CB – Third Sector Contracts	29		COO	Q1	Draft – Issued September 19	Draft Reasonable	Sept
Surgery CB – Medical Staff Governance Follow-up	37		COO	Q1	Draft – Issued September 19	Draft Reasonable	Sept
Deprivation of Liberties Safeguards (DoLS)	19		Medical	Q1	Work in Progress – Fieldwork delay due to Resource availability		Sept

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Safeguarding Adults & Children	**22**		**Nursing**	**Q1**	**Work in Progress – Fieldwork delay due to Resource availability**		**Sept**
Charitable Funds	15		Finance	Q2	Work in Progress		Dec
Infection Prevention and Control	21		Nursing	Q2	Work in progress		Dec
PCIC CB – Business Continuity	35		COO	Q2	Work in Progress		Dec
Consultant Job Planning Follow-up	41		Medical	Q2	Work in Progress		Dec
Control of Contractors	SSU		Planning	Q2	Work in Progress		Dec
Maelfa Wellbeing Hub	SSU		Planning	Q3	Work in Progress		Feb
Kier Prompt Payments	SSU		Planning	Q3	Work in Progress		Feb
Tentacle IT System	24		Transformation, Improvement & Informatics	Q1	Delay in agreeing brief with Executive lead		Dec
Continuing Healthcare (CHC) Follow-up	07		COO	Q2	Rescheduled from Q1 to allow appropriate resourcing		Dec
Brexit Planning	09		Planning	Q2			Dec
Management of Long Term Agreements (LTAs)	16		Finance	Q2	Director of Finance requested removed from plan. TBA by AC		Dec
Use of Digital Technology	25		Transformation, Improvement & Informatics	Q2	Rescheduled from Q1 due to change of scope from IT Strategy		Dec

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Surgery CB – Specialing of Ward Patients	31		COO	Q2			Dec
Medicine CB – Specialing of Ward Patients	32		COO	Q2			Dec
Claims Reimbursement	02		Nursing	Q3			Dec
Strategic Planning / IMTP	08		Planning	Q3			Feb
Strategic Performance Reporting	11		Transformation, Improvement & Informatics	Q3			Feb
UHB Core Financial Systems	13		Finance	Q3			Feb
Budgetary Control	14		Finance	Q3			Feb
Integrated Health Pathways	20		Transformation, Improvement & Informatics	Q3			Feb
Freedom of Information Reviews	23		Transformation, Improvement & Informatics	Q3			Feb
Cyber Security Follow-up	47		Transformation, Improvement & Informatics	Q3			Feb
C&W CB – Consultant Leave	30		COO	Q3			Feb
CD&T CB – Laboratory Turnaround Times (TAT)	33		COO	Q3			Feb

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Medicine CB – Internal Medicine Follow-up	38		COO	Q3			Feb
Medical Staff Study Leave	39		Workforce	Q3			Feb
Service Improvement Team	42		Planning	Q3	Rescheduled from Q1 to allow appropriate resourcing		Feb
Commercial Outlets	43		Planning	Q3			Feb
Health & Care Standards	01		Nursing	Q4			April
Risk Management / BAF Development / Risk Registers	03		Governance	Q4	Rescheduled from Q3 to allow cross resourcing with Mamhilad Team		April
Management of Health Board Policies	04		Governance	Q4	Rescheduled from Q3 at request of Director of Governance		April
Engagement around Service Planning	10		Planning	Q4	Rescheduled from Q2 to allow appropriate resourcing		April
Data Quality Performance Reporting	12		Transformation, Improvement & Informatics	Q4			April
GDPR Follow-up	27		Transformation, Improvement & Informatics	Q4			April
IT Service Management (ITIL)	28		Transformation, Improvement & Informatics	Q4			April
Pre-Employment Checks	40		Workforce	Q4			April

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Facilities / Estates Service Board Governance	46		Planning	Q4			April
IM&T Backlog	*SSU*		*Transformation, Improvement & Informatics*	*Q4*			*April*
Neonatal and Obstetrics Capital Project	*SSU*		*Planning*	*Q4*			*April*
Rookwood Relocation Capital Project	*SSU*		*Planning*	*Q4*			*April*
Deferred reviews							

C&V UHB AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN 2019/20 (Draft reports highlighted in red italics)									
Assurance domain	**Audits**		**Final & Draft Audit Assurance Rating**					**Audits to be completed**	**Deferred Audits**
			Not rated	**No**	**Limited**	**Reasonable**	**Substantial**		
Corporate Governance, Risk and Regulatory Compliance	6					● Legislative Comp Follow-up	● Standards of Behaviour Follow-up	● H&CS ● Claims ● Risk Management ● Management of HB Policies	
Financial Governance and Management	5					● *Private & Overseas Patients (Draft)*		● Core Financials ● Budgetary Control ● Charitable Funds ● Management of LTAs	
Clinical Governance, Quality and Safety	5						● Annual Quality Statement	● DoLS ● Integrated Health Pathways ● Infection Prevention & Control ● Safeguarding Adults & Children	
Strategic Planning, Performance Management and Reporting	6							● CHC Follow-up ● Strat Plan / IMTP ● Brexit Planning ● Engagement Arounf Service Planning ● Strategic Performance Reporting ● Data Quality	

C&V UHB AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN 2019/20 (Draft reports highlighted in red italics)									
Assurance domain	**Audits**		**Final & Draft Audit Assurance Rating**					**Audits to be completed**	**Deferred Audits**
			Not rated	**No**	**Limited**	**Reasonable**	**Substantial**		
								Performance Reporting	
Information Governance and Security	7							● Freedom of Information Reviews ● Use of Digital Technology ● Tentacle IT System ● IM&T Backlog ● GDPR Follow-up ● IT Service Management (ITIL) ● Cyber Security Follow-up	
Operational Service and Functional Management	10					● MH CB – Sickness Management Follow-up ● PCIC CB – Business Continuity *● MH CB –Third Sector Contracts (Draft)* *● Surgery CB – Medical Staff Governance Follow-up (Draft)*		● C&W CB – Consultant Leave ● Surgery CB – Specialing of Ward Patients ● Medicine CB – Specialing of Ward Patients ● CD&T CB – Laboratory Turnaround Times (TAT) ● Specialist CB - Rosterpro	

C&V UHB AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN 2019/20 (Draft reports highlighted in red italics)									
Assurance domain	**Audits**		**Final & Draft Audit Assurance Rating**					**Audits to be completed**	**Deferred Audits**
			Not rated	**No**	**Limited**	**Reasonable**	**Substantial**		
								● Medicine CB – Internal Medicine Follow-up	
Workforce Management	3							● Medical Staff Study Leave ● Pre-Employment Checks ● Consultant Job Planning Follow-up	
Capital and Estates Management	9					● Sustainability Reporting	● Carbon Reduction Commitment	● Service Improvement Team ● Commercial Outlets ● Facilities / Estates Service Board Governance ● Neonatal & Obstetrics Project ● Penarth Wellbeing Hub ● Rookwood Relocation ● Control of Contractors	

INTERNAL AUDIT REPORT RESPONSE TIMES								
Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G	
Annual Quality Statement	Substantial	Final	21/05/19	12/06/19	22/05/19	22/05/19	G	
MH CB – Sickness Man Follow-up	Reasonable	Final	25/06/19	16/07/19	18/07/19	22/07/19	A	
Sustainability Reporting	Reasonable	Final	12/07/19	02/08/19	05/08/19	16/08/19	A	
Carbon Reduction Commitment	Substantial	Final	24/07/19	12/08/19	07/08/19	16/08/19	G	
Standards of Behaviour Follow-up	Substantial	Final	03/09/19	24/09/19	03/09/19	05/09/19	G	
Specialist CB Rosterpro	Reasonable	Final	15/08/19	06/09/19	04/09/19		G	
Legislative / Regulatory Compliance Follow-up	Reasonable	Final	20/09/19	11/10/19	23/09/19	23/09/19	G	
Private & Overseas Patients	Reasonable	Draft						
MH CB – Third Sector Contracts	Reasonable	Draft						
Surgery CB – Medical Staff Governance Follow-up	Reasonable	Draft						

AUDIT & ASSURANCE KEY PERFORMANCE INDICATORS						
Indicator Reported to NWSSP Audit Committee	**Status**	**Actual**	**Target**	**Red**	**Amber**	**Green**
Operational Audit Plan agreed for 2019/20	**G**	April 2019	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 2019/20	**A**	83% 10 from 12	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	**G**	100% 10 from 10	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	**R**	71% 5 from 7	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	**G**	100% 7 from 7	80%	v>20%	10%<v< 20%	v<10%

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WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

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

Date issued: September 2019

Document reference: CVACU2019

Contents

Summary report

About this document

1 This document updates the Audit Committee on current and planned Wales Audit Office work. It covers financial audit, performance audit and the Auditor General's programme of national value-for-money examinations.

Financial audit update

Exhibit 1: Financial audit update

Annual Accounts and other financial-audit work
On 30 May 2019 the Audit Committee and Board considered our Financial Statements Report, and on 11 June the Auditor General for Wales certified the Health Board's 2018-19 Accountability Report and Financial Statements. On 30 September the Audit Committee will consider our Financial Statement Report Addendum, which sets out our audit recommendations and the Health Board's management responses. This autumn we are: • Auditing the 2018-19 Funds Held on Trust Account. The Trustee Members will consider our audit report at their meeting in December 2019 (date to be arranged). The Account is therefore scheduled to be certified by the Auditor General well ahead of the Charity Commission's deadline of 31 January 2020. • Auditing the Health Board's 2018-19 Substance Misuse Action Fund grant claim. • Assisting with aspects of the Structured Assessment review. • Commencing our initial planning of the audit of the Health Board's 2019-20 Accountability Report and Financial Statements.

Performance audit update

Work completed since the last Audit Committee update

Exhibit 2: Work completed since last Audit Committee update

Topic	Conclusions	Status	Executive lead	Considered by Audit Committee	Management response status
Clinical Coding (local review)	We concluded that the Health Board is generally producing good quality coded data, which is being used to support service improvement. However, more work is needed to fully address many of our recommendations.	Final report	David Thomas	September 2019	Completed
Integrated Care Fund (thematic review)	We concluded the fund has had a positive impact, supporting improved partnership working and better integrated health and social care services. However, aspects of the way the fund has been managed at national, regional and project levels have limited its potential to date. There is little evidence of successful projects yet being mainstreamed and funded as part of public bodies' core service delivery.	National report published July 2019 Regional report published September 2019	Abi Harris	December 2019	N/a

Work underway

Exhibit 3: Work currently underway

Topic	Focus of the work	Status	Executive Lead	For Audit Committee
Examination under the Well-being of Future Generations Act 2015 (thematic review)	This examination is being undertaken to help discharge the Auditor General's statutory functions under section 15 of the Well-being of Future Generations (Wales) Act 2015. The Auditor General for Wales is statutorily required to examine public bodies to assess the extent to which they have acted on accordance with the sustainable development principle when: a. setting their wellbeing objectives; and b. taking steps to meet them.	Draft reporting	Fiona Kinghorn	December 2019
Follow-up of operating theatres (local)	Between 2011 and 2013, the Wales Audit Office reviewed operating theatres across Wales. In 2015 we carried out work to assess the health board's progress. We concluded that the Health Board had improved theatre utilisation by focussing on processes and performance management. But there wasn't the same focus on improving service quality and addressing problems with staff engagement. At that time, we made some additional recommendations. In 2019 we will follow up progress against these recommendations.	Fieldwork	Steve Curry	December 2019
Orthopaedic Services follow-up (thematic review)	This work will examine the progress made in orthopaedic services since our 2015 all Wales review. The work will assess whether recommendations and areas we identified for improvement have been effectively responded to and to determine whether health boards are developing arrangements to help manage the demand on, and supply of, orthopaedic services.	Fieldwork	Steve Curry	December 2019
Follow-up of previous IM&T recommendations (local)	In 2014, we carried out work to assess progress in addressing previous IM&T related issues and recommendations. We concluded that the Health Board had made some progress, but further work was needed. At that time, we made some additional recommendations. In 2019 we will follow up progress against these recommendations.	Briefing to be issued	David Thomas	To be confirmed

Topic	Focus of the work	Status	Executive Lead	For Audit Committee
Structured Assessment 2019	Structured Assessment will continue to form the basis of the work we do at each NHS body to examine the existence of proper arrangements for the efficient, effective and economical use of resources. Building on previous years' work, we will seek to describe the progress that is being made in embedding sound arrangements for corporate governance and financial management, alongside other key processes such as strategic planning, workforce management, procurement and asset management.	Fieldwork	Nicola Foreman	December 2019

Work planned

Exhibit 4: Work currently planned

Topic	Focus of the work	Status	Executive Lead	For Audit Committee
Quality Governance arrangements (thematic review)	As an extension of our structured assessment work, we plan to undertake a specific thematic review of quality governance arrangements and how these underpin the work of quality and safety committees. In recent years our structured assessment work across Wales has pointed to various challenges with such governance arrangements. We therefore intend to undertake a review that will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows and reporting.	Scoping	To be confirmed	To be confirmed

Responses to queries

Exhibit 5: Further information about queries raised at previous audit committees

Raised	Query
	No queries raised.

Other Auditor General studies

Since the last Audit Committee, we have published the following reports, which are of relevance to the NHS.

Exhibit 6: Auditor General Reports published since last audit committee

Output	Summary
Counter Fraud Arrangements in the Welsh Public Sector	This paper provides an overview for the National Assembly's Public Accounts Committee of the counter-fraud landscape across the Welsh public sector. The Committee has expressed an interest in this topic following the recent publication of the 2018 National Fraud Initiative report, which provides some insight into aspects of public sector fraud in Wales but does not provide a robust evaluation of the underlying arrangements for prevention and detection. This paper therefore describes the allocation of resources, collaboration between organisations, scrutiny arrangements and overall impact.
NHS Wales Finances Data Tool	This interactive data tool draws on data from Welsh Government budgets, NHS bodies' independently audited financial statements and from monthly financial data submissions from the NHS bodies to the Welsh Government.
Integrated Care Fund	This report examines whether the fund is being used effectively to deliver sustainable services that achieve better outcomes for service users. It focuses on whether the Welsh Government is effectively managing the fund to deliver against its intentions, as well as understanding whether Regional Partnership Boards are demonstrating effective use of the fund. The report also considers whether the projects supported by the fund are making a clear difference at a local level. The report is supported by a supplementary report which focuses on the regional findings.

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 in Exhibit 7 lists recent and forthcoming events.

Exhibit 7: Good Practice Exchange

Recent and forthcoming events
Recent events
Working in partnership to combat fraud May 2019 The aim of this event was to share investigation techniques, intelligence and the use of data analytics in fraud prevention and detection. It is aimed at all public service officers and members who have counter fraud responsibilities or interests
Key issues for Regional Partnership Boards July 2019 These webinars highlighted solutions to issues relating to fund implementation and ways of working in multi-agency partnership. They aimed to assist RPBs with making changes to improve the way they work. Experts discussed the issues and offered advice and assistance for RPB members and their committees.
Innovative approaches to public services in rural communities July 2019 This seminar shared innovative approaches to help understand how public services can meet the needs of rural communities in Wales.
Future proofing public services 4 September 2019 This webinar identified practical examples of services doing things differently to plan for the future and optimise benefits across public services in Wales. It looked at how we can recalibrate and think outside of our sector boundaries to achieve collective long-term change. We discussed how strategic and operational decision makers must balance the needs of today with the needs of tomorrow.
Upcoming
Making an Equal Wales a reality 12 September 19 September This seminar will look at what public services are doing to contribute to a More Equal Wales. It is the starting point of knowledge sharing and knowledge gathering around this topic over the next two years for the Wales Audit Office. An all Wales study, the focus of which is yet to be determined, will follow in early spring, reporting in 2021 with a follow up event. This topic cuts across all public services in Wales and will therefore be relevant to all policy makers as well as to those who design and engage with public services.
How technology is enabling collaborative working across public services 17 October

24 October

The possibilities that digital technologies can provide are endless. This seminar will provide better understanding of tools available and how they can improve collaboration and help deliver smarter and higher quality services.

This seminar will also share examples of organisations that are maximising the use of digital technology, enabling them to deliver services that promote independence (including through housing services), combat social isolation, promote carbon reduction and community wellbeing.

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.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Audit of Financial Statements Report addendum – Recommendations – **Cardiff and Vale University Health Board**

Audit year: 2018-19

Date issued: July 2019

Document reference: 1391A2019-20

Status of report

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 infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Contents

Summary Report

Introduction

1 This report is an addendum to our Audit of the Financial Statements Report that we presented to Members of Cardiff and Vale University Health Board (the Health Board) on 30 May 2019. The report sets out the recommendations arising from our audit of 2018-19 financial statements; and an update on the Health Board's progress with last year's recommendations. We would like to take this opportunity to once again thank all Health Board staff who helped us throughout the audit.

Recommendations arising from our audit of the Health Board's 2018-19 financial statements

2 In our Audit of Financial Statements Report we set out that we would present a separate report with details of the recommendations arising from our financial audit work. This report sets out 10 audit recommendations at Exhibits 1 to 10, which include management's response to each of them.

Follow-up of our recommendations arising from our audit of the Health Board's 2017-18 financial statements

3 We also raised 10 recommendations last year, of which the Health Board's management fully accepted seven and partially accepted three. Appendix 1 sets out the recommendations together with brief commentary on the action taken by management, who have made generally good progress with their intended actions. We continue to review ongoing actions as part of our audit work.

Exhibit 1

Matter arising 1: the 'retire and return' arrangements require strengthening	
Findings	In May we reported in our 2018-19 Audit of Financial Statements Report that there is a 'need to strengthen the Heath Board's policy and process for the evaluation and approval of 'retire and return' applications by staff, with a particular need to apply the Department of Health's (DoH's) guidance in full.' The DoH's 2017 guidance[1], which the Welsh Government has adopted, includes an important checklist (Annex B of the guidance) that national health service employers should follow. While the Health Board does have guidance in place, titled 'NHS Pension Retire and Return Procedure', it is not as comprehensive as the DoH's guidance and it therefore requires updating.
Recommendation	The Health Board should strengthen its current guidance so that it clearly sets out all the key elements of the DoH guidance. The revised guidance should include all the DoH's employer-checks, which the Health Board should always apply and clearly evidence when assessing a business case for an employee to retire and return. The Health Board should ensure that its updated guidance is shared with all Clinical Boards and Departmental Heads.
Accepted in full by management	
Management response	
Implementation date	

1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/634529/NHS_retire_and_return_guidance.pdf

Exhibit 2

Matter arising 2: the quality of the draft 'Remuneration and Staff Report' requires improvement	
Findings	This year the Health Board's Remuneration and Staff Report required a particularly high level of audit amendment. Examples of the amendments required were: • incorrect dates for changes in senior officer roles, such as the Board Secretary position. • incorrect dates for the Director of Finance's retire and return. • a statement that the Remuneration and Terms of Service Committee had agreed to take forward steps to recruit to the Director of Finance post on a permanent basis. This statement was incorrect and removed. • the incorrect classification of some of the Board Member remunerations. • an incorrect salary banding for one senior officer. • a Board Member's pension disclosures were incorrect. As reported in our 2019 Audit Plan, we judge many of the disclosures within the Remuneration and Staff Report to be material by nature. We therefore increase our examination of these disclosures and any uncorrected misstatements could result in a modified audit opinion on the financial statements.
Recommendation	The Health Board should review why the level of error increased for 2018-19; and it should strengthen the management review and 'sign-off' of the Remuneration and Staff Report prior to its submission to us for audit.
Accepted in full by management	
Management response	
Implementation date	

Exhibit 3

Matter arising 3: the Annual Governance Statement requires a revamp	
Findings	The draft 2018-19 Annual Governance Statement (AGS) presented for audit exceeded 60 pages, being considerably longer than the 2017-18 AGS which was 27 pages. During our audit we raised the large increase in the length of the AGS with officers, who then reduced and reshaped its content. The audited and signed 2018-19 AGS is 46 pages. Guidance and good practice encourage public bodies to produce AGSs that are concise, transparent, and designed to help the reader 'see the wood for the trees' by sign-posting key messages and avoiding overly detailed process descriptions.
Recommendation	The Health Board should review the style, structure and content of its 2019-20 AGS. The Health Board should look to complete the review by early 2020 so that it has an agreed basis for its preparation and submission for audit. If the Health Board wishes, we could provide audit input into its early review of the style, structure and content of the 2019-20 AGS.
Accepted in full by management	Accepted
Management response	Accept this finding and agreed to do a much more concise document for 2019/20 and also agree to get early input from WAO into the document. It would be useful if WAO could sign post Cardiff and Vale to a LHB who have developed a good document which meets all the requirements
Implementation date	May 2020

Exhibit 4

Matter arising 4: the Phase 2 and Phase 3 continuing healthcare claims require concluding	
Findings	In 2017 we reported on the slow progress being made by Powys Teaching Health Board in reviewing the Health Board's longstanding 'Phase 3' continuing healthcare claims. Phase 3 relates to claims that the Heath Board received between 1 May 2014 and 31 July 2014.There were 204 claims outstanding as at 31 March 2017. In 2018 we reported that the number of outstanding Phase 3 claims had decreased, with 159 claims outstanding as at 31 March 2018. During 2018-19 the responsibility for assessing Phase 3 claims returned to each local health board. While the Health Board made good progress during 2018-19, there were still 75 claims outstanding as at 31 March 2019. There are also two 'Phase 2' claims that were outstanding as at 31 March 2019. Phase 2 relates to claims received between 16 August 2010 and 30 April 2014.
Recommendation	The Health Board should establish the reason for the ongoing delay with each of the remaining Phase 2 and Phase 3 claims and it should seek to conclude them promptly.
Accepted in full by management	
Management response	
Implementation date	

Exhibit 5

Matter arising 5: some of the related party declarations require more detail	
Findings	As reported in Appendix 1 the Health Board strengthened its related-party process for 2018-19 and all related-party declarations from the independent members (IMs) and senior officers (SOs) were available for us at the start of our audit. We do however have a different related-party finding from this year's audit. We found that some of the declarations lacked sufficient detail for us, and the Health Board's Finance Team, to establish whether a disclosable related party existed. For example: • a SO's declaration recorded that their son owned a website company, but the return did not name the company; • an IM's declaration recorded the details of a company but did not state their position or interest in that company; and • a SO's declaration stated that his wife worked at an optician, which was named in the declaration, but did not provide the wife's position within that optician. Disclosures that are too generic do not enable the required checks to be undertaken, principally in terms of whether: • the SO / IM, or a stated member of their close family, hold a position of influence within an entity; and • the Health Board had used the services of a declared entity during 2018-19, and the value of all transactions. Where these issues arose we asked the Finance Team to establish the precise circumstances so that, where necessary, they could be disclosed as related parties.
Recommendation	The Health Board should review its guidance to IMs and SOs to ensure that it is clear on the level of detail required in their annual related party declarations. The Health Board's Finance Team should promptly return any inadequate information to the relevant IM / SO, and request their prompt clarification.
Accepted in full by management	
Management response	
Implementation date	

Exhibit 6

Matter arising 6: some of the arrangements around the year-end stocktake require improving	
Findings	While we consider the Health Board's stocktake procedures to be adequate, we found that some officers had not fully complied with them when undertaking their year-end stocktake. This lack of compliance led to inaccuracy in some of the counting and recording of the year-end stock. During our partial attendance at the year-end stocktake of the UHW Theatre stock, we found three discrepancies (from our audit sample of ten stock lines). The discrepancies arose because the counted and recorded stock on the day did not agree to our reperformed physical count of the stock. While we agreed the discrepancies with the stocktaking officers on the day (at the end of March 2019), when we audited the financial statements in May we found that the officers had not reflected the agreed adjustments within the final stock records that supported the 2018-19 financial statements. We were able to establish that the discrepancies did not represent a risk of material misstatement to the 2018-19 financial statements.
Recommendation	The Health Board should ensure that all officers who undertake and record stock counts are regularly trained so that they fully understand the procedures and key requirements that are in in place.
Accepted in full by management	
Management response	
Implementation date	

Exhibit 7

Matter arising 7: there is no contract for the GHX electronic invoicing system	
Findings	Last year we reported a number of weaknesses in one of the Health Board's electronic accounts-payable invoicing systems (see Appendix 1). This year's sample-based testing transactions processed by the system was satisfactory. However, one of the weaknesses that we highlighted last year still exists, in that there is no contract in place between NWSSP and the third party that provides the system.
Recommendation	The Health Board should confirm with NWSSP whether a contract with the supplier is now in place. If there is still no contract with the supplier, the Health Board should evaluate any associated risks and if necessary consider suspending its use of the portal until a suitable contract is in place.
Accepted in full by management	
Management response	
Implementation date	

Exhibit 8

Matter arising 8: there is an absence of classifying prepayments between short term and long term	
Findings	Our sample-based testing identified two prepayments that should have been classified as non-current assets (greater than 12 months) instead of current assets (less than 12 months). The misclassification totalled £435,000, which the Health Board decided not to correct in its 2018-19 accounts (as we reported on 30 May 2019 to the Audit Committee and the Board). While the classification error affected the split of the two classifications within the Statement of Financial Position (the balance sheet), it did not affect any of the disclosures within the Statement of Comprehensive Net Expenditure.
Recommendation	The Health Board should remind all relevant officers of the importance of considering the classification of prepayments, in terms of the period that they cover and whether any of the year-end prepayments extend beyond two months after 31 March year-end. The Health Board should ensure that its review of the draft financial statements is sufficiently robust in this area, prior to the submission of the statements for our audit.
Accepted in full by management	
Management response	
Implementation date	

Exhibit 9

Matter arising 9: the accounting for purchase-order accruals requires improvement	
Findings	Our sample-based testing of expenditure accruals found the following errors in respect of the purchase-order accruals: • the incorrect inclusion of VAT that resulted in overstated year-end accruals and in-year expenditure by £5,600. This type of error arose last year, as set out at Appendix 1. • the incorrect accrual of £41,368 for goods that the Health Board had received after 31 March 2019, which resulted in overstated year-end accruals and in-year expenditure. We established that the goods had been received in 2019-20 but were incorrectly entered in the purchase-order system as received in 2018-19. We increased our sample-based testing which identified no further errors. We were able to conclude that the discrepancies did not represent a risk of material misstatement to the 2018-19 financial statements.
Recommendation	The Health Board should review its arrangements for the identification and assessment of the year-end purchase order accruals. The review should consider the adequacy of the accruals process in place, and whether the relevant staff receive adequate training each year.
Accepted in full by management	
Management response	
Implementation date	

Exhibit 10

Matter arising 10: a senior officer has been underpaid	
Findings	We test all the senior officer remunerations in the Remuneration and Staff Report. We found that the Health Board had underpaid one senior officer by £2,983.50 in 2018-19. We established that the underpayment had arisen because the Health Board had processed the officer's appointment to their new post (which commenced on 1 October 2018) based on 2017-18 pay scales rather than the 2018-19 pay scales. We informed officers of the error at the time of the audit.
Recommendation	The Health Board should ensure that the officer's salary is corrected and paid accordingly. The Health Board should also review, and if necessary strengthen, its process for the appointment of new or promoted staff to pay scales.
Accepted in full by management	
Management response	
Implementation date	

Appendix 1

Recommendations arising from our 2017-18 financial audit work

Exhibit 11 sets out last year's recommendations and our follow-up review of the Health Board's actions. The full detail in respect of our reported findings, together with the comments by the Health Board's management, can be found on the Health Board's website at: http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Audit%20Boardbook%2025.09.18.pdf.

Exhibit 11: an update on last year's audit recommendations

Recommendation	Follow-up comments
The GHX electronic invoicing system The Health Board should identify the key risks to which it may be exposed and then obtain formal assurances from NWSSP as to how any risks are, or can be, mitigated. The Health Board should assess the adequacy of the controls and mitigation in place and if it is not satisfied with the controls in place consider stopping the use of the portal. As part of this review the Health Board should ensure that it can readily obtain the appropriate documentation to support a payment, when requested as part of our annual audit.	Our 2018-19 testing of a sample of transactions processed through the GHX system was satisfactory as we were able to obtain the relevant supporting documentation. One matter remains outstanding in that we understand that there is still no contract in place, as referred to at Exhibit 7 on page 11.
The production of the Comprehensive Expenditure and Income Statement The Health Board should evaluate why manual adjustments are necessary, and in doing so engage with some of the health boards that have the same finance system and avoid manual intervention. Also, the Health Board should always correct mispostings within the ledger.	The Health Board largely retained the same processing method for 2018-19. Our audit of the 2018-19 financial statements went well in this area, with fewer issues than the previous year. It is an area that we will keep under review each year.
Related party declarations The Health Board should ensure that when senior officers or independent members are due to leave, they should be required to provide the finance team with their related party return (ie. prior to their departure).	The Health Board strengthened its process for 2018-19 and all related party returns were available at the end of April 2019 when we commenced our audit of the draft financial statements. We have raised a separate related-party issue this year, at Exhibit 5 on page 9.

Recommendation	Follow-up comments
Bringing assets-under-construction into use The Health Board should liaise with other health boards that use the same fixed asset register in order to ascertain whether there is an alternative way to record these impairments.	The Health Board has not identified an alternative way to record impairments and is therefore using its longstanding method, which is adequate.
Primary care documentation The Health Board should provide us with the primary-care documentation in accordance with the agreed audit deliverables document.	We worked with the Health Board to strengthen our joint 2018-19 Audit Deliverables Agreement, and in accordance with the Agreement the Health Board improved a number of its working papers which it provided electronically and on time.
Fixed asset identification and recording of disposals As reported last year, due to similar audit findings, the Health Board should review its process for the recording and control of plant and equipment assets, which should include a review of the instructions to departments and of the adequacy of the monitoring arrangements over departmental compliance. All staff with responsibility for assets should ensure that they correctly inform the finance team of asset disposals.	In March 2019 the Director of Finance wrote to all departments to remind them of their responsibility to properly verify the existence of the assets recorded in their departmental asset registers. Our audit inspection of a sample of assets was satisfactory.
Purchase order accruals The Health Board should review its purchase-order accruals to ensure that the treatment of VAT is correct.	For 2018-19 we have again found an error due to the incorrect inclusion of VAT in a purchase order accrual, which we have reported again this year (see Exhibit 9 at page 13).
GP out of hours expenditure The Health Board should ensure that any similar recharge in future years is appropriately evidenced.	The Health Board provided us with a satisfactory calculation to evidence its 2018-19 recharge to General Medical Services.
Associate Board Member appointments The Health Board should formally verify with the two individuals whether they have formally accepted their appointments.	The Health Board clarified the position regarding the two associate members and the matter was closed satisfactorily.

Recommendation	Follow-up comments
Information Technology The Health Board should improve its password and access controls on some of the key financial systems by: • strengthening RAM access passwords by requiring both alpha and numeric characters; • establishing an access amendment and removal of leaver access form to manage Hospital Pharmacy user access accounts; • strengthening the Hospital Pharmacy system password controls by having at least eight characters in length and by using special characters or capitals in the password; • strengthening the Rosterpro system password access controls by setting a password expiry at 60 days and a requirement for a password to contain a combination of alpha and numeric characters. • establishing a number of proper security questions to authenticate the users' ID on network password resets; • updating the UHB's IT change control procedure; • tidying loose cabling in the racks of the UHW SAC1 and SAC2 data centre rooms; and • tidying the floor of the UHW IT1 and IT2 data centre rooms.	Pending.

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Auditor General for Wales

Clinical coding follow-up review – **Cardiff and Vale University Health Board**

Audit year: 2018

Date issued: June 2019

Document reference: 1185A2019-20

The person who delivered the work was Emily Howell.

Contents

The Health Board is generally producing good quality coded data, which is being used to support service improvement. However more work is needed to fully achieve many of our previous recommendations.

Summary Report

Introduction

1 Clinical coding involves the translation of written clinical information (such as a patient's diagnosis and treatment) into a code format. A clinical coder will analyse information about an episode of patient care and assign internationally recognised standardised codes[1].

2 Good quality clinically coded data plays a fundamental role in the management of hospitals and services. Coded data underpins much of the day to day management information used within the NHS and is used in many different systems and presented in different formats. It can be used to support healthcare planning, resource allocation, cost analysis, assessments of treatment effectiveness and can be an invaluable starting point for many clinical audits.

3 Coding departments within Welsh NHS bodies are required to satisfy standards set by the Welsh Government on completeness and accuracy of coded data. Performance against these standards form part of NHS bodies' annual data quality and information governance reporting.

4 During 2014-15 the Auditor General reviewed the clinical coding arrangements in all relevant NHS bodies in Wales. That work pointed to several areas for improvement such as the accuracy of coding, the quality of medical records and engagement between coders, clinicians and medical records staff.

5 We also found that NHS bodies routinely saw clinical coding as a back-office role, often with little recognition of the specialist staff knowledge and understanding needed. In addition, not all health bodies understood the importance of clinical coding to their day to day business.

6 In October 2014 we reported our findings for Cardiff and Vale University Health Board (the Health Board) and concluded that 'whilst there had been a strong focus on clinical coding, there were a number of weaknesses in arrangements and processes, which were affecting the generation of timely, accurate and robust management information. The current level of investment provided opportunities to make the necessary improvements'. More specifically, we found that:

- clinical coding had a high profile at Board level supported by a good level of investment and there were opportunities to strengthen the coding team's management structure and improve integration with medical records and the wider informatics agenda;
- the effectiveness and sustainability of the clinical coding process was undermined by the quality and availability of information, a lack of clinical engagement, limited validation and audit processes and an unsustainable management structure; and

[1] For diagnoses, the International Classification of Diseases 10th edition (ICD-10), and for treatment, the OPCS Classification of Interventions and Procedures version 4 (OPCS)

- clinical coding data was used appropriately but despite positive progress in clearing the backlog of uncoded episodes, the Health Board had failed to achieve timeliness targets, some coding was inaccurate and there were concerns that problems with coding were distracting attention away from poor performance

7 We made several recommendations, which focused on the need to:

- strengthen the management of the clinical coding team;
- improve the management of medical records;
- further build Board engagement; and
- strengthen engagement with medical staff.

8 As part of the Auditor General's 2018 audit plan for Cardiff and Vale University Health Board, we have examined the progress made in addressing the recommendations set out in the 2014 Review of Clinical Coding and any resulting improvement in clinical coding performance.

9 In undertaking this work, we have:

- reviewed documentation, including reports to the board and committees;
- asked the Health Board to self-assess its progress;
- analysed clinical coding data sent to Welsh Government;
- sought board member views[2] on their understanding of clinical coding; and
- interviewed staff to discuss progress, current issues and future challenges.

10 We summarise our findings in the following section. Appendix 1 provides specific commentary on progress against each of our previous recommendations.

Our findings

11 We conclude that the Health Board is generally producing good quality coded data, which is being used to support service improvement. However, more work is needed to fully address many of our recommendations.

Clinical coding performance is generally good, albeit that accuracy has deteriorated slightly

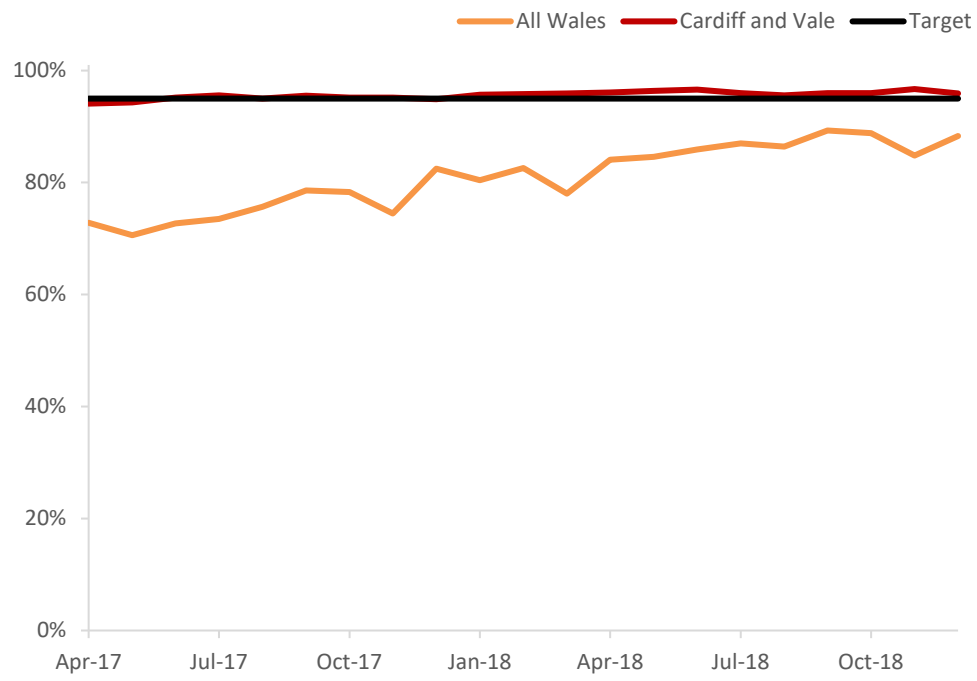
12 The Welsh Government has two coding related Tier 1 targets which NHS bodies are required to meet. These relate to completeness and accuracy.

13 Each year, NHS bodies send data to the Welsh Government showing their performance against the Tier 1 target for **completeness**. The target is that 95% end date. NHS bodies need to meet this target monthly rather than at the end of

[2] A number of questions relating to clinical coding were included in the board member survey which formed part of our 2018 Structured Assessment work. A total of 7 responses out of a possible 25 responses were received.

each financial year which was previously the case. Based on this data, Exhibit 1 shows that the Health Board has been consistently meeting the completeness target since 2017, with performance well above the all-Wales average.

Exhibit 1: percentage of all episodes coded within one month of the episode end date.



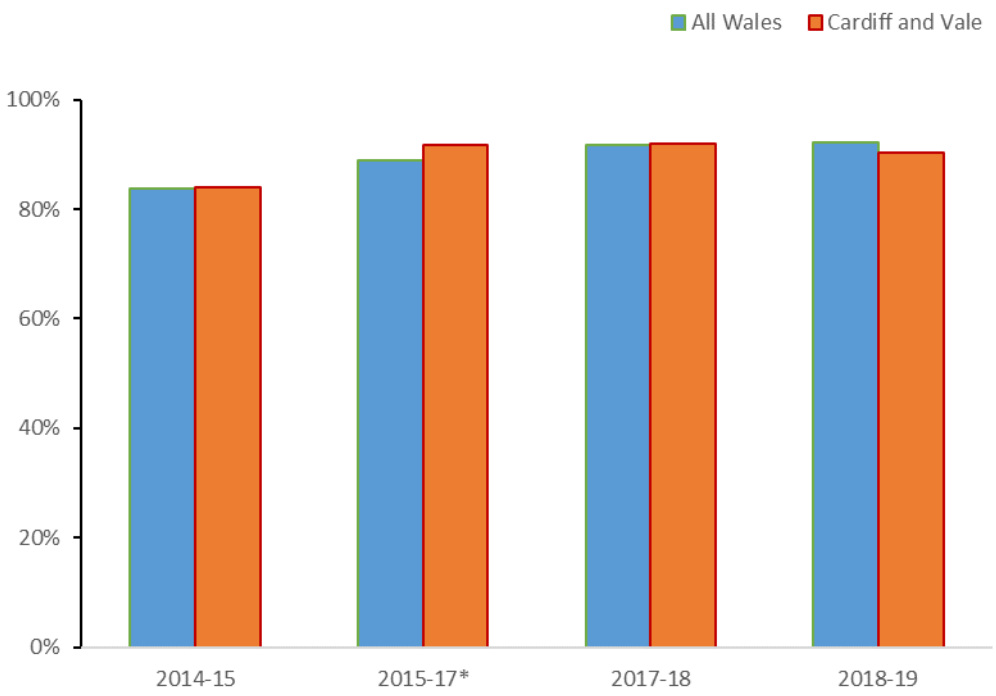
Source: Wales Audit Office analysis of data sent to Welsh Government

14 As part of our 2014 review we requested the backlog position as at 30 September 2013, this was 16,700 finished consultant episodes. We requested the backlog position as at year end March 2018 which shows the Health Board reported a small backlog of 2,145. This is a positive position and shows the backlog has been decreasing year on year.

15 Each year, the NHS Wales Informatics Service (NWIS) Standards Team check the **accuracy** of clinical coding. They do this by reviewing a sample of coded episodes and checking the information against evidence within the patients' medical record to assess accuracy. NHS bodies are expected to show an annual improvement in their accuracy. Based on this review, Exhibit 2 shows that the Health Board's accuracy has slightly deteriorated over the last 12 months. NWIS note in their report for the Health Board that there has been a drop in the overall accuracy figure from 91.85% to 89.54%, which can be directly attributed to a rise in the

number of secondary diagnosis omissions in a specific specialty where NWIS have recommended staff receive additional training.

Exhibit 2: percentage of episodes coded accurately



Source: Wale Audit Office analysis of data sent to Welsh Government
* Note that due to capacity within the NWIS clinical coding team, a single accuracy review was undertaken during the period 2015-16 and 2016-17.

The value of coded data is recognised and used by the Health Board to support service improvement

16 Previously we found that not all NHS bodies understood the wider importance of clinical coding to their business and they were missing opportunities to use this information more extensively. For example, to plan and monitor services, where coding can be used to:

- assess volumes of patients following particular clinical pathways; and
- provide comparative activity data to evaluate productivity, quality and performance.

17 The Health Board has been using coded data to support service improvement. For example, using data to inform the winter plan and capacity plan, and looking at

variance in medical and nursing practice compared to outcomes. This is positive, with recognition by the Health Board of the importance of this data in day-to-day business.

The Health Board has made some progress implementing our recommendations but more needs to be done to implement them fully

18 Exhibit 3 summarises the status of our 2014 recommendations.

Exhibit 3: Progress status of our 2014 recommendations

Total number of recommendations	Implemented	In progress	Overdue	Superseded
25	7	12	4	2

Source: Wales Audit Office

19 Our follow-up work has found that the Health Board has made some progress against our 2014 recommendations, although there is significant work remaining to full address all the recommendations.

20 Our previous review highlighted concerns around the management of the clinical coding team, as well as the lack of stability and supervisory support. Since our review, the acting clinical coding manager was made permanent. However, recent changes to the directorate structure have resulted in some interim appointments being made. The clinical coding manager has subsequently been appointed to a new role in respect of information governance. This has meant temporary appointments have been made into the head of coding and clinical coding manager positions. Currently, the Health Board has no band 5 supervisors in place. These arrangements are interim until the new structure is finalised which is due imminently.

21 There has been mixed progress on other areas of focus on coding resources. Positively staff now have regular performance appraisals and development reviews and difficulties accessing some clinical systems and the internet has been addressed. Staff are being supported to obtain the accredited clinical coder qualifications and routine validation is undertaken with results fed back to coders. However, little has been done to rotate coders across specialities so opportunities to improve knowledge and succession planning have not been realised. Additionally, although there are induction arrangements for new starters and training plans there seems to be little awareness of these amongst teams. The coding teams also still do not have the opportunity to meet regularly, and communication of important messages has been raised as a concern.

22 Issues remain with medical records which may impact on the coding departments ability to code quickly and accurately. There are still temporary records in circulation and tracking of casenotes is still problematic. We are not aware of any training or checks on medical records to improve quality, although it is positive that coding is now represented on the Medical Records Operational Group. We are unable to confirm whether coders have access to digital records from the Teenage Cancer Unit, to address the previous concerns that coders had difficulties access the paper-based records for patients admitted into the unit.

23 Board engagement with coding is good, and there is good visibility of coding performance and accuracy within the Health Board. Coding has also now been linked to the work of the Information Governance Group and board members are reporting positive levels of awareness of clinical coding, although more work is needed to raise awareness of the potential use of coded data with Independent Members. The full board survey results are available in Appendix 2.

24 However, there is still work to do to improve clinical engagement with the coding process. Clinical engagement has been described as the single most valuable resource to a coding department. This gap is recognised by the coding team, however visibility of coders is affected by their distance from the wards. The coding team have attempted to engage with clinical staff by delivering presentations to directorates on the importance of the coding function and feeding back inaccurate discharge summaries to clinicians. However, more needs to be done to ensure clinical staff receive ongoing training on the importance of coding, and the role they play in ensuring good quality data.

Recommendations still outstanding

25 In undertaking this work, we have made one additional recommendation. This is set out in Exhibit 4. The Health Board also needs to continue to make progress in addressing our previous recommendations. The outstanding recommendations are set out in Exhibit 5.

Exhibit 4: new recommendation

2019 Recommendation	
Clinical Coding Resources	
R1	Resolve the current interim arrangements by agreeing the coding management structure following the directorate reconfiguration, ensuring there is sufficient management and supervisory capacity.

Exhibit 5: recommendations still outstanding

2014 recommendations not yet complete
Clinical Coding Resources R1 Strengthen the management of the clinical coding team to ensure that good quality clinical coding data is produced. This should include: c) ensuring that there is capacity to allow band 4 coders to undertake mentoring and checking of coding of band 3 staff in line with job descriptions; d) revisiting the allocation of specialities across staff to ensure that there is sufficient flexibility within the existing capacity to cover periods of absence and succession planning is in place for staff who are due to retire in the next five to ten years; g) increasing levels of engagement between the different teams within the Health Board, to provide opportunities to raise issues, develop peer support arrangements and share knowledge; h) updating the clinical coding policy to reflect the current operational management arrangements; and k) increasing the range of validation and audit processes, including the consideration of the appointment of an accredited clinical coding auditor.
Medical Records R2 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include: a) reinforcing the Royal College of Physician (RCP) standards across the Health Board and developing a programme of audits which monitors compliance with the RCP standards; b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS); c) putting steps in place to ensure that notes that require coding are clearly identified at ward level and that clinical coding staff have early access to medical records, particularly at UHW; e) reducing the level of temporary medical records in circulation; f) considering the roll out of the digitalisation of health records to the Teenage Cancer Unit to allow easier access to clinical information for clinical coders; and g) revisiting the availability of training on the importance of good quality medical records to all staff.
Board Engagement R3 Build on the good level of awareness of clinical coding at Board to ensure members are fully informed of the Health Board's clinical coding performance. This should include: c) raising the awareness amongst Board members of the wider business uses of clinically coded data.

2014 recommendations not yet complete	
Clinical Engagement	
R4	Strengthen engagement with medical staff to ensure that the positive role that doctors have within the clinical coding process is recognised. This should include:
a)	re-enforcing the importance of completing discharge summaries to aid the coding process;
b)	ensuring that clinical staff receive an appropriate level of on-going training with regards to the process and purposes of clinical coding, outside of initial junior inductions;
c)	establishing validation processes that involve clinical staff, which will act to both improve clinical engagement and act as a form of accuracy review; and
d)	improving the 'visibility' of coding staff, to ensure that clinical engagement operates as a two-way process.

Source: Wales Audit Office

Appendix 1

Health Board progress against our 2014 recommendations

Exhibit 6: assessment of progress

Recommendation	Target date for implementation	Status	Summary of progress
Clinical Coding Resources R1 Strengthen the management of the clinical coding team to ensure that good quality clinical coding data is produced. This should include;			
a) ensuring a permanent arrangement is put in place for the Clinical Coding Manager post;	June 2014	Superseded	During our original review there was an acting clinical coding manager overseeing the operation of the clinical coding function. We recommended that a permanent appointment was made. This was because the short-term nature of the interim arrangements had the risk of making the clinical coding team unstable and it was unsettling for staff. Following our review, the Health Board produced an action plan and noted that on the 1 June 2014 a permanent Clinical Coding Manager was appointed. Following a merger of Information Technology and Information Governance there has been a temporary change in the management arrangements. Subsequently the substantive coding manager was promoted, and temporary appointments were made to the head of coding and the clinical coding manager roles. At the time of current fieldwork, there was lack of clarity about what would happen to this position post February 2019.
b) establishing the role of clinical coding supervisors within the existing structure	July 2014	Superseded	At the time of our previous review there was a surplus within the core clinical coding team which raised the potential for the Health

Recommendation	Target date for implementation	Status	Summary of progress
to support the day-to-day management of the clinical coding teams across the Health Board and provide opportunities for career progression;			Board to consider the creation of supervisor posts within its existing establishment. This would reduce pressure on the acting clinical coding manager. Following our review two clinical coding supervisors were appointed in July 2014. However, following the moves within the team there are now no Band 5 clinical coding supervisors in place despite the roles being offered internally to the teams. Due to the uncertainty with the manager positions, the Health Board made a decision to pause recruitment to these roles until there was further clarity with the manager positions. The Health Board needs to make a longer-term plan for band 5 and band 6 positions going forward.
c) ensuring that there is capacity to allow band 4 coders to undertake mentoring and checking of coding of band 3 staff in line with job descriptions;	No target date specified	In progress	In our 2014 review we found that there was no formal mentoring programme in place for new starters within the team. However, this has now been addressed and there is a detailed induction process for all new clinical coding staff that is set out in the department's 'Trainee Clinical Coder Induction Programme'. Experienced ACC qualified staff are expected to undertake mentoring within their own speciality. However, awareness of this training seems low and staff have reported however that the support for new staff is not always consistent.
d) revisiting the allocation of specialities across staff to ensure that there is sufficient flexibility within the existing capacity to cover periods of absence and succession planning is in place for staff who are due to retire in the next five to ten years;	December 2014	In progress	Our last review found there was a good level of clinical coding experience in the department. At that time, clinical coding workload was managed through a speciality allocation. All coders were allocated a speciality except the recently appointed coders who covered all specialities. Coders did not routinely rotate specialities and therefore remain coding a specific speciality for a considerable period. Arrangements have remained the same and staff code in specialities, but they do support each other in all areas which helps keep their knowledge up to date. The most recent NWIS report

Recommendation	Target date for implementation	Status	Summary of progress
			notes that the coding management should look into the possibility of rotating staff who are requesting or require a change of speciality for their own personal development. NWIS recommend that this would allow the coding staff to gain a comprehensive understanding and experience in all areas of coding applicable to the Health Board. There is no evidence of succession planning.
e) considering the implementation of the accredited clinical coding qualification;	August 2014	Implemented	We found in 2014 that the Health Board did not require any of its clinical coding staff to be accredited at appointment or to gain accreditation whilst in post. Subsequently the Health Board has introduced the clinical coding qualification and all trainees are currently working towards this, with a requirement to obtain the qualification to progress to Band 4. However, some staff expressed concern about the level of support they receive during their training and the Health Board may wish to consider its approach.
f) putting arrangements in place to ensure that all staff receive an annual performance appraisal and development review;	December 2014	Implemented	In 2014 many staff had not received an annual performance appraisal and development review (PADR), with some not having an appraisal for some years. This is now resolved, and the department is 100% compliant with PADRs with staff all now having annual appraisals.
g) increasing levels of engagement between the different teams within the Health Board, to provide opportunities to raise issues, develop peer support arrangements and share knowledge;	October 2014	In progress	We previously found that coding teams within the Health Board have not had the opportunity to meet as whole team, nor did they have routine meetings at site level. This lack of engagement has remained and there is no engagement between the two sites. There are no formal team meetings in place, and staff we spoke to felt that team meetings would be a more positive way of communicating major announces of changes than via email which is currently the preferred method of communication.
h) updating the clinical coding policy to reflect the current operational management arrangements;	September 2014	In progress	The Health Board has always had a comprehensive coding policy, and this is supported by the recent NWIS review. The policy covers standard coding procedures as well as validation practices within

Recommendation	Target date for implementation	Status	Summary of progress
			the organisation, the structure of the department as well as local policies. Unfortunately, due to the recent staff changes and interim arrangements the structure set out in the policy is not reflective of the current operational management of the coding team and could be updated.
i) working with colleagues within the Informatics Directorate to look at the potential to move Medicode to a central server arrangement;	September 2014	Implemented	Medicode is a specific system used by coders to produce the coding output. Our previous review found that there were several issues with the system. It was held on individual machines within the Health Board and therefore when an update was required it was necessary to update each machine individually. This was time consuming and resource intensive compared to hosting Medicode on a central server. This has now been resolved and Medicode is held centrally which has addressed this issue.
j) allowing all clinical coding staff access to the appropriate clinical information systems and the internet; and	September 2014	Implemented	Previously coding staff had limited access to systems and had no access to the Internet, which impacting on the ability of coding staff to be efficient in finding out relevant information. Staff now have access to the internet, and other clinical systems which has had a positive impact. It has made their job easier, as they are not clinically trained, they can look terms up for clarification.
k) increasing the range of validation and audit processes, including the consideration of the appointment of an accredited clinical coding auditor.	November 2014	In progress	To ensure that clinical coded data submitted centrally is of good quality it is important that Health Boards have appropriate mechanisms to verify and validate the data as it is processed. Previously there was little validation work undertaken, however there is now evidence of an improved validation and audit process whereby managers pick one to two sets of case notes per coder every week to validate at random. Errors are fed back to the individual and a spreadsheet is kept of all validations completed. A report is produced every quarter to show coders how they are performing. However, there has been no formal appointment of a clinical auditor and no plans currently to do this.

Recommendation	Target date for implementation	Status	Summary of progress
Medical Records			
R2 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include;			
a) reinforcing the Royal College of Physician (RCP) standards across the Health Board and developing a programme of audits which monitors compliance with the RCP standards;	No date specified by the Health Board	Overdue	The quality of medical records can have a direct impact on the quality of coding. The quality of the information recorded in medical records however rests with the clinical staff. We have not seen evidence that the RCP standards are being enforced but the coding team do continually return case notes that fall below a standard making them unable to code. The most recent NWIS report highlights that the patients case notes continued to be an issue for the Health Board with regards to their poor physical condition and the quality of the documentation.
b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS);	No date specified by the Health Board	In progress	To facilitate the achievement of the Welsh Government target that 95% of coding activity should be completed within one month of the end of the hospital episode, it is important that clinical coders get timely access to the patient's medical records. From our last review we found that tracking of records was an issue. If records are not tracked effectively this means it can take longer for coders to access them. Coders are reporting that they are tracking records, however practices across the Health Board are not consistent and still cause issues.
c) putting steps in place to ensure that notes that require coding are clearly identified at ward level and that clinical coding staff have early access to medical records, particularly at UHW;	No date specified by the Health Board	In progress	This was an area of focus to enable coders quick access to records that needed to be coded, as it affects the ability of coders to meet the deadlines. Coders felt that they had efficient access to notes from the wards, but problem arose when wards took them back without telling them or tracking them on the system. Tracking of case notes is a standing item on the Medical Records Operational Group however there has been little impact in dealing with this.

Recommendation	Target date for implementation	Status	Summary of progress
d) improving engagement between the clinical coding department and medical records, including the establishment of a Health Records Committee with representation from the clinical coding team;	No date specified by the Health Board	Implemented	In 2014 the Health Board did not have a Health Records Group, which meant there was little opportunity for escalating issues relating to the quality of medical records. Subsequently the Health Board has improved engagement between the coding department and medical records by having coding representation on the Medical Records Operational Group.
e) reducing the level of temporary medical records in circulation;	No date specified by the Health Board	In progress	Our review in 2014 found a considerable number of temporary folders. As well as a clinical risk, this has implications for the quality of clinical coding as relevant previous medical history may be omitted from the coding of a patient's episode of care. Coders and the recent NWIS report are highlighting that temporary folders are still an area of concern, and it has been raised in the Medical Records Operational Group as a concern.
f) considering the roll out of the digitalisation of health records to the Teenage Cancer Unit to allow easier access to clinical information for clinical coders; and	No date specified by the Health Board	Overdue	We do not have an update on the position in respect of this action. In 2014 we made the recommendation as accessing the records on the Teenage Cancer Unit was problematic to coders and meant they were having to attend the wards in person to code on site. Access to digital records would have resolved this issue but we are not aware whether digital records have been rolled out to include the Unit.
g) revisiting the availability of training on the importance of good quality medical records to all staff.	No date specified by the Health Board	In progress	The quality of medical records has a direct impact on the quality of coded data. Our 2014 report highlighted that when looking at the standards of medical records the areas which were most problematic fell under the responsibility of clinical staff. Various activities have been held by the Health Board such as presentations to clinical staff groups, however it is difficult to gauge how effective these have been. This will need to be an ongoing area of focus for the Health Board.

Recommendation	Target date for implementation	Status	Summary of progress
Board Engagement R3 Build on the good level of awareness of clinical coding at Board to ensure members are fully informed of the Health Board's clinical coding performance. This should include:			
a) ensuring that information that gets reported to the Board and through its sub-committees reports the accuracy of clinical coding;	No date specified by the Health Board	Implemented	Previously clinical coding had received significant attention at the Board with a primary focus on the Risk Adjusted Mortality Index (RAMI). There had also been dedicated coding updates. This focus has remained and improved as the Health Board has taken steps towards addressing this recommendation by including coding completeness and accuracy figures in monthly performance papers. Coding completeness figures are also included as a data quality indicator on the mortality dashboard circulated to the board.
b) considering the potential to link clinical coding performance and the wider implications for data quality into the business of the Information Governance Group; and	August 2014	Implemented	Clinical coding forms part of the Informatics Directorates with direct links with the data quality agenda and the wider Information Governance arrangements. Coding has been linked to the business of the Information, Technology and Governance Sub-Committee. Positively the previous coding manager now has an Information governance role which also improves the links between coding and information governance. Coding and functionality have been developed on DATIX to ensure that all incidents that could potentially relate to Information Governance breaches can be identified by coding or deliberately flagged by reporters or managers. These arrangements commenced in January 2017 and are being progressively refined.
c) raising the awareness amongst Board members of the wider business uses of clinically coded data.	No date specified by the Health Board	In progress	Positively the board member survey in 2018 shows that members have some or full awareness of the factors which can affect the robustness of clinical coding and most were satisfied that the organisation is doing enough to make sure that clinical coding arrangements are robust. However, some said they would find it helpful to have more information on clinical coding and the extent to which it affects the quality of key performance information.

Recommendation	Target date for implementation	Status	Summary of progress
Clinical Engagement R4 Strengthen engagement with medical staff to ensure that the positive role that doctors have within the clinical coding process is recognised. This should include;			
a) re-enforcing the importance of completing discharge summaries to aid the coding process;	No date specified by the Health Board	In progress	Our previous review found issues with the lack of completed discharge summaries which can cause problems for coders as it becomes difficult to identify and code the diagnoses and procedures undertaken. Steps have been taken by the team with inaccurate discharge summaries sent back to clinicians for clarification but there are still issues with discharge summaries within the Health Board.
b) ensuring that clinical staff receive an appropriate level of on-going training with regards to the process and purposes of clinical coding, outside of initial junior inductions;	No date specified by the Health Board	Overdue	Clinical engagement has been described as the single most valuable resource to a coding department. Our previous review found limited clinical engagement. Although positively clinical coding training was included within the induction training for junior doctors, there was little other training around the benefits and uses of coded data which may have in turn improved the quality of information being coded. There is no evidence to suggest that clinical staff receive on-going training with regards to the process and purposes of clinical coding.
c) establishing validation processes that involve clinical staff, which will act to both improve clinical engagement and act as a form of accuracy review; and	No date specified by the Health Board	Overdue	One of the identified models of good practice is to engage clinicians in the validation process. Our previous fieldwork found limited engagement of clinicians in validation of data. This position remains, and although the coding team recognise the importance of clinical engagement, there are barriers such as being based far from wards and finding the time to access clinicians.
d) improving the 'visibility' of coding staff, to ensure that clinical engagement operates as a two-way process.	No date specified by the Health Board	In progress	There is a recognition that to improve engagement with clinicians, staff must be more visible. The coding team recognise this and have been trying to improve their visibility. For example, a coding manager gave a presentation to the Child Health Directorate in November 2018 to show them how important coding is. However, assessing the impact of these activities is challenging. They

Recommendation	Target date for implementation	Status	Summary of progress
			recognise that more could be done to engage clinicians, although the physical location some way from the clinical areas is not helpful.

Source: Wales Audit Office

Appendix 2

Results of the board member survey

Responses were received from 7 of the board members in the Health Board.
The breakdown of responses is set out below.

Exhibit 7: rate of satisfaction with aspects of coding

	How satisfied are you with the information you receive on the robustness of clinical coding arrangements in your organisation?		How satisfied are you that your organisation is doing enough to make sure that clinical coding arrangements are robust?	
	This Health Board	**All Wales**	**This Health Board**	**All Wales**
Completely satisfied	2	6	-	5
Satisfied	2	34	5	40
Neither satisfied nor dissatisfied	2	46	2	46
Dissatisfied	1	10	-	4
Completely dissatisfied	-	-	-	1
Total	7	96	7	96

Exhibit 8: rate of awareness of factors affecting the robustness of clinical coding

	How aware are you of the factors which can affect the robustness of clinical coding arrangements in your organisation?	
	This Health Board	**All Wales**
Full awareness	3	26
Some awareness	4	50
Limited awareness	-	17
No awareness	-	3
Total	7	96

Exhibit 9: Level of concern and helpfulness of training

	Are you concerned that your organisation too readily attributes under performance against key indicators to problems with clinical coding?		Would you find it helpful to have more information on clinical coding and the extent to which it affects the quality of key performance information?	
	This Health Board	**All Wales**	**This Health Board**	**All Wales**
Yes	-	8	3	77
No	7	84	4	19
Total	7	92	7	96

Exhibit 10: additional comments provided by respondents from the Health Board

- Moving to SNOWMED will make a huge difference, we are leading the way in Wales with this work.
- Robust work on clinical coding has been done and it is well understood.
- Clinical coding is regularly considered as part of the performance discussions and there is awareness of the pressures on the service and the important of accurate and timely coding. There are areas where improvements are being made to improve the resilience of the service considering the key role it plays.

Appendix 3

Management response

Exhibit 11: management response

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	**Clinical Coding Resources** Resolve the current interim arrangements by agreeing the coding management structure following the directorate reconfiguration, ensuring there is sufficient management and supervisory capacity.	To improve clarity around management structure	Yes	Yes	The clinical coding teams are included in the restructure of the directorate, with the launch taking place on 4/6/19. The new structure will provide adequate management and supervisory capacity.	New structure in place by September 2019	Director of Digital

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Cardiff & Vale University Health Board

Medical PPV Progress Report: 1st April 2019 to 30th September 2019

	0-4%	Low risk
	5-9%	Medium risk
	10%+	High risk

UHB Claim error % Ave	3.61%
Wales claim error % Ave	TBC
2019/20 recovery amount	£2,779.41

	Visit 1				Visit 2				Visit 3			
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors
Practice 1	3/14/2017	Routine	6.57%	£610.59	6/6/2018	Revisit	40.00%	£2,933.18	4/15/2019	Routine	137	6
Practice 2	3/12/2015	Routine	1.73%	£77.44	3/21/2016	Revisit	14.02%	£115.05	4/1/2019	Routine	290	2
Practice 3	8/20/2015	Routine	0.00%	£0.00					6/28/2019	Routine	523	18
Practice 4	11/19/2014	Routine	1.07%	£788.81	4/5/2018	Routine	3.48%	£759.83	6/6/2019	Revisit	297	20
Practice 5	10/10/2013	Revisit	23.51%	£14,718.88	2/15/2018	Routine	2.84%	£129.20	7/25/2019	Revisit	42	2
Practice 6	2/26/2016	Revisit	4.47%	£1,417.73	5/25/2018	Routine	6.38%	£474.85	7/10/2019	Revisit	96	2
Practice 7	12/17/2014	Routine	3.57%	£89.33					8/9/2019	Revisit		
Practice 8	2/17/2015	Routine	9.35%	£4,195.66					9/30/2019	Routine		
Practice 9	7/1/2015	Revisit	4.98%	£3,100.04					9/6/2019	Routine		
Practice 10	5/1/2015	Routine	5.71%	£383.74	5/27/2016	Revisit	9.84%	£527.31	9/4/2019	Routine		

Claim error %	Recovery
4.38%	£195.10
0.69%	£75.00
3.44%	£560.63
6.73%	£1,762.00
4.76%	£51.68
2.08%	£135.00

Health Board	Year	Anti-Coagulation Monitoring	Anti-Coagulation Slow Loading	Care Homes	Contraceptive	Flu	Gonadorelin	Homeless	Learning Disabilities	Minor Surgery	MMR	Near Patient Testing
Cardiff & Vale	2019/2020											
	2018/2019	**26**	**13**	**8**	**8**	**112**	**38**	**0**	**18**	**244**	**4**	**122**
	2017/2018	**118**	**118**	**0**	**5**	**239**	**52**	**2**	**15**	**139**	**4**	**112**

	Health Board			All Wales		
	2017/2018	**2018/2019**	**2019/2020**	**2017/2018**	**2018/2019**	**2019/2020**
Number of practices visited	24	35	10	193	216	
Amount of claims sampled	7,793	11,180	1,385	106,956	88,044	
Claim errors identified	833	746	50	9,969	6,495	
Average admin error rate	**5.16%**	**9.21%**	TBC	**9.77%**	**4.52%**	
Average claim error rate	**10.69%**	**6.67%**	**3.61%**	**9.32%**	**7.38%**	
Recovery amount	£22,624.81	£33,885.74	£2,779.41	£223,547.14	£194,539.64	

Key report points:
For the first six months of the visit cycle for GP practices it is good to see that we have practices improving wholesale. There are no practices currently sat in a red rating and no concerns to raise.
We hold quarterly meetings with Primary Care, Counter Fraud and Finance to discuss performance and any issues arising. From the last meeting in July 2019 we identified two practices for PPV to offer one-on-one training and we have reached out to them to offer those services.
We are currently in discussions with Primary Care around a wider audience for a presentation style of training and are looking into attending practice manager forums to deliver this style of support.
So far this financial year is showing evidence in a drastic reduction in recovery amounts which is pleasing and shows improvements from the practices.

NOAC	NOAR	Non UK Residents	Nursing Home	Pertussis	Substance Misuse	Totals
20	15	8	103	7	0	746
3	0	8	10	6	2	833

Cardiff & Vale University Health Board

Ophthalmic PPV Progress Report: 1st April 2019 to 30th September 2019

	0-4%	Low risk
	5-9%	Medium risk
	10%+	High risk

UHB Claim error % Ave	6.26%
Wales claim error % Ave	TBC
2019/20 recovery amount	£4,390.65

	Visit 1				Visit 2				Visit 3			
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors
Practice 1	4/21/2016	Routine	8.00%	£254.00	5/2/2017	Revisit	9.00%	£1,260.00	4/5/2019	Routine	103	2
Practice 2	4/29/2016	Routine	4.00%	£119.40					4/12/2019	Routine	103	1
Practice 3									4/3/2019	Routine	103	0
Practice 4	5/11/2017	Routine	5.00%	£188.80	7/20/2018	Revisit	3.33%	£341.00	5/16/2019	Routine	103	0
Practice 5	5/27/2014	Routine	8.33%	£348.60	2/7/2018	Routine	3.00%	£140.40	5/23/2019	Revisit	300	14
Practice 6	7/23/2013	Routine	3.00%	£87.30	1/30/2017	Routine	2.00%	£80.00	5/30/2019	Routine	103	0
Practice 7	11/16/2016	Routine	6.00%	£298.70					5/17/2019	Routine	103	0
Practice 8	9/26/2016	Routine	3.00%	£120.00					6/12/2019	Routine	103	4
Practice 9	1/23/2013	Routine	0.00%	£0.00	7/27/2016	Routine	0.00%	£0.00	6/3/2019	Routine	103	3
Practice 10									6/13/2019	Routine	103	12
Practice 11	8/10/2015	Routine	0.00%	£0.00					6/25/2019	Routine	103	0
Practice 12	4/13/2015	Routine	6.00%	£52.40	5/2/2018	Routine	15.53%	£401.15	7/9/2019	Revisit	300	76
Practice 13	3/30/2015	Routine	1.00%	£38.30	8/16/2018	Routine	3.23%	£137.50		Routine		
Practice 14	5/8/2013	Routine	0.00%	£0.00	2/13/2017	Routine	0.00%	£0.00	7/24/2019	Routine	103	3
Practice 15	5/28/2013	Routine	0.00%	£0.00	11/24/2016	Routine	0.00%	£0.00	7/18/2019	Routine	103	0
Practice 16	1/24/2017	Routine	14.00%	£389.80	4/6/2018	Revisit	7.67%	£1,101.60	8/12/2019	Routine		
Practice 17	1/26/2017	Routine	1.00%	£60.00					8/28/2019	Routine		
Practice 18	9/16/2016	Routine	10.00%	£422.90	11/15/2017	Revisit	51.65%	£1,229.80	9/9/2019	Routine		
Practice 19	10/3/2013	Routine	3.00%	£173.80	8/18/2016	Routine	0.00%	£0.00	9/19/2019	Routine		
Practice 20	10/26/2015	Routine	8.00%	£207.30	10/17/2016	Revisit	26.58%	£792.95	9/12/2019	Routine		

Claim error %	Recovery
1.94%	£61.20
0.97%	£39.10
0.00%	£0.00
0.00%	£0.00
4.67%	£483.20
0.00%	£0.00
0.00%	£0.00
3.88%	£134.45
2.91%	£137.20
11.65%	£461.20
0.00%	£0.00
25.33%	£3,011.35
2.91%	£62.95
0.00%	£0.00

Health Board	Year	GOS 3	GOS 4	EHEW
Cardiff & Vale	2019/2020			
	2018/2019	10	31	136
	2017/2018	22	59	101

	Health Board			All Wales		
	2017/2018	2018/2019	2019/2020	2017/2018	2018/2019	2019/2020
Number of practices visited	30	18	20	172	141	
Amount of claims sampled	3,882	2,547	1,836	22,083	17,506	
Claim errors identified	180	176	115	1,342	1,080	
Average admin error rate	**16.63%**	**22.61%**	TBC	**7.37%**	**4.30%**	
Average claim error rate	**4.64%**	**6.91%**	**6.26%**	**40.19%**	**40.79%**	
Recovery amount	£6,703.30	£7,050.95	£4,390.65	£54,640.34	£37,808.65	

Key report points:

On the whole there are great improvements in the record keeping for GOS practices. We have two that have triggered a red rating, one we will offer training and the other will receive a revisit from us so we can give assurance of improvements.

We have a date booked for October 2019 to deliver a training presentation to contractors in an evening to show correct record keeping technique and highlight the importance of patient safety via record keeping.

We are in conversation with Primary Care in our quarterly meetings to ensure that we remain ahead of the curve and offer support where it is required.

Cardiff & Vale University Health Board

Pharmacy PPV Progress Report: 1st April 2019 to 30th September 2019

	0-4%	Low risk
	5-9%	Medium risk
	10%+	High risk

UHB Claim error % Ave	1.10%
Wales claim error % Ave	TBC
2019/20 recovery amount	£282.00

	Visit 1				Visit 2				Visit 3			
Practice code	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Claim error %	Recovery	Visit date	Visit type	Sample size	Claim errors
Practice 1	2/24/2017	Routine	0.00%	£0.00					4/12/2019	Routine	97	0
Practice 2	2/24/2017	Routine	5.00%	£28.00					4/12/2019	Routine	44	0
Practice 3	8/12/2016	Routine	0.00%	£0.00					5/14/2019	Routine	100	4
Practice 4	4/19/2016	Routine	0.00%	£0.00					5/14/2019	Routine	95	1
Practice 5	11/15/2016	Routine	4.17%	£56.00					5/21/2019	Routine	87	0
Practice 6									5/21/2019	Routine	50	0
Practice 7									6/26/2019	Routine	94	1
Practice 8	10/21/2016	Routine	0.00%	£0.00					6/26/2019	Routine	24	1
Practice 9	12/6/2016	Routine	21.00%	£112.00					6/11/2019	Routine	95	0
Practice 10	9/2/2016	Routine	0.00%	£0.00					7/23/2019	Routine		
Practice 11	3/7/2017	Routine	0.00%	£0.00					7/23/2019	Routine		Waste
Practice 12					4/20/2018	Routine	5.00%	£28.00	7/5/2019	Routine	97	2
Practice 13									7/5/2019	Routine	38	0
Practice 14	8/12/2016	Routine	0.00%	£0.00	8/22/2018	Routine	4.76%	£45.41	8/14/2019	Revisit		
Practice 15	3/11/2016	Routine	0.00%	£0.00					8/22/2019	Routine		
Practice 16									8/22/2019	Routine		
Practice 17									9/11/2019	Routine		
Practice 18									9/11/2019	Routine		
Practice 19									9/24/2019	Routine		
Practice 20									9/24/2019	Routine		

Claim error %	**Recovery**
0.00%	£0.00
0.00%	£0.00
4.00%	£140.00
1.05%	£28.00
0.00%	£0.00
0.00%	£0.00
1.06%	£28.00
12.50%	£28.00
0.00%	£0.00
e only	
2.06%	£58.00
0.00%	£0.00

Health Board	Year	MUR	Flu
Cardiff & Vale	2019/2020		
	2018/2019	30	56
	2017/2018	36	18

	Health Board			All Wales	
	2017/2018	2018/2019	2019/2020	2017/2018	2018/2019
Number of practices visited	35	36	20	298	230
Amount of claims sampled	3,008	2,657	821	22,931	18,570
Claim errors identified	53	83	9	520	870
Average admin error rate	**21.40%**	**19.10%**	TBC	**16.83%**	**16.16%**
Average claim error rate	**1.76%**	**3.12%**	**1.10%**	**2.27%**	**4.68%**
Recovery amount	£1,252.49	£1,702.50	£282.00	£14,079.99	£20,003.71

Key report points:
With the introduction of CHOOSE Pharmacy we are no longer going to verify flu claims. The sy with the Pharmacy Board our resource could be more effectively used. We are currently scopir
We are consistently informing contractors of the requirements on them to both make a claim pa ensure that patient safety is paramount and any record is reflective of that person.
The recovery rates and percentages have dropped again which is pleasing to see. We are in o it shows that feedback from initial visits has been taken on board.
We are in conversation with Primary Care in our quarterly meetings to ensure that we remain a support where it is required.

2019/2020

ystem is robust and it was agreed ng new areas to look into.
ayable, and also accurate to
ur second cycle of practices and
ahead of the curve and offer

Report Title:	**External Audit Recommendation Tracking Report**								
Meeting:	Audit Committee						**Meeting Date:**	30.09.2019	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

SITUATION

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

BACKGROUND

The WAO Structured Assessment for 2018, issued in January 2019, recommended that the Health Board should improve its recommendation tracking by :

(i) addressing the outstanding 2016 structured assessment recommendation to strengthen tracking arrangements for external audit recommendations;
(ii) including the tracking of internal audit recommendations;
(iii) completing a review of all outstanding internal and external audit recommendations and reporting the finding to the Audit Committee.

This report deals with external audit recommendation tracking.

ASSESSMENT

External Audit recommendation tracking has not previously taken place at Cardiff and Vale Health Board in an effective way for quite some time hence the recommendation made by Wales Audit Office in their Structured Assessment for 2018. This piece of work has now been undertaken and all external audit reports for the last two are now on the External Audit Tracker (attached at appendix 1).

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

The table below shows a summary status of each of the recommendations made for external audits undertaken in **17/18, 18/19 and 19/20** as at 20th September 2019. On the main WAO tracker are audit recommendations which go back to the financial year 13/14 however, there is no proposal to bring a summary of those recommendations to the Audit Committee unless the Committee feel this is necessary.

External Audit	Complete	%	Not due	%	In progress	%	< 3 mths	%	> 3 mths	%	+6 mths	%	+ 1 year	%	Total
Structured Assessment 2018	10	37	3	11	6	22	-		5	19	-		3	11	27
Clinical Coding Follow Up							1	100							1
Discharge Planning									4	40	4	40	2	20	10
Primary Care Service			2	14							12	86			14
Review of GP Out of Hours Service													10	100	10
Review of Medical Equipment									3	37	4	50	1	13	8
Total	**10**	**15**	**5**	**7**	**6**	**8**	**1**	**2**	**12**	**17**	**20**	**28**	**16**	**22**	**70**

As can be seen from the above tables there is further work to be done to ensure that recommendations made by WAO and agreed by Executive Directors are implemented in a timely manner. With tracking now starting to take place on a quarterly basis there is an expectation that this will improve.

Reports will, in future, be discussed at Management Executives and HSMB which includes the entire leadership team of the organisation.

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

RECOMMENDATION

The Audit Committee Members are asked to:

(a) Note the tracking report which is now in place for tracking audit recommendations made by External Audit (WAO).

(b) Note that progress will be seen over coming months in the number of recommendations which are completed/closed.

Shaping our Future Wellbeing Strategic Objectives

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

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X

4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

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

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

Audit Log Ref No.	Financial Year Fieldwork Undertaken	Final Report Issued on	Audit Title	Executive Lead for Report	No. of Recs Made	Rec No.	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implement ation Date	Committee Implementation Monitored by	Age Group
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R1/11	The Health Board should complete our 2017 structured assessment recommendations by the end of 2019.	Agreed and these will be monitored to ensure this happens through Management Executives and reported to Audit Committee	Director of Corporate Governance	Dec-19	Audit and Assurance Committee	Due Date Not Reached
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R1a/11	R13 [2016] 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 he relevant committees of the Board.	There is a tracker for WAO recommendations. The current arrangements don't provide enough clarity around what happens to recommendations where committees other than the audit committee are responsible	Director of Corporate Governance	Dec-16	Audit and Assurance Committee	Complete
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R1b/11	R2 [2017] To ensure compliance with the NHS planning framework, the Health Board needs to ensure that the Strategy and Engagement Committee regularly scrutinises progress on delivery of the Annual Operating Plan, and subsequent three year integrated medium term plans.	The new S&D Committee's work plan includes scrutiny of key elements of the Annual Operating Plan, 10-year strategy and transformation programme. The Committee and the Board still need to receive appropriate progress updates against the Annual Operating Plan deliverables to ensure they are on track.	Director of Governance	Dec-16	Strategy and Delivery Committee	Complete
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R1c/11	R3 [2017] To enable effective scrutiny, the Health Board needs to improve the quality of its papers to Board and Committees by ensuring that the length and content of the papers presented is appropriate and manageable.	The length of Board and committee papers has improved compared to last year, but inconsistencies and variation remain. The Health Board's introduction in September 2018 of a revised cover report template should encourage more succinct reporting	Director of Governance	Dec-16	Audit and Assurance Committee	Over One Year
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R1d/11	R4 [2017] To improve transparency, the Health Board needs to ensure that the Finance Committee papers are made available on its website in a timely manner.	At December 2018, the October 2018 Finance Committee papers were not available on the Health Board's website.	Director of Governance	Dec-16	Finance Committee	Over One Year

WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R1e/11	R5 [2017] The Health Board needs to strengthen its corporate risk assurance framework (CRAF) by: - mapping risks to the Health Board's strategic objectives; - reviewing the required assurances; - improving clarity of risk descriptors; and clarifying to the reader the date when risks are updated and/or added.	Until recently, the Health Board had made little progress in updating the CRAF. The CRAF was last presented to the Board and committees in November 2017. We recognise the Health Board has recently taken steps to start developing a separate Board Assurance Framework and Corporate Risk Register. The draft BAF was received at both the Audit Committee and Board in November and December respectively.	Director of Governance	Dec-16	Audit and Assurance Committee	In progress
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R1f/11	R6 [2017] The Health Board needs to focus its attention on strengthening its information governance arrangements in readiness for the General Data Protection Regulations, which come into force in May 2018. This should include: - updating the information governance strategy; - putting in place arrangements for monitoring compliance of the primary care information governance toolkit; and - developing and completing an Information Asset Register; - ensuring that an identified data protection officer is in place; and - improving the uptake of information governance training.	- An up-to-date Information Governance strategy does not yet exist. The Health Board has drafted its strategic approach in the Information Governance Policy. The Health Board plans to agree and implement this approach later in 2018. - NWIS has developed the information governance toolkit for primary care GP's and intend to monitor compliance at a GP cluster level. These compliance monitoring arrangements for are still being developed. The Primary Care Clinical Board is liaising with the NHS Wales Informatics Service to confirm and agree these arrangements. - Information asset registers have been developed within the corporate directorates and clinical boards, but further work is required to fully complete this. The Health Board is planning further work to: identify personal information held; identify	Director of Transformation and Informatics	Dec-16	Digital and Health Intelligence Committee	In progress

WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R1g/11	to ensure that the level of information reported to the Resource and Delivery Committee on its performance is sufficient to enable the Committee to scrutinise effectively. This should include: - ensuring that the Committee receives more detailed performance information than that received by the Board. Consideration should be made to including a summary of the Clinical and Service Board dashboards used in the monthly executive performance management reviews; - expanding the range of performance metrics to include a broader range of key performance indicators relating to workforce. Consideration should	Overall this recommendation has been partly addressed. - The S&D Committee continues to receive a high-level performance dashboard, which is less detailed than the performance report received by the Board. - Since September 2018, the S&D Committee receives six-monthly updates against the workforce plans, including key workforce metrics.	Director of Transformation and Informatics	Dec-16	Strategy and Delivery Committee	Complete
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R1h/11	R9 [2017] To ensure resilience to security issues, such as cyber-attacks, the Health Board should consider identifying a dedicated resource for managing IT security.	In early 2018, the Health Board received an external review of cyber security arrangements. The review recommended improvements to cyber security arrangements. In response the Health Board is developing a formal cyber security improvement action plan. It plans to bring in specialist cyber security skills in early 2019 to address these recommendations and establish a specialist cyber security team.	Director of Transformation and Informatics	Dec-16	Digital and Health Intelligence Committee	In progress
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R1i/11	R10 [2017] To improve scrutiny of the Health Board's informatics service, the Health Board should expand the range of key performance indicators relating to informatics to include the cause and impact of informatics incidents.	The Health Board plans to review in early 2019 the structure and governance of its information and information technology functions to deliver the digital strategy.	Director of Transformation and Informatics	Dec-16	Digital and Health Intelligence Committee	Over One Year

WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R2a/11	The Health Board should improve its recommendation tracking by: a. addressing our outstanding 2016 structured assessment recommendation to strengthen tracking arrangements for external audit recommendations;	Agreed this will be presented to the next Audit Committee	Director of Corporate Governance	Feb-19	Audit and Assurance Committee	complete
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R2b/11	b. including the tracking of internal audit recommendations; and	Agreed	Director of Corporate Governance	Feb-19	Audit and Assurance Committee	complete
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R2c/11	c. completing a review of all outstanding internal and external audit recommendations and reporting the findings to the Audit Committee.	Agreed	Director of Corporate Governance	Feb-19	Audit and Assurance Committee	complete

WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R3a/11	The Health Board should: a. Update the Scheme of Delegation to reflect the delegated responsibility for calculating nurse staffing levels for designated acute medical and surgical inpatient wards;	Agreed in progress as result of Internal Audit Report	Director of Corporate Governance	Mar-19	Audit and Assurance Committee	In progress
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R3b/11	b. Review and update the Standing Orders and Standing Financial Instructions, ensuring these documents are reviewed and approved on an annual basis;	Agreed and timetabled to be undertaken on an annual basis going forward	Director of Corporate Governance	Mar-19	Audit and Assurance Committee	Complete
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R3c/11	c. Improve the format of the registers for declarations of interest and gifts, hospitality and sponsorship and clarify the frequency with which the registers are presented to the Audit Committee;	Agreed registers will be improved in format and reported to Audit Committee twice a year	Director of Corporate Governance	Apr-19	Audit and Assurance Committee	Complete
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R3d/11	d. Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date;	Agreed	Director of Corporate Governance	Oct-19	Audit and Assurance Committee	In progress
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R3e/11	e. Review all committee terms of reference to make sure they are up to date, do not overlap, and are reviewed annually;	Agreed in progress	Director of Corporate Governance	Mar-19	Audit and Assurance Committee	Complete

WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R3f/11	f. Ensure all committees have an up-to-date work programme, which is linked to the cycle of Board meetings and reviewed annually.	Agreed work plans for each Committee and the Board are in development	Director of Corporate Governance	Mar-19	Audit and Assurance Committee	complete
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R4/11	The Health Board should update its performance management framework to reflect the organisational changes that have taken place since 2013.	We accept that the performance management framework should be reviewed to ensure it fully supports the organisational business.	Director of Transformation and Informatics	Sep-19	Strategy and Delivery Committee	In progress
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R5/11	The Health Board should provide the Finance Committee, or Board, with an update on progress with its testing and delivery of the All Wales Costing System Implementation Project.	The UHB accepts the need to provide an update on progress with this project. As a series of Welsh Costing Returns (WCRs) have now been submitted to Welsh Government using the new system, a comprehensive update on the implementation and future use of the costing development can now be made. It is intended to provide a paper to the Finance Committee following finalisation and publication of WCRs within Wales.	Director of Finance	Apr-19	Finance Committee	Over 3 Months
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R6/11	The Health Board should ensure that all recommended matches from the next NFI exercise in January 2019 are reviewed and where necessary investigated in a timely manner.	For the forthcoming NFI exercise, the Health Board will endeavour to increase its compliance in respect of the number of recommended matches checked. A large number of these matches are however in relation to Accounts Payable and this will require further matching and review by the NHS Wales Shared Service Partnership. Consequently this is not wholly within the control of the Health Board.	Director of Finance	Dec-19	Finance Committee	Due Date Not Reached

WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R7/11	The Health Board should complete the outstanding actions from the Information Commissioner's Office (ICO) 2016 review of the Health Board's data protection arrangements.	CAV UHB is committed to continually improving mitigation of its risks of non-compliance. We are taking an improvement approach in line with the rest of Wales and in regular discussion with the ICO's office. Progress has been made on the registering of major assets and new flows of information. We intend to progress the assessment of our existing significant flows, adopting a risk based approach.	Director of Transformation and Informatics	Jun-19	Digital and Health Intelligence Committee	Over 3 Months
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R8/11	The Health Board should achieve full compliance with the General Data Protection Requirement by May 2019.	Delivery of the CAV UHB's updated action plan will reduce the risks we carry in relation to noncompliance with GDPR. Prioritisation of risks and mitigating actions are part of our continuous improvement plan, aimed at achieving full GDPR compliance during 2019.	Director of Transformation and Informatics	Dec-19	Digital and Health Intelligence Committee	Due Date Not Reached
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R9/11	The Health Board should improve its response times to requests for information from Freedom of Information Act and Data Protection Subject Access Requests.	CAV UHB has recently appointed additional staff resulting in a positive impact on response times for FOI and Subject Access Requests. This will be monitored as we continue to move towards achieving fully compliant response times.	Director of Transformation and Informatics	Mar-19	Digital and Health Intelligence Committee	Over 3 Months
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R10/11	The Health Board should complete a review of the structure and governance of its information and information technology functions to support delivery of the strategic digital approach	The newly appointed head of digital and health intelligence is developing a new structure to reflect combined information and IT services with the aim of stablishing functions that can best support the digital transformation agenda.	Director of Transformation and Informatics	Mar-19	Digital and Health Intelligence Committee	Over 3 Months

WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R11/11	The Health Board should routinely update IT Disaster Recovery plans after key changes to IT infrastructure and networks and at scheduled intervals and test plans to ensure they are effective	The CAV IT Disaster Recovery plan is reviewed annually at a minimum and in response to specific circumstances. Testing is undertaken (both Check list and Technical) and multiple system restores are performed successfully annually. Additional infrastructure and software have been put in place to improve this process. A schedule of testing is being developed as part of the technical roadmap work.	Director of Transformation and Informatics	Mar-19	Digital and Health Intelligence Committee	Over 3 Months
	2017-18	Mar-18	Review of GP Out-of-Hours Services	Chief Operating Officer			R1a Develop a process for regularly comparing its out-of-hours expenditure with other health boards, given the GP out-of-hours service's mixed performance.	Historically, the Cardiff and Vale Out of Hours service benchmarked the lowest in Wales in terms of investment per patient; however, due to significant investment, this has increased. C&V will look to review funding per 1000 population, and compare against the Welsh average if this information is available and reliable from other Health Boards. All Wales expenditure to be reviewed through the Out of Hours QSE group, taking into account the difference in Health Board population, and where possible service skill mix.	Chief Operating Officer	Oct-17	Strategy and Delivery Committee	Over One Year

	2017-18	Mar-18	Review of GP Out-of-Hours Services	Chief Operating Officer			R1b Develop a long-term workforce plan aimed at permanently resolving problems with filling GP shifts and improving the timeliness of all aspects of the service.	Workforce and governance reviews currently being undertaken to inform the future workforce development prior to the implementation of 111. 111 may have signifant implications for the C&V workforce which will have to be taken into account as and when more information is known. Work has already been undertaken to identify those shifts that are regularly difficult to fill considering alternative clinical cover. It has been acknowledged that the traditional GP OOHs model is not necessarily sustainable in the current climate, with ongoing difficulties in filling core shifts, as such skill mix will be a key factor moving forward. This includes consideration of salaried GPs as well the wider workforce.	Chief Operating Officer	Nov-17	Strategy and Delivery Committee	Over One Year
	2017-18	Mar-18	Review of GP Out-of-Hours Services	Chief Operating Officer			R2a Introduce processes for learning from patient feedback to improve GP out-of-hours services.	Develop more patient feedback mechanisms in conjunction with corporate services to for use by OOHs patients. Analysis with themes and trends to be discussed at Out of Hours QSE meeting. Produce information leaflets and posters for patients, along with a section on the service webpage to promote selfcare.	Chief Operating Officer	Sep-17	Strategy and Delivery Committee	Over One Year
	2017-18	Mar-18	Review of GP Out-of-Hours Services	Chief Operating Officer			R2b Prioritise clinical audit to ensure all GPs have their out-of-hours clinical contacts regularly reviewed, to meet the national standards.	Agreed audit process in place; feedback to OOHs QSE meeting.	Chief Operating Officer	Sep-17	Quality,Safety and Effectiveness	Over One Year

	2017-18	Mar-18	Review of GP Out-of-Hours Services	Chief Operating Officer			R2c Check its out-of-hours data relating to the number of call terminations, to ensure the information is accurate	Work is underway to review this information working with the Vale Local Authority who provide some of the telephony statistics. Further work on an All Wales basis is taking place to review OOHs telephony statistics which Cardiff and Vale are leading on.	Chief Operating Officer	Oct-17	Quality,Safety and Effectiveness	Over One Year
	2017-18	Mar-18	Review of GP Out-of-Hours Services	Chief Operating Officer			R3a Improve signposting on its website by including information about GP out-of-hours on the landing page, providing a description of the service, details of the opening hours and locations, and the conditions and circumstances in which patients should use it.	This information has been updated on the intranet for GP OOHs. The internet information is being led by a primary care group, which is also looking at GP OOHs. The refreshed GP OOHs internet site will include all information about the service and advice for the public on self care and other services that can be accessed.	Chief Operating Officer	Dec-17	Quality,Safety and Effectiveness	Over One Year
	2017-18	Mar-18	Review of GP Out-of-Hours Services	Chief Operating Officer			R3b Work with GP practices to ensure all practices have a standard answerphone message that provides appropriate information about the out-of-hours service.	A standardised message was promoted through the primary care access group, of which 27 practices used a standardised message. However, this cannot be enforced with the practices. Work is ongoing with practices to improve the uptake rate to ensure that a consistent message is provided to patients.	Chief Operating Officer	Oct-17	Quality,Safety and Effectiveness	Over One Year
	2017-18	Mar-18	Review of GP Out-of-Hours Services	Chief Operating Officer			R3c As part of the eventual introduction of 111, consider replacing the five different telephone numbers with a single number for accessing GP out-of-hours.	Work towards rationalising the numbers down to one number, impact on stakeholders will need to be assessed during this change process. The Head of OOHs is a member of the Directory of Services group, which is looking at this issue longer term, and will continue to work to ensure a single point of access.	Chief Operating Officer	Nov-17	Quality,Safety and Effectiveness	Over One Year

	2017-18	Mar-18	Review of GP Out-of-Hours Services	Chief Operating Officer			R4a Share data with all practices showing the variation in use of out-of-hours services between 6.30pm and 7.30pm, with a view to highlighting outliers and resolving issues that are driving out-of-hours demand.	Information included in the desktop assessment of practice sustainability as an additional indicator of performance. Send out monthly to practices and clusters. To be included in the information shared and discussed at annual Practice Development Visits as well as sharing through CD forum.	Chief Operating Officer	Sep-17	Quality,Safety and Effectiveness	Over One Year
	2017-18	Mar-18	Review of GP Out-of-Hours Services	Chief Operating Officer			R4b Identify and address the reasons that are preventing out-of-hours staff from accessing the GP Record.	Ongoing issues with IHR have impacted on the ability for staff working in the Out of Hours service in being able to acess the GP record. This has been raised with NWIS and C&V IT colleagues as a priority area for change. A meeting with the C&V IT dept arranged for August 2017 to review IT related issues and agree actions to address these.	Chief Operating Officer	Aug-17	Quality,Safety and Effectiveness	Over One Year
WAO 14	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science	8	R1/8	R1 Review the effectiveness of the Medical Equipment Group, focusing on: • Membership of the group • Attendance • Executive Support • Reporting lines	Review and Refresh ToR based on recommendations of this report. Set out reporting mechanisms within UHB governance framework and reporting lines.	Director of Therapies & Health Science	Sep-18	Strategy and Delivery Committee	Over One Year
WAO 14	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science		R2/8	R2 Improve the effectiveness of the Medical Device Safety Officer role, by: • providing clarity on the purpose of the role; • ensuring attendance at Medical Equipment Group meetings; • ensuring attendance at Clinical Board Quality, Safety and Experience meetings; • ensuring that MDSOs engage with their respective Clinical Board on medical equipment risks and issues; • ensuring MDSOs have the necessary time and resources to perform the role; and • giving MDSOs access to potential learning and development opportunities.	Fully embed MDSO in CB QSE structures. Review MDSO role profile and resourcing and communicate requirements of the role with Clinical Boards. Develop MDSO dashboard to include: • Attendance at MEG & QSE meetings • QSE Med Equip reports, CB Datix reports, • CB med equipment risks Take learning from comprehensive specialist services' CB compliance audit against the UHB's Medical Equipment Management Policy to all CBs and audit as part of annual self-assessment process.	Director of Therapies & Health Science	Mar-19	Strategy and Delivery Committee	Over 3 Months

WAO 14	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science		R3/8	R3 Review medical equipment risk management throughout the organisation, ensuring alignment between the corporate and operational approach.	Ensure CBs capture medical equipment risks as part of their risk management processes. These will be monitored via MEG, and escalated through relevant strategic committees, eg Strategy and Resources/Capital Management/QSE/Management Executive as required.	Director of Therapies & Health Science	Apr-19	Strategy and Delivery Committee	Over 3 Months
WAO 14	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science		R4/8	R4 The Health Board should determine how it can develop an effective medical equipment inventory with available resources.	The MEG will review the WHO good practice guidance and determine what is feasible to introduce, with resources available, to improve medical equipment inventory.	Director of Therapies & Health Science	Apr-19	Strategy and Delivery Committee	Over 3 Months
WAO 14	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science		R5/8	R5 The Medical Equipment Group should assure itself that clinical boards operate effective systems and processes for the monitoring, purchase and replacement of medical equipment below £5,000.	Ensure MSDOs include key under £5,000 items on their risk log and escalate replacement needs within the CB. Ensure medical devices procurement officer scrutinises under £5,000 items to identify opportunities for standardisation and efficiency	Director of Therapies & Health Science	Jan-19	Strategy and Delivery Committee	Over 6 Months
WAO 14	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science		R6/8	R6 Ensure that Clinical Boards include the Medical Device Safety Officer report as a standing agenda item at the Quality, Safety and Experience meetings to discuss and address any medical equipment risks and incidents that arise.	Develop MDSO metrics for reporting to their CB QSE meetings, and MEG reporting.	Director of Therapies & Health Science	Nov-18	Strategy and Delivery Committee	Over 6 Months

WAO 14	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science		R7/8	R7 Ensure all relevant service areas collaborate, consult and engage on medical equipment issues. It should give particular attention to the arrangements in place for maintenance and replacement of beds and hoists.	Monitor attendance and engagement of CB MSDOs and other members at MEG, escalate non-attendance or lack of engagement. Monitor progress of action plan developed by Health and Safety Advisor following the Arjo Proact 2017 survey Health and Safety Committee 18/005 minute (25 January 2018). Maintain hoists within the Clinical Engineering Department at the end of external supplier contract. Ensure Clinical Engineering is represented at the Bed Management Group	Director of Therapies & Health Science	Dec-18	Strategy and Delivery Committee	Over 6 Months
WAO 14	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science		R8/8	R8 Evaluate the medical equipment arrangements in place within Pathology Services (Laboratory Medicine).	Agree Pathology MDSO role with CD&T with same CB functions at a directorate level reporting through to CB MDSO.	Director of Therapies & Health Science	Nov-18	Strategy and Delivery Committee	Over 6 Months
WAO 15	2018-19	May-19	Primary care services	Chief Operating Officer	6	R1/6	R1 The Health Board has developed an ambitious plan for primary care, but the plan does not consider the impacts of projected population growth as a result of housing developments in Cardiff. The Health Board should therefore revisit its primary care plan to ensure it includes specific actions to meet the needs of the projected population growth in Cardiff.	The UHB is commissioning an independent assessment of the impact of population growth on the demand for services and to identify opportunities for meeting this increased demand.	Director of Planning	Jan-19	Strategy and Delivery Committee	Over 6 Months

WAO 15	2018-19	May-19	Primary care services	Chief Operating Officer		R2/6	R2 The Health Board's plans for primary care have been developed with only limited consultation and collaboration with some key groups of stakeholders. The Health Board should therefore develop the necessary consultation and communications plans to ensure meaningful public and stakeholder engagement in any further development / refinement of its primary care plans.	Communication plan to be developed and actions to be carried out this financial year, with the plan to be incorporated as a core part of the 2019-20 Primary and Community Intermediate Care Integrated Medium Term Plan (PCIC IMTP).	Chief Operating Officer	Dec-18	Strategy and Delivery Committee	Over 6 Months
WAO 15	2018-19	May-19	Primary care services	Chief Operating Officer		R3a/6	R3 While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should: a. Calculate a baseline position for its current investment and resource use in primary and community care.	Financial resource shift framework developed and will be used to track investment and resource use from secondary to primary care, starting with the investment in MSK (Musculoskeletal) and MH (Mental Health).	Director of Finance	Oct-18	Strategy and Delivery Committee	Over 6 Months
WAO 15	2018-19	May-19	Primary care services	Chief Operating Officer		R3b/6	b. Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	Build into IMTP annual review process.	Director of Finance	Mar-20	Strategy and Delivery Committee	Due Date Not Reached

WAO 15	2018-19	May-19	Primary care services	Chief Operating Officer		R4a/6	R4 Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should: a. Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models. .	Formally evaluate cluster nursing posts and cluster pharmacists. Communicate the evaluation of cluster-based nursing posts and cluster pharmacies, to inform future decision making. Ensure future cluster models (MSK, MH) have robust evaluation built into the process.	Chief Operating Officer	Mar-20	Strategy and Delivery Committee	Due Date Not Reached
WAO 15	2018-19	May-19	Primary care services	Chief Operating Officer		R4b/6	b. Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters.	Communicate the evaluation of cluster-based nursing posts and cluster pharmacies at CD (Clinical Directors) forum. Use CD forum to help sharing and learning by publicising the key messages via Cluster Leads.	Chief Operating Officer	Nov-18	Strategy and Delivery Committee	Over 6 Months
WAO 15	2018-19	May-19	Primary care services	Chief Operating Officer		R4c/6	c. Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund.	Many Primary Care funding has now been mainstreamed as core business. Cluster pilots to continue to be evaluated to assess the option of rolling out at scale, starting with MSK and MH. Subject to affordability within the resource available.	Director of Finance	Mar-19	Strategy and Delivery Committee	Over 6 Months
WAO 15	2018-19	May-19	Primary care services	Chief Operating Officer		R4d/6	d. Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments.	As per R2 – develop Communications Plan. Start communication and engagement by engaging with the UHB Stakeholder Reference Group on new ways of working.	Chief Operating Officer	Dec-18	Strategy and Delivery Committee	Over 6 Months
WAO 15	2018-19	May-19	Primary care services	Chief Operating Officer		R5a/6	R5 We found variation in the maturity of primary care clusters. The Health Board should: a. Review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary.	Continue to prioritise the OD (Organisational Development) programme for cluster development.	Chief Operating Officer	Mar-19	Strategy and Delivery Committee	Over 6 Months

WAO 15	2018-19	May-19	Primary care services	Chief Operating Officer		R5b/6	b. Review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups.	Discussion on cluster membership to be built into the cluster OD programme, to include an initial discussion at the CD forum on 31 October 2018.	Chief Operating Officer	Nov-18	Strategy and Delivery Committee	Over 6 Months
WAO 15	2018-19	May-19	Primary care services	Chief Operating Officer		R5c/6	c. Ensure all cluster leads attend the Confident Primary Care Leaders course	We will ensure lessons are learnt from the current CDs attending the Confident Primary Care Leaders course and encourage this course for new CDs and existing CDs who have not attended.	Chief Operating Officer	Dec-18	Strategy and Delivery Committee	Over 6 Months
WAO 15	2018-19	May-19	Primary care services	Chief Operating Officer		R6a/6	R6 We found scope to improve the way in which primary care performance is monitored and reported at Board and committee level. The Health Board should: a. Ensure the contents of its Board and committee performance reports adequately cover primary care. .	Review currently being undertaken of Performance reporting to the Board and its Committees.	Director of Transformation and Informatics	Nov-18	Strategy and Delivery Committee	Over 6 Months
WAO 15	2018-19	May-19	Primary care services	Chief Operating Officer		R6b/6	b. Increase the frequency with which Board and committees receive performance reports regarding primary care.	See R6a	Director of Transformation and Informatics	Nov-18	Strategy and Delivery Committee	Over 6 Months
WAO 15	2018-19	May-19	Primary care services	Chief Operating Officer		R6c/6	c. Ensure that reports to Board and committees provide sufficient commentary on progress in delivering Health Board plans for primary care, and the extent to which those plans are resulting in improved experiences and outcomes for patients	See R6a	Director of Transformation and Informatics	Nov-18	Strategy and Delivery Committee	Over 6 Months

WAO *	2017-18	Dec-17	Discharge Planning	Chief Operating Officer		R1a	Develop a system where ward staff are able to access up-to-date information about community health and social care services.	the first point of contact within the Health Board and provide a signposting service for all UHB staff in relation to any queries they may have in relation to community service provision. An Intranet Website is available currently and information on how to access the content is included within training programmes. Website address for DEWIS is also available. First Point of Contact and Single Point of Access, both ICF funded projects, are assisting with the provision of information and advice to patients, their families and to staff as part of the overarching compliance with the Social Services and Wellbeing Act 2014. Additional Discharge Support Officers and IDS team are in place to offer advice and to act as a point of contact. A review of the web site is planned to ensure that information is	Chief Operating Officer	Dec-18	Strategy and Delivery Committee	Over 6 Months
WAO *	2017-18	Dec-17	Discharge Planning	Chief Operating Officer		R1b	Review the range and frequency of data collated about community health and social care services. For example waiting times for some services and the frequency data on services available through other NHS bodies and housing options is collated.	Information relating to how to access community services is available on the UHB intranet site. The UHB is participating in the All Wales development of an integrated Community and Social Care information system which when developed will provide a platform for sharing of information and data. How staff can access the current information on the UHB website and its content will be reinforced during training programmes.	Chief Operating Officer	Dec-18	Quality, Safety and Effectiveness	Over 6 Months

WAO *	2017-18	Dec-17	Discharge Planning	Chief Operating Officer		R2	The Health Board should seek to involve patients and carers when the next policy revisions are due.	The draft Choice Protocol and Discharge Policy are currently out for consultation. The current draft Discharge Policy and Choice protocol has been provided to South East Wales Carers Trust, Engagement Project for comment.	Chief Operating Officer	Oct-17	Quality, Safety and Effectiveness	Over One Year
WAO *	2017-18	Dec-17	Discharge Planning	Chief Operating Officer		R3	The Health Board should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in discharge planning understand how to use it.	training and development plan in place. Short-term Plan Discharge Planning Weekly training sessions of 1-1 ½ hrs on both UHW and Llandough Topics: Discharge Policy Choice Protocol simple/supported complex. Integrated discharge Service; Care Homes; CRT; CWS and its use purpose. (20 session completed to date 64 staff attended) "Get me Home" 3 monthly workshops have been held which focus on the Home First principles. The HB has also embarked on an organisation wide De-conditioning campaign which aims to maintain Patient independence in order to reduce avoidable harm, improve the Patient experience and expedite discharge (two workshops held to dates with two further dates agreed – 120 staff	Chief Operating Officer	Nov-17	Quality, Safety and Effectiveness	Over One Year
WAO *	2017-18	Dec-17	Discharge Planning	Chief Operating Officer		R4a	Explore developing an e-learning course for discharge planning which ward staff may find more accessible.	Work is ongoing with LED colleagues to develop a discharge planning focused e-learning resource.	Chief Operating Officer	Dec-18	Quality, Safety and Effectiveness	Over 6 Months

WAO *	2017-18	Dec-17	Discharge Planning	Chief Operating Officer		R4b	Ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring.	Each Staff member now has the ability to register their own academic achievement and course attendance on ESR, whilst the IDS team are now maintaining a record of all those attending training. Formal workshops are also recorded on the ESR system.	Chief Operating Officer	Dec-18	Quality, Safety and Effectiveness	Over 6 Months
WAO *	2019-20	Jun-19	Clinical Coding Follow-up	Director of Transformation and Informatics	1	R1	Clinical Cloding Resources: Resolve the current interim arrangements by agreeing the coding management structure following the directorate reconfiguration, ensuring there is sufficient management and supervisory capacity	The clinical coding teams are included in the restructure of the directorate with the launch taking place on 04/06/19. The new structure will provide adequate management and supervisory capacity	Director of Transformation and Informatics	Sep-19	Quality, Safety and Effectiveness	Less Than 3 Months

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

Audit Title	Executive Lead for Report	Rec No.	Recommendation Narrative	Management Response	Status of Report Overall
Clinical Coding Follow-up	Director of Transformation and Informatics	R1	Clinical Cloding Resources: Resolve the current interim arrangements by agreeing the coding management structure following the directorate reconfiguration, ensuring there is sufficient management and supervisory capacity	The clinical coding teams are included in the restructure of the directorate with the launch taking place on 04/06/19. The new structure will provide adequate management and supervisory capacity	(blank)
			Clinical Cloding Resources: Resolve the current interim arrangements by agreeing the coding management structure following the directorate reconfiguration, ensuring there is sufficient management and supervisory capacity Total		
	Director of Transformation and Informatics Total				
Combined follow up of Informatics and Communications Technology audits	Director of Transformation and Informatics	R1/7	R1 Data quality procedures are inconsistent across the UHB with no routine audit programme in place to monitor compliance. The UHB should establish a data quality policy and document procedures, to set out the ways of working required to comply with the policy.	(blank)	(blank)
			R1 Data quality procedures are inconsistent across the UHB with no routine audit programme in place to monitor compliance. The UHB should establish a data quality policy and document procedures, to set out the ways of working required to comply with the policy. Total		
		R2/7	R2 The UHB should identify any material/key clinical systems that have not been tested for disaster recovery and test them appropriately.	(blank)	(blank)
			R2 The UHB should identify any material/key clinical systems that have not been tested for disaster recovery and test them appropriately. Total		
		R3/7	R3 There are no documented business continuity plans relating to the Health Edge, Theatreman and Maternity systems. The department responsible for managing these systems should formally document their business continuity plans.	(blank)	(blank)
			R3 There are no documented business continuity plans relating to the Health Edge, Theatreman and Maternity systems. The department responsible for managing these systems should formally document their business continuity plans. Total		
		R4/7	R4 Although the ICT department states they review their business continuity plans annually, there is no evidence to support this. The department should incorporate annual review dates into its plan, which should be updated after every review.	(blank)	(blank)
			R4 Although the ICT department states they review their business continuity plans annually, there is no evidence to support this. The department should incorporate annual review dates into its plan, which should be updated after every review. Total		
		R5/7	R5 The hosting and backup agreement/SLA for the Artificial Limbs and Appliance Service is out of date and does not accurately reflect the arrangements in place. The UHB should update the agreement and ensure it is signed by the new data owner to reflect staff changes and the end of life server dates removed.	(blank)	(blank)
			R5 The hosting and backup agreement/SLA for the Artificial Limbs and Appliance Service is out of date and does not accurately reflect the arrangements in place. The UHB should update the agreement and ensure it is signed by the new data owner to reflect staff changes and the end of life server dates removed. Total		
		R6/7	R6 The draft ICT Strategy has been largely superseded by the UHB's Integrated Medium Term Plan (IMTP) but there remains a need to bring together the strategic intentions for ICT into an updated document. The UHB should clearly document its strategic approach to ICT.	(blank)	(blank)
			R6 The draft ICT Strategy has been largely superseded by the UHB's Integrated Medium Term Plan (IMTP) but there remains a need to bring together the strategic intentions for ICT into an updated document. The UHB should clearly document its strategic approach to ICT. Total		
		R7/7	R7 The UHB's overall approach to IM&T is piecemeal with the division of responsibilities between ICT and business departments unclear and inconsistent. Approaches need to be joined up.	(blank)	(blank)

			R7 The UHB's overall approach to IM&T is piecemeal with the division of responsibilities between ICT and business departments unclear and inconsistent. Approaches need to be joined up. Total		
	Director of Transformation and Informatics Total				
Diagnostic review of ICT capacity and resources	Director of Transformation and Informatics	R1/6	R1 To ensure that the totality of ICT resources within the Health Board are used effectively, the Health Board needs to understand the roles and responsibility of ICT staff managed outside of the main department to ensure that these roles are aligned with those within the central managed team and that they are used to their full potential.	(blank)	(blank)
			R1 To ensure that the totality of ICT resources within the Health Board are used effectively, the Health Board needs to understand the roles and responsibility of ICT staff managed outside of the main department to ensure that these roles are aligned with those within the central managed team and that they are used to their full potential. Total		
		R2/6	R2 As a result of the high level of one-way links between clinical systems and the main patient administration system, the Health Board needs to consider the potential for strengthening integration between systems, and at the very minimum, ensure that robust mechanisms are in place to make sure that same data items contained on multiple clinical information systems are consistent at all times, for example, patient demographics.	(blank)	(blank)
			R2 As a result of the high level of one-way links between clinical systems and the main patient administration system, the Health Board needs to consider the potential for strengthening integration between systems, and at the very minimum, ensure that robust mechanisms are in place to make sure that same data items contained on multiple clinical information systems are consistent at all times, for example, patient demographics. Total		
		R3/6	R3 To ensure that staff remain aware of information governance principles, and to improve the reliability of data contained on the Health Board"s clinical information systems, the Health Board should consider mandating information governance refresher training, which should include data quality, for all staff.	(blank)	(blank)
			R3 To ensure that staff remain aware of information governance principles, and to improve the reliability of data contained on the Health Board"s clinical information systems, the Health Board should consider mandating information governance refresher training, which should include data quality, for all staff. Total		
		R4/6	R4 To ensure that staff are proficient in the use of the clinical systems, the Health Board needs to ensure that all temporary staff received appropriate and timely training in order to prevent them from accessing the systems without having the necessary training.	(blank)	(blank)
			R4 To ensure that staff are proficient in the use of the clinical systems, the Health Board needs to ensure that all temporary staff received appropriate and timely training in order to prevent them from accessing the systems without having the necessary training. Total		
		R5/6	R5 The Health Board needs to understand and address the negative perceptions from staff in relation to access, reliability and inability to use the clinical information systems that currently exist within the Health Board to ensure that the systems potential is maximised.	(blank)	(blank)
			R5 The Health Board needs to understand and address the negative perceptions from staff in relation to access, reliability and inability to use the clinical information systems that currently exist within the Health Board to ensure that the systems potential is maximised. Total		
		R6/6	R6 To minimise the potential to which there is lost time due to system failures, the Health Board needs to ensure that the extent to which ICT equipment is classed as „out-of-life" reduces and that appropriate records are maintained to monitor planned and unplanned downtime.	(blank)	(blank)

			R6 To minimise the potential to which there is lost time due to system failures, the Health Board needs to ensure that the extent to which ICT equipment is classed as „out-of-life" reduces and that appropriate records are maintained to monitor planned and unplanned downtime. Total		
	Director of Transformation and Informatics Total				
Discharge Planning	Chief Operating Officer	R1a	Develop a system where ward staff are able to access up-to-date information about community health and social care services.	The Integrated Discharge Service is the first point of contact within the Health Board and provide a signposting service for all UHB staff in relation to any queries they may have in relation to community service provision. An Intranet Website is available currently and information on how to access the content is included within training programmes. Website address for DEWIS is also available. First Point of Contact and Single Point of Access, both ICF funded projects, are assisting with the provision of information and advice to patients, their families and to staff as part of the overarching compliance with the Social Services and Wellbeing Act 2014. Additional Discharge Support Officers and IDS team are in place to offer advice and to act as a point of contact. A review of the web site is planned to ensure that information is current and accessible to all UHB staff. Reinforcement of available information sources will continue to be included in ongoing training programmes.	(blank)
			Develop a system where ward staff are able to access up-to-date information about community health and social care services. Total		
		R1b	Review the range and frequency of data collated about community health and social care services. For example waiting times for some services and the frequency data on services available through other NHS bodies and housing options is collated.	Information relating to how to access community services is available on the UHB intranet site. The UHB is participating in the All Wales development of an integrated Community and Social Care information system which when developed will provide a platform for sharing of information and data. How staff can access the current information on the UHB website and its content will be reinforced during training programmes.	(blank)
			Review the range and frequency of data collated about community health and social care services. For example waiting times for some services and the frequency data on services available through other NHS bodies and housing options is collated. Total		
		R2	The Health Board should seek to involve patients and carers when the next policy revisions are due.	The draft Choice Protocol and Discharge Policy are currently out for consultation. The current draft Discharge Policy and Choice protocol has been provided to South East Wales Carers Trust, Engagement Project for comment.	(blank)
			The Health Board should seek to involve patients and carers when the next policy revisions are due. Total		
		R3	The Health Board should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in discharge planning understand how to use it.	development plan in place. Short-term Plan Discharge Planning Weekly training sessions of 1-1 ½ hrs on both UHW and Llandough Topics: Discharge Policy Choice Protocol simple/supported complex. Integrated discharge Service; Care Homes; CRT; CWS and its use purpose. (20 session completed to date 64 staff attended) "Get me Home" 3 monthly workshops have been held which focus on the Home First principles. The HB has also embarked on an organisation wide De-conditioning campaign which aims to maintain Patient independence in order to reduce avoidable harm, improve the Patient experience and expedite discharge (two workshops held to dates with two further dates agreed – 120 staff attended). SNAP Training Daily for 2 weeks – 30min sessions, ward-based Topics: Discharge Policy Choice Protocol simple/supported complex; Integrated discharge Service; Care Homes; CRT; CWS and its use purpose; Fast Track CHC.	(blank)

			The Health Board should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in discharge planning understand how to use it. Total		
		R4a	Explore developing an e-learning course for discharge planning which ward staff may find more accessible.	Work is ongoing with LED colleagues to develop a discharge planning focused e-learning resource.	(blank)
			Explore developing an e-learning course for discharge planning which ward staff may find more accessible. Total		
		R4b	Ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring.	Each Staff member now has the ability to register their own academic achievement and course attendance on ESR, whilst the IDS team are now maintaining a record of all those attending training. Formal workshops are also recorded on the ESR system.	(blank)
			Ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring. Total		
	Chief Operating Officer Total				
Hospital Catering and Patient Nutrition Follow-up Review	Director of Planning	R 1/9	R1b We recommend that NHS bodies use the results presented in our local audit reports as a basis for ensuring that they are effectively implementing the all-Wales Nutritional Care Pathway. In particular, ensure that nutritional screening effectively identifies all patients who have nutritional problems, or are at risk of developing them, and that appropriate care plans and monitoring activities are instigated (national).	(blank)	(blank)
			R1b We recommend that NHS bodies use the results presented in our local audit reports as a basis for ensuring that they are effectively implementing the all-Wales Nutritional Care Pathway. In particular, ensure that nutritional screening effectively identifies all patients who have nutritional problems, or are at risk of developing them, and that appropriate care plans and monitoring activities are instigated (national). Total		
		R 2/9	R9 Through the fundamentals of care forum monitor the effectiveness of the red tray system approach, its development and the emerging traffic light systems (local 2010).	(blank)	(blank)
			R9 Through the fundamentals of care forum monitor the effectiveness of the red tray system approach, its development and the emerging traffic light systems (local 2010). Total		
		R 3/9	R11 Improve the nutritional assessment tool to include an assessment of oral health and the ability to communicate (local 2010)	(blank)	(blank)
			R11 Improve the nutritional assessment tool to include an assessment of oral health and the ability to communicate (local 2010) Total		
		R 4/9	R3a We recommend that NHS bodies ensure that their menus provide an appropriate choice of food and that the arrangements for ordering and serving food support adequate patient choice (national).	(blank)	(blank)
			R3a We recommend that NHS bodies ensure that their menus provide an appropriate choice of food and that the arrangements for ordering and serving food support adequate patient choice (national). Total		
		R 5/9	R3b We recommend that NHS bodies continue to roll out the protected mealtime policy to as wide a range of wards as possible, communicating its importance to all the relevant staff groups working in the hospital, and regularly reviewing compliance with the policy (national).	(blank)	(blank)
			R3b We recommend that NHS bodies continue to roll out the protected mealtime policy to as wide a range of wards as possible, communicating its importance to all the relevant staff groups working in the hospital, and regularly reviewing compliance with the policy (national). Total		
		R 6/9	R4b We recommend that NHS bodies introduce computerised catering information systems, supported by clear cost benefit analysis in comparison to existing manual based information systems (national).	(blank)	(blank)
			R4b We recommend that NHS bodies introduce computerised catering information systems, supported by clear cost benefit analysis in comparison to existing manual based information systems (national). Total		
		R 7/9	R7a We recommend that set pricing policies and income generation targets that aim to ensure that non-patient catering services at least break even, or, if they do not, it is the result of a deliberate subsidy policy that is based on a detailed analysis of costs (national).	(blank)	(blank)

			R7a We recommend that set pricing policies and income generation targets that aim to ensure that non-patient catering services at least break even, or, if they do not, it is the result of a deliberate subsidy policy that is based on a detailed analysis of costs (national). Total		
		R8/9	R2 The Restaurant Non-Patient Subsidy Group should reinforce its strong focus on key performance indicators to achieve the target of zero subsidy for non-patient catering services (local 2013).	(blank)	(blank)
			R2 The Restaurant Non-Patient Subsidy Group should reinforce its strong focus on key performance indicators to achieve the target of zero subsidy for non-patient catering services (local 2013). Total		
		R9/9	R10b We recommend that NHS bodies systematically collate the information from nutritional screening on the number of patients identified with, or at risk of, nutritional problems to understand the scale of the problem and the likely impact on catering and nutrition services to meet these patients' needs (national).	(blank)	(blank)
			R10b We recommend that NHS bodies systematically collate the information from nutritional screening on the number of patients identified with, or at risk of, nutritional problems to understand the scale of the problem and the likely impact on catering and nutrition services to meet these patients' needs (national). Total		
	Director of Planning Total				
Primary care services	Chief Operating Officer	R1/6	R1 The Health Board has developed an ambitious plan for primary care, but the plan does not consider the impacts of projected population growth as a result of housing developments in Cardiff. The Health Board should therefore revisit its primary care plan to ensure it includes specific actions to meet the needs of the projected population growth in Cardiff.	The UHB is commissioning an independent assessment of the impact of population growth on the demand for services and to identify opportunities for meeting this increased demand.	(blank)
			R1 The Health Board has developed an ambitious plan for primary care, but the plan does not consider the impacts of projected population growth as a result of housing developments in Cardiff. The Health Board should therefore revisit its primary care plan to ensure it includes specific actions to meet the needs of the projected population growth in Cardiff. Total		
		R2/6	R2 The Health Board's plans for primary care have been developed with only limited consultation and collaboration with some key groups of stakeholders. The Health Board should therefore develop the necessary consultation and communications plans to ensure meaningful public and stakeholder engagement in any further development / refinement of its primary care plans.	Communication plan to be developed and actions to be carried out this financial year, with the plan to be incorporated as a core part of the 2019-20 Primary and Community Intermediate Care Integrated Medium Term Plan (PCIC IMTP).	(blank)
			R2 The Health Board's plans for primary care have been developed with only limited consultation and collaboration with some key groups of stakeholders. The Health Board should therefore develop the necessary consultation and communications plans to ensure meaningful public and stakeholder engagement in any further development / refinement of its primary care plans. Total		
		R3a/6	R3 While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should: a. Calculate a baseline position for its current investment and resource use in primary and community care.	Financial resource shift framework developed and will be used to track investment and resource use from secondary to primary care, starting with the investment in MSK (Musculoskeletal) and MH (Mental Health).	(blank)
			R3 While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should: a. Calculate a baseline position for its current investment and resource use in primary and community care. Total		
		R3b/6	b. Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	Build into IMTP annual review process.	(blank)
			b. Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care. Total		

	R4a/6	R4 Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should: a. Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models. .	Formally evaluate cluster nursing posts and cluster pharmacists. Communicate the evaluation of cluster-based nursing posts and cluster pharmacies, to inform future decision making. Ensure future cluster models (MSK, MH) have robust evaluation built into the process.	(blank)
		R4 Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should: a. Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models. . Total		
	R4b/6	b. Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters.	Communicate the evaluation of cluster-based nursing posts and cluster pharmacies at CD (Clinical Directors) forum. Use CD forum to help sharing and learning by publicising the key messages via Cluster Leads.	(blank)
		b. Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters. Total		
	R4c/6	c. Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund.	Many Primary Care funding has now been mainstreamed as core business. Cluster pilots to continue to be evaluated to assess the option of rolling out at scale, starting with MSK and MH. Subject to affordability within the resource available.	(blank)
		c. Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund. Total		
	R4d/6	d. Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments.	As per R2 – develop Communications Plan. Start communication and engagement by engaging with the UHB Stakeholder Reference Group on new ways of working.	(blank)
		d. Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments. Total		
	R5a/6	R5 We found variation in the maturity of primary care clusters. The Health Board should: a. Review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary.	Continue to prioritise the OD (Organisational Development) programme for cluster development.	(blank)
		R5 We found variation in the maturity of primary care clusters. The Health Board should: a. Review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary. Total		
	R5b/6	b. Review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups.	Discussion on cluster membership to be built into the cluster OD programme, to include an initial discussion at the CD forum on 31 October 2018.	(blank)
		b. Review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups. Total		
	R5c/6	c. Ensure all cluster leads attend the Confident Primary Care Leaders course	We will ensure lessons are learnt from the current CDs attending the Confident Primary Care Leaders course and encourage this course for new CDs and existing CDs who have not attended.	(blank)
		c. Ensure all cluster leads attend the Confident Primary Care Leaders course Total		
	R6a/6	R6 We found scope to improve the way in which primary care performance is monitored and reported at Board and committee level. The Health Board should: a. Ensure the contents of its Board and committee performance reports adequately cover primary care. .	Review currently being undertaken of Performance reporting to the Board and its Committees.	(blank)
		R6 We found scope to improve the way in which primary care performance is monitored and reported at Board and committee level. The Health Board should: a. Ensure the contents of its Board and committee performance reports adequately cover primary care. . Total		

		R6b/6	b. Increase the frequency with which Board and committees receive performance reports regarding primary care.	See R6a	(blank)
			b. Increase the frequency with which Board and committees receive performance reports regarding primary care. Total		
		R6c/6	c. Ensure that reports to Board and committees provide sufficient commentary on progress in delivering Health Board plans for primary care, and the extent to which those plans are resulting in improved experiences and outcomes for patients	See R6a	(blank)
			c. Ensure that reports to Board and committees provide sufficient commentary on progress in delivering Health Board plans for primary care, and the extent to which those plans are resulting in improved experiences and outcomes for patients Total		
	Chief Operating Officer Total				
Review of follow-up outpatients – assessment of progress	Chief Operating Officer	(blank)	R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it: • covers a broader range of specialities; and • clearly reports clinical risks associated with delayed follow-up appointments.	had not received information on the volume of delayed follow-up appointments. The People, Planning and Performance Committee (the PPP Committee) is responsible for the oversight of outpatient follow-up care. We found that the PPP Committee had received information about delayed ophthalmology appointments, and updates on the progress of outpatient follow-up waiting list improvement actions. However, the PPP Committee did not receive information about specialties beyond ophthalmology, nor receive adequate assurance on the clinical risks associated with delayed appointments. Since our review, the Board and the PPP Committee have received regular progress reports on the steps taken to validate the outpatient follow-up list and to modernise outpatient services. The PPP Committee has also monitored closely the progress of the Clinical Risk Assessment (see recommendation two). After our report, initially, the PPP Committee were provided with updates on progress with transforming outpatient care every meeting, although the committee members now feel that twice-yearly updates are more appropriate. Performance information reported to the PPP Committee includes the number of patients on	(blank)
			R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it: • covers a broader range of specialities; and • clearly reports clinical risks associated with delayed follow-up appointments. Total		
			R2 Implemented	(blank)	(blank)
			R2 Implemented Total		
			R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date.	(blank)	(blank)
			R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date. Total		
			R4 Develop an outpatient transformation programme to create sustainable, efficient and good-quality services that meet population demand in the long term, considering: • projected demand and capacity for outpatient services; • impacts of local service changes that may result from wider South Wales Programme regional change; • potential for integrated acute, community and primary-level services; • advances in medical practices and potential to utilise technology; and • creation of lean clinical condition pathways.	(blank)	(blank)
			R4 Develop an outpatient transformation programme to create sustainable, efficient and good-quality services that meet population demand in the long term, considering: • projected demand and capacity for outpatient services; • impacts of local service changes that may result from wider South Wales Programme regional change; • potential for integrated acute, community and primary-level services; • advances in medical practices and potential to utilise technology; and • creation of lean clinical condition pathways. Total		

			R5 Identify the change management arrangement needed to accelerate the pace of long-term outpatient transformation. The Health Board should consider: • the clinical resources, including medical, nursing and allied health practitioners, required; • the change capacity and skills required; • internal and external engagement with stakeholders; and • primary and community care capacity to support outpatient modernisation.	(blank)	(blank)
			R5 Identify the change management arrangement needed to accelerate the pace of long-term outpatient transformation. The Health Board should consider: • the clinical resources, including medical, nursing and allied health practitioners, required; • the change capacity and skills required; • internal and external engagement with stakeholders; and • primary and community care capacity to support outpatient modernisation. Total		
	Chief Operating Officer Total				
Review of GP Out-of-Hours Services	Chief Operating Officer	(blank)	R1a Develop a process for regularly comparing its out-of-hours expenditure with other health boards, given the GP out-of-hours service's mixed performance.	Historically, the Cardiff and Vale Out of Hours service benchmarked the lowest in Wales in terms of investment per patient; however, due to significant investment, this has increased. C&V will look to review funding per 1000 population, and compare against the Welsh average if this information is available and reliable from other Health Boards. All Wales expenditure to be reviewed through the Out of Hours QSE group, taking into account the difference in Health Board population, and where possible service skill mix.	(blank)
			R1a Develop a process for regularly comparing its out-of-hours expenditure with other health boards, given the GP out-of-hours service's mixed performance. Total		
			R1b Develop a long-term workforce plan aimed at permanently resolving problems with filling GP shifts and improving the timeliness of all aspects of the service.	Workforce and governance reviews currently being undertaken to inform the future workforce development prior to the implementation of 111. 111 may have signifant implications for the C&V workforce which will have to be taken into account as and when more information is known. Work has already been undertaken to identify those shifts that are regularly difficult to fill considering alternative clinical cover. It has been acknowledged that the traditional GP OOHs model is not necessarily sustainable in the current climate, with ongoing difficulties in filling core shifts, as such skill mix will be a key factor moving forward. This includes consideration of salaried GPs as well the wider workforce.	(blank)
			R1b Develop a long-term workforce plan aimed at permanently resolving problems with filling GP shifts and improving the timeliness of all aspects of the service. Total		
			R2a Introduce processes for learning from patient feedback to improve GP out-of-hours services.	Develop more patient feedback mechanisms in conjunction with corporate services to for use by OOHs patients. Analysis with themes and trends to be discussed at Out of Hours QSE meeting. Produce information leaflets and posters for patients, along with a section on the service webpage to promote selfcare.	(blank)
			R2a Introduce processes for learning from patient feedback to improve GP out-of-hours services. Total		
			R2b Prioritise clinical audit to ensure all GPs have their out-of-hours clinical contacts regularly reviewed, to meet the national standards.	Agreed audit process in place; feedback to OOHs QSE meeting.	(blank)
			R2b Prioritise clinical audit to ensure all GPs have their out-of-hours clinical contacts regularly reviewed, to meet the national standards. Total		
			R2c Check its out-of-hours data relating to the number of call terminations, to ensure the information is accurate	Work is underway to review this information working with the Vale Local Authority who provide some of the telephony statistics. Further work on an All Wales basis is taking place to review OOHs telephony statistics which Cardiff and Vale are leading on.	(blank)
			R2c Check its out-of-hours data relating to the number of call terminations, to ensure the information is accurate Total		

			R3a Improve signposting on its website by including information about GP out-of-hours on the landing page, providing a description of the service, details of the opening hours and locations, and the conditions and circumstances in which patients should use it.	This information has been updated on the intranet for GP OOHs. The internet information is being led by a primary care group, which is also looking at GP OOHs. The refreshed GP OOHs internet site will include all information about the service and advice for the public on self care and other services that can be accessed.	(blank)
			R3a Improve signposting on its website by including information about GP out-of-hours on the landing page, providing a description of the service, details of the opening hours and locations, and the conditions and circumstances in which patients should use it. Total		
			R3b Work with GP practices to ensure all practices have a standard answerphone message that provides appropriate information about the out-of-hours service.	A standardised message was promoted through the primary care access group, of which 27 practices used a standardised message. However, this cannot be enforced with the practices. Work is ongoing with practices to improve the uptake rate to ensure that a consistent message is provided to patients.	(blank)
			R3b Work with GP practices to ensure all practices have a standard answerphone message that provides appropriate information about the out-of-hours service. Total		
			R3c As part of the eventual introduction of 111, consider replacing the five different telephone numbers with a single number for accessing GP out-of-hours.	Work towards rationalising the numbers down to one number, impact on stakeholders will need to be assessed during this change process. The Head of OOHs is a member of the Directory of Services group, which is looking at this issue longer term, and will continue to work to ensure a single point of access.	(blank)
			R3c As part of the eventual introduction of 111, consider replacing the five different telephone numbers with a single number for accessing GP out-of-hours. Total		
			R4a Share data with all practices showing the variation in use of out-of-hours services between 6.30pm and 7.30pm, with a view to highlighting outliers and resolving issues that are driving out-of-hours demand.	Information included in the desktop assessment of practice sustainability as an additional indicator of performance. Send out monthly to practices and clusters. To be included in the information shared and discussed at annual Practice Development Visits as well as sharing through CD forum.	(blank)
			R4a Share data with all practices showing the variation in use of out-of-hours services between 6.30pm and 7.30pm, with a view to highlighting outliers and resolving issues that are driving out-of-hours demand. Total		
			R4b Identify and address the reasons that are preventing out-of-hours staff from accessing the GP Record.	Ongoing issues with IHR have impacted on the ability for staff working in the Out of Hours service in being able to acess the GP record. This has been raised with NWIS and C&V IT colleagues as a priority area for change. A meeting with the C&V IT dept arranged for August 2017 to review IT related issues and agree actions to address these.	(blank)
			R4b Identify and address the reasons that are preventing out-of-hours staff from accessing the GP Record. Total		
	Chief Operating Officer Total				
Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science	R1/8	R1 Review the effectiveness of the Medical Equipment Group, focusing on: • Membership of the group • Attendance • Executive Support • Reporting lines	Review and Refresh ToR based on recommendations of this report. Set out reporting mechanisms within UHB governance framework and reporting lines.	(blank)
			R1 Review the effectiveness of the Medical Equipment Group, focusing on: **• Membership of the group** **• Attendance** **• Executive Support** **• Reporting lines Total**		
		R2/8	R2 Improve the effectiveness of the Medical Device Safety Officer role, by: • providing clarity on the purpose of the role; • ensuring attendance at Medical Equipment Group meetings; • ensuring attendance at Clinical Board Quality, Safety and Experience meetings; • ensuring that MDSOs engage with their respective Clinical Board on medical equipment risks and issues; • ensuring MDSOs have the necessary time and resources to perform the role; and • giving MDSOs access to potential learning and development opportunities.	Fully embed MDSO in CB QSE structures. Review MDSO role profile and resourcing and communicate requirements of the role with Clinical Boards. Develop MDSO dashboard to include: • Attendance at MEG & QSE meetings • QSE Med Equip reports, CB Datix reports, • CB med equipment risks Take learning from comprehensive specialist services' CB compliance audit against the UHB's Medical Equipment Management Policy to all CBs and audit as part of annual self-assessment process.	(blank)

			R2 Improve the effectiveness of the Medical Device Safety Officer role, by: **• providing clarity on the purpose of the role;** **• ensuring attendance at Medical Equipment Group meetings;** **• ensuring attendance at Clinical Board Quality, Safety and Experience meetings;** **• ensuring that MDSOs engage with their respective Clinical Board on medical equipment risks and issues;** **• ensuring MDSOs have the necessary time and resources to perform the role; and** **• giving MDSOs access to potential learning and development opportunities. Total**		
		R3/8	R3 Review medical equipment risk management throughout the organisation, ensuring alignment between the corporate and operational approach.	Ensure CBs capture medical equipment risks as part of their risk management processes. These will be monitored via MEG, and escalated through relevant strategic committees, eg Strategy and Resources/Capital Management/QSE/Management Executive as required.	(blank)
			R3 Review medical equipment risk management throughout the organisation, ensuring alignment between the corporate and operational approach. Total		
		R4/8	R4 The Health Board should determine how it can develop an effective medical equipment inventory with available resources.	The MEG will review the WHO good practice guidance and determine what is feasible to introduce, with resources available, to improve medical equipment inventory.	(blank)
			R4 The Health Board should determine how it can develop an effective medical equipment inventory with available resources. Total		
		R5/8	R5 The Medical Equipment Group should assure itself that clinical boards operate effective systems and processes for the monitoring, purchase and replacement of medical equipment below £5,000.	Ensure MSDOs include key under £5,000 items on their risk log and escalate replacement needs within the CB. Ensure medical devices procurement officer scrutinises under £5,000 items to identify opportunities for standardisation and efficiency	(blank)
			R5 The Medical Equipment Group should assure itself that clinical boards operate effective systems and processes for the monitoring, purchase and replacement of medical equipment below £5,000. Total		
		R6/8	R6 Ensure that Clinical Boards include the Medical Device Safety Officer report as a standing agenda item at the Quality, Safety and Experience meetings to discuss and address any medical equipment risks and incidents that arise.	Develop MDSO metrics for reporting to their CB QSE meetings, and MEG reporting.	(blank)
			R6 Ensure that Clinical Boards include the Medical Device Safety Officer report as a standing agenda item at the Quality, Safety and Experience meetings to discuss and address any medical equipment risks and incidents that arise. Total		
		R7/8	R7 Ensure all relevant service areas collaborate, consult and engage on medical equipment issues. It should give particular attention to the arrangements in place for maintenance and replacement of beds and hoists.	Monitor attendance and engagement of CB MSDOs and other members at MEG, escalate non-attendance or lack of engagement. Monitor progress of action plan developed by Health and Safety Advisor following the Arjo Proact 2017 survey Health and Safety Committee 18/005 minute (25 January 2018). Maintain hoists within the Clinical Engineering Department at the end of external supplier contract. Ensure Clinical Engineering is represented at the Bed Management Group	(blank)
			R7 Ensure all relevant service areas collaborate, consult and engage on medical equipment issues. It should give particular attention to the arrangements in place for maintenance and replacement of beds and hoists. Total		
		R8/8	R8 Evaluate the medical equipment arrangements in place within Pathology Services (Laboratory Medicine).	Agree Pathology MDSO role with CD&T with same CB functions at a directorate level reporting through to CB MDSO.	(blank)
			R8 Evaluate the medical equipment arrangements in place within Pathology Services (Laboratory Medicine). Total		
	Director of Therapies & Health Science Total				
Review of Operating Theatres	Chief Operating Officer	(blank)	R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it: • covers a broader range of specialities; and • clearly reports clinical risks associated with delayed follow-up appointments.	(blank)	(blank)
			R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it: **• covers a broader range of specialities; and** **• clearly reports clinical risks associated with delayed follow-up appointments. Total**		
			R2 Identify clinical conditions across all specialties where patients could come to irreversible harm through delays in follow-up appointments.	(blank)	(blank)

			R2 Identify clinical conditions across all specialties where patients could come to irreversible harm through delays in follow-up appointments. Total		
			R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date.	(blank)	(blank)
			R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date. Total		
	Chief Operating Officer Total				
Structured Assessment 2018	Chief Executive Officer	R1/11	The Health Board should complete our 2017 structured assessment recommendations by the end of 2019.	Agreed and these will be monitored to ensure this happens through Management Executives and reported to Audit Committee	(blank)
			The Health Board should complete our 2017 structured assessment recommendations by the end of 2019. Total		
		R10/11	The Health Board should complete a review of the structure and governance of its information and information technology functions to support delivery of the strategic digital approach	The newly appointed head of digital and health intelligence is developing a new structure to reflect combined information and IT services with the aim of stablishing functions that can best support the digital transformation agenda.	(blank)
			The Health Board should complete a review of the structure and governance of its information and information technology functions to support delivery of the strategic digital approach Total		
		R11/11	The Health Board should routinely update IT Disaster Recovery plans after key changes to IT infrastructure and networks and at scheduled intervals and test plans to ensure they are effective	The CAV IT Disaster Recovery plan is reviewed annually at a minimum and in response to specific circumstances. Testing is undertaken (both Check list and Technical) and multiple system restores are performed successfully annually. Additional infrastructure and software have been put in place to improve this process. A schedule of testing is being developed as part of the technical roadmap work.	(blank)
			The Health Board should routinely update IT Disaster Recovery plans after key changes to IT infrastructure and networks and at scheduled intervals and test plans to ensure they are effective Total		
		R1a/11	R13 [2016] 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 he relevant committees of the Board.	There is a tracker for WAO recommendations. The current arrangements don't provide enough clarity around what happens to recommendations where committees other than the audit committee are responsible	(blank)
			R13 [2016] 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 he relevant committees of the Board. Total		
		R1b/11	R2 [2017] To ensure compliance with the NHS planning framework, the Health Board needs to ensure that the Strategy and Engagement Committee regularly scrutinises progress on delivery of the Annual Operating Plan, and subsequent three year integrated medium term plans.	The new S&D Committee's work plan includes scrutiny of key elements of the Annual Operating Plan, 10-year strategy and transformation programme. The Committee and the Board still need to receive appropriate progress updates against the Annual Operating Plan deliverables to ensure they are on track.	(blank)
			R2 [2017] To ensure compliance with the NHS planning framework, the Health Board needs to ensure that the Strategy and Engagement Committee regularly scrutinises progress on delivery of the Annual Operating Plan, and subsequent three year integrated medium term plans. Total		
		R1c/11	R3 [2017] To enable effective scrutiny, the Health Board needs to improve the quality of its papers to Board and Committees by ensuring that the length and content of the papers presented is appropriate and manageable.	The length of Board and committee papers has improved compared to last year, but inconsistencies and variation remain. The Health Board's introduction in September 2018 of a revised cover report template should encourage more succinct reporting	(blank)
			R3 [2017] To enable effective scrutiny, the Health Board needs to improve the quality of its papers to Board and Committees by ensuring that the length and content of the papers presented is appropriate and manageable. Total		
		R1d/11	R4 [2017] To improve transparency, the Health Board needs to ensure that the Finance Committee papers are made available on its website in a timely manner.	At December 2018, the October 2018 Finance Committee papers were not available on the Health Board's website.	(blank)
			R4 [2017] To improve transparency, the Health Board needs to ensure that the Finance Committee papers are made available on its website in a timely manner. Total		

	R1e/11	R5 [2017] The Health Board needs to strengthen its corporate risk assurance framework (CRAF) by: ▪ mapping risks to the Health Board's strategic objectives; ▪ reviewing the required assurances; ▪ improving clarity of risk descriptors; and clarifying to the reader the date when risks are updated and/or added.	Until recently, the Health Board had made little progress in updating the CRAF. The CRAF was last presented to the Board and committees in November 2017. We recognise the Health Board has recently taken steps to start developing a separate Board Assurance Framework and Corporate Risk Register. The draft BAF was received at both the Audit Committee and Board in November and December respectively.	(blank)
		R5 [2017] The Health Board needs to strengthen its corporate risk assurance framework (CRAF) by: ▪ mapping risks to the Health Board's strategic objectives; ▪ reviewing the required assurances; ▪ improving clarity of risk descriptors; and clarifying to the reader the date when risks are updated and/or added. Total		
	R1f/11	R6 [2017] The Health Board needs to focus its attention on strengthening its information governance arrangements in readiness for the General Data Protection Regulations, which come into force in May 2018. This should include: ▪ updating the information governance strategy; ▪ putting in place arrangements for monitoring compliance of the primary care information governance toolkit; and ▪ developing and completing an Information Asset Register; ▪ ensuring that an identified data protection officer is in place; and ▪ improving the uptake of information governance training.	▪ An up-to-date Information Governance strategy does not yet exist. The Health Board has drafted its strategic approach in the Information Governance Policy. The Health Board plans to agree and implement this approach later in 2018. ▪ NWIS has developed the information governance toolkit for primary care GP's and intend to monitor compliance at a GP cluster level. These compliance monitoring arrangements for are still being developed. The Primary Care Clinical Board is liaising with the NHS Wales Informatics Service to confirm and agree these arrangements. ▪ Information asset registers have been developed within the corporate directorates and clinical boards, but further work is required to fully complete this. The Health Board is planning further work to: identify personal information held; identify information flows; and identify information	(blank)
		R6 [2017] The Health Board needs to focus its attention on strengthening its information governance arrangements in readiness for the General Data Protection Regulations, which come into force in May 2018. This should include: ▪ updating the information governance strategy; ▪ putting in place arrangements for monitoring compliance of the primary care information governance toolkit; and ▪ developing and completing an Information Asset Register; ▪ ensuring that an identified data protection officer is in place; and ▪ improving the uptake of information governance training. Total		
	R1g/11	R7 [2017] The Health Board needs to ensure that the level of information reported to the Resource and Delivery Committee on its performance is sufficient to enable the Committee to scrutinise effectively. This should include: ▪ ensuring that the Committee receives more detailed performance information than that received by the Board. Consideration should be made to including a summary of the Clinical and Service Board dashboards used in the monthly executive performance management reviews; ▪ expanding the range of performance metrics to include a broader range of key performance indicators relating to workforce. Consideration should be made to revisiting the previous workforce KPIs reported to the previous People, Planning and Performance Committee.	Overall this recommendation has been partly addressed. ▪ The S&D Committee continues to receive a high-level performance dashboard, which is less detailed than the performance report received by the Board. ▪ Since September 2018, the S&D Committee receives six-monthly updates against the workforce plans, including key workforce metrics.	(blank)

		R7 [2017] The Health Board needs to ensure that the level of information reported to the Resource and Delivery Committee on its performance is sufficient to enable the Committee to scrutinise effectively. This should include: **▪ ensuring that the Committee receives more detailed performance information than that received by the Board. Consideration should be made to including a summary of the Clinical and Service Board dashboards used in the monthly executive performance management reviews;** **▪ expanding the range of performance metrics to include a broader range of key performance indicators relating to workforce. Consideration should be made to revisiting the previous workforce KPIs reported to the previous People, Planning and Performance Committee. Total**		
	R1h/11	R9 [2017] To ensure resilience to security issues, such as cyber-attacks, the Health Board should consider identifying a dedicated resource for managing IT security.	In early 2018, the Health Board received an external review of cyber security arrangements. The review recommended improvements to cyber security arrangements. In response the Health Board is developing a formal cyber security improvement action plan. It plans to bring in specialist cyber security skills in early 2019 to address these recommendations and establish a specialist cyber security team.	(blank)
		R9 [2017] To ensure resilience to security issues, such as cyber-attacks, the Health Board should consider identifying a dedicated resource for managing IT security. Total		
	R1i/11	R10 [2017] To improve scrutiny of the Health Board's informatics service, the Health Board should expand the range of key performance indicators relating to informatics to include the cause and impact of informatics incidents.	The Health Board plans to review in early 2019 the structure and governance of its information and information technology functions to deliver the digital strategy.	(blank)
		R10 [2017] To improve scrutiny of the Health Board's informatics service, the Health Board should expand the range of key performance indicators relating to informatics to include the cause and impact of informatics incidents. Total		
	R2a/11	The Health Board should improve its recommendation tracking by: a. addressing our outstanding 2016 structured assessment recommendation to strengthen tracking arrangements for external audit recommendations;	Agreed this will be presented to the next Audit Committee	(blank)
		The Health Board should improve its recommendation tracking by: **a. addressing our outstanding 2016 structured assessment recommendation to strengthen tracking arrangements for external audit recommendations;** **Total**		
	R2b/11	b. including the tracking of internal audit recommendations; and	Agreed	(blank)
		b. including the tracking of internal audit recommendations; and Total		
	R2c/11	c. completing a review of all outstanding internal and external audit recommendations and reporting the findings to the Audit Committee.	Agreed	(blank)
		c. completing a review of all outstanding internal and external audit recommendations and reporting the findings to the Audit Committee. Total		
	R3a/11	The Health Board should: a. Update the Scheme of Delegation to reflect the delegated responsibility for calculating nurse staffing levels for designated acute medical and surgical inpatient wards;	Agreed in progress as result of Internal Audit Report	(blank)
		The Health Board should: **a. Update the Scheme of Delegation to reflect the delegated responsibility for calculating nurse staffing levels for designated acute medical and surgical inpatient wards;** **Total**		
	R3b/11	b. Review and update the Standing Orders and Standing Financial Instructions, ensuring these documents are reviewed and approved on an annual basis;	Agreed and timetabled to be undertaken on an annual basis going forward	(blank)
		b. Review and update the Standing Orders and Standing Financial Instructions, ensuring these documents are reviewed and approved on an annual basis; Total		

	R3c/11	c. Improve the format of the registers for declarations of interest and gifts, hospitality and sponsorship and clarify the frequency with which the registers are presented to the Audit Committee;	Agreed registers will be improved in format and reported to Audit Committee twice a year	(blank)
		c. Improve the format of the registers for declarations of interest and gifts, hospitality and sponsorship and clarify the frequency with which the registers are presented to the Audit Committee; Total		
	R3d/11	d. Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date;	Agreed	(blank)
		d. Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date; Total		
	R3e/11	e. Review all committee terms of reference to make sure they are up to date, do not overlap, and are reviewed annually;	Agreed in progress	(blank)
		e. Review all committee terms of reference to make sure they are up to date, do not overlap, and are reviewed annually; Total		
	R3f/11	f. Ensure all committees have an up-to-date work programme, which is linked to the cycle of Board meetings and reviewed annually.	Agreed work plans for each Committee and the Board are in development	(blank)
		f. Ensure all committees have an up-to-date work programme, which is linked to the cycle of Board meetings and reviewed annually. Total		
	R4/11	The Health Board should update its performance management framework to reflect the organisational changes that have taken place since 2013.	We accept that the performance management framework should be reviewed to ensure it fully supports the organisational business.	(blank)
		The Health Board should update its performance management framework to reflect the organisational changes that have taken place since 2013. Total		
	R5/11	The Health Board should provide the Finance Committee, or Board, with an update on progress with its testing and delivery of the All Wales Costing System Implementation Project.	The UHB accepts the need to provide an update on progress with this project. As a series of Welsh Costing Returns (WCRs) have now been submitted to Welsh Government using the new system, a comprehensive update on the implementation and future use of the costing development can now be made. It is intended to provide a paper to the Finance Committee following finalisation and publication of WCRs within Wales.	(blank)
		The Health Board should provide the Finance Committee, or Board, with an update on progress with its testing and delivery of the All Wales Costing System Implementation Project. Total		
	R6/11	The Health Board should ensure that all recommended matches from the next NFI exercise in January 2019 are reviewed and where necessary investigated in a timely manner.	For the forthcoming NFI exercise, the Health Board will endeavour to increase its compliance in respect of the number of recommended matches checked. A large number of these matches are however in relation to Accounts Payable and this will require further matching and review by the NHS Wales Shared Service Partnership. Consequently this is not wholly within the control of the Health Board.	(blank)
		The Health Board should ensure that all recommended matches from the next NFI exercise in January 2019 are reviewed and where necessary investigated in a timely manner. Total		
	R7/11	The Health Board should complete the outstanding actions from the Information Commissioner's Office (ICO) 2016 review of the Health Board's data protection arrangements.	CAV UHB is committed to continually improving mitigation of its risks of non-compliance. We are taking an improvement approach in line with the rest of Wales and in regular discussion with the ICO's office. Progress has been made on the registering of major assets and new flows of information. We intend to progress the assessment of our existing significant flows, adopting a risk based approach.	(blank)
		The Health Board should complete the outstanding actions from the Information Commissioner's Office (ICO) 2016 review of the Health Board's data protection arrangements. Total		
	R8/11	The Health Board should achieve full compliance with the General Data Protection Requirement by May 2019.	Delivery of the CAV UHB's updated action plan will reduce the risks we carry in relation to noncompliance with GDPR. Prioritisation of risks and mitigating actions are part of our continuous improvement plan, aimed at achieving full GDPR compliance during 2019.	(blank)
		The Health Board should achieve full compliance with the General Data Protection Requirement by May 2019. Total		
	R9/11	The Health Board should improve its response times to requests for information from Freedom of Information Act and Data Protection Subject Access Requests.	CAV UHB has recently appointed additional staff resulting in a positive impact on response times for FOI and Subject Access Requests. This will be monitored as we continue to move towards achieving fully compliant response times.	(blank)

			The Health Board should improve its response times to requests for information from Freedom of Information Act and Data Protection Subject Access Requests. Total		
	Chief Executive Officer Total				
(blank)	(blank)	(blank)	(blank)	(blank)	(blank)
			(blank) Total		
	(blank) Total				

Grand Total

Audit Reference	(All)

Audit Title	Executive Lead for Report	Status of Report Overall	Age Group
Clinical Coding Follow-up	**Director of Transformation and Informatics**	(blank)	Less Than 3 Months
Combined follow up of Informatics and Communications Technology audits	**Director of Transformation and Informatics**	(blank)	Date not Specified
Diagnostic review of ICT capacity andresources	**Director of Transformation and Informatics**	(blank)	Date not Specified
Discharge Planning	**Chief Operating Officer**	(blank)	Over 6 Months
			Over One Year
Hospital Catering and Patient Nutrition Follow-up Review	**Director of Planning**	(blank)	Date not Specified
Primary care services	**Chief Operating Officer**	(blank)	Due Date Not Reached
			Over 6 Months
Review of follow-up outpatients – assessment of progress	**Chief Operating Officer**	(blank)	Date not Specified
			Over One Year
Review of GP Out-of-Hours Services	**Chief Operating Officer**	(blank)	Over One Year
Review of Medical Equipment: Update on Progress	**Director of Therapies & Health Science**	(blank)	Over 3 Months
			Over 6 Months
			Over One Year
Review of Operating Theatres	**Chief Operating Officer**	(blank)	Date not Specified
Structured Assessment 2018	**Chief Executive Officer**	(blank)	Due Date Not Reached
			Over 3 Months
			Over 6 Months
			Over One Year
(blank)	**(blank)**	(blank)	Date not Specified
			(blank)
Grand Total			

Report Title:	**Internal Audit Recommendation Tracking Report**								
Meeting:	Audit Committee						**Meeting Date:**	30.09.2019	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

SITUATION

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

BACKGROUND

The WAO Structured Assessment for 2018, issued in January 2019, recommended that the Health Board should improve its recommendation tracking by :

(i) addressing the outstanding 2016 structured assessment recommendation to strengthen tracking arrangements for external audit recommendations;
(ii) including the tracking of internal audit recommendations;
(iii) completing a review of all outstanding internal and external audit recommendations and reporting the finding to the Audit Committee.

This report deals with internal audit recommendation tracking.

ASSESSMENT

Internal Audit recommendation tracking has not previously taken place at Cardiff and Vale Health Board in an effective way for quite some time hence the recommendation made by Wales Audit Office in their Structured Assessment for 2018. This piece of work has now been undertaken and all internal audit reports for the last two years (timescale agreed within internal audit) are now on the Internal Audit Tracker (attached at appendix 1).

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

The table below show the number of internal audits which have been undertaken over the last two years and their overall assurance rating.

	Substantial Assurance	Reasonable Assurance	Limited Assurance	Total
Internal Audits 17/18	10	24	6	40
Internal Audits 18/19	10	24	7	41
Total	**20**	**48**	**13**	**81**

The tables below shows a summary status of each of the recommendations made for internal audits undertaken in **17/18** as at 20th September 2019.

	High	%	Medium	%	Low	%
Complete/closed	8	30	27	36	19	47
Date not specified	6	22	2	3	10	24
Over 6 months	2	7	7	9	0	0
Over 1 year	11	41	39	52	12	29
Total	**27**	**100**	**75**	**100**	**41**	**100**

The tables below shows a summary status of each of the recommendations made for internal audits undertaken in **18/19** as at 20th September 2019.

	High	%	Medium	%	Low	%
Complete/closed	5	15	19	21	16	28
Date not specified	1	3	5	6	5	9
Date not reached	2	6	8	9	6	11
Less than 3 months	9	26	15	17	7	13
Over 3 months	8	24	21	23	13	23
Over 6 months	7	20	18	20	7	13
Over 1 year	2	6	3	4	2	3
Total	**34**	**100**	**89**	**100**	**56**	**100**

As can be seen from the above tables there is further work to be done to ensure that recommendation made by internal audit and agreed by Executive Directors are implemented in a timely manner. With tracking now starting to take place on a quarterly basis there is an expectation that this will improve.

Reports will, in future, be discussed at Management Executives and HSMB which includes the entire leadership team of the organization.

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

RECOMMENDATION

The Audit Committee Members are asked to:

(a) Note the tracking report which is now in place for tracking audit recommendations made by Internal Audit.

(b) Note that progress will be seen over coming months in the number of recommendations which are completed/closed.

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

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

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

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date
IA 1819	8/1/2018	Ombudsman Report	Director of Nursing	Substantial	N/A	N/A	N/A	N/A	
IA 1819	9/10/2017	Charitable Funds	Director of Finance	Substantial	M	The Finance Department should undertake a regular review of dormant Charitable Fund balances, focusing on those funds with highest values. Fund holders must be contacted and reminded that they should not allow funds to remain dormant and expenditure plans developed to ensure appropriate use of the funds.	Agreed	Director of Finance	12/1/2018
IA 1819	9/10/2017	Charitable Funds	Director of Finance	Substantial	M	Dormant Fund balances should be periodically reported to the Charitable Funds Committee.	Agreed	Director of Finance	12/1/2018
IA 1819	10/3/2018	Specialist ServicesFollow up -	Chief Operating Officer	Substantial	M	A process should be established to periodically test the backups.	Discussions are underway with IM&T and a test of the backup is due to be scheduled and undertaken following these.	Chief Operating Officer	11/1/2018
IA 1819	11/21/2018	Cost Improvement Programm	Director of Finance	Substantial	M	Management should ensure that sufficient detailed supporting documentation is in place for all Cost Improvement Programme savings schemes.The standard Impact Assessment form should also be completed by the scheme lead and forwarded to Finance for all Green rated schemes.	CIP Impact statements have been developed and filtered through Clinical Boards for completion when savings schemes are identified and progressed to Amber. Impact statements are required to be completed where schemes have a financial value > £75K or for all schemes that have any patient impact. To be discussed at Directors of Operations meeting with the COO. Completion of impact statements in development of the 2019/20 savings programme will be monitored through Clinical Board Management Teams and inancial Review meetings with the Deputy Director of Finance.	Director of Finance	4/1/2019
IA 1819	11/21/2018	Cost Improvement Programm	Director of Finance	Substantial	L	Where it is identified that actual savings are higher or lower than originally anticipated, the monitoring section of the tracker should be amended by the Clinical Board Finance teams to reflect this.	Actual savings delivered are reported on a monthly basis as part of the monthly accounts process. Variances against profiled planned savings schemes are clearly reported. The current CIP monitoring process that is in place identifies actual savings against anticipated savings profiles.	Director of Finance	Closed
IA 1819	11/21/2018	Cost Improvement Programm	Director of Finance	Substantial	L	NHS Wales Audit & Assurance Services Page 11 of 12 Recommendation 3 Priority level The pay and non-pay element of savings schemes should be combined when compiling the top 20 savings schemes monitoring return for the Welsh Government.	A process merging pay and non-pay elements of savings schemes will be put in place to ensure this is actioned from month 9 2018/19 onwards. Process now in place.	Director of Finance	Closed
IA 1819	1/11/2019	Claims Reimbursement	Director of Nursing	Substantial	L	Management should ensure that staff members complete the status section as a form of good practise.	This will be audited through regular peer datix reviews of files by each claims manager	Director of Nursing	Closed
IA 1819	1/11/2019	Claims Reimbursement	Director of Nursing	Substantial	L	Signatories should ensure that all documents are appropriately dated. Management should ensure that all relevant documents are uploaded onto Datix on a timely basis for ease of access.	There was no problem with any authorities in signing off the Appendix forms; these were minor errors all of which were rectified. From now on we will check all forms for dates and ensure that any interim or final forms are scanned/copied to Datix.	Director of Nursing	Closed

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date
IA 1819	2/12/2019	Performance Reporting Data	Director of Public Health	Substantial	M	Consideration should be given to aligning the Performance Report and Tier 1 scorecard to the NHS Delivery Measures.	Discussions at a national level are happening between Welsh Government and the NHS in Wales to ensure that the Health Boards are sighted on the data being submitted to Welsh Government to report on the Q&D framework targets. This is not the case at the moment and there is no mechanism other than via the NHS	Director or Transformation and Informatics	
IA 1819	2/12/2019	Performance Reporting Data	Director of Public Health	Substantial	L	The Performance Report working spreadsheet should be linked to data sources and SOPs in order to aid collation and ensure the on-going robustness of the process.	As identified above – not all the data is available to achieve this. The UHB is actively contributing, via membership of WG & NHS Wales committees to changing and improving data flows and making the required data available.	Director or Transformation and Informatics	
IA 1819	2/12/2019	Performance Reporting Data	Director of Public Health	Substantial	L	Consideration should be given to re-formatting the Performance Report to improve usability.	Accept	Director or Transformation and Informatics	
IA 1819	4/14/2019	Delayed Transfers of Care Reg	Chief Operating Officer	Substantial	L	The Medically Fit spreadsheet used to identify DToCs weekly is updated using the comments column. However, it is not always clear from this what date certain process started, eg, funding authorised, housing confirmation, package of care agreement. It therefore makes it difficult to decipher whether a DToC is apparent.	The date of referral and compliance with time scales is checked verbally within the weekly scrutiny meetings and is often times included in the clinical workstation entries. The spread sheet will be altered to include the agreed timescales and any divergence clearly noted	Chief Operating Officer	4/1/2019
IA 1819	4/14/2019	Delayed Transfers of Care Rep	Chief Operating Officer	Substantial	L	Due to the patient impact of delayed discharge, it would be beneficial to include DToC in the information presented to the Clinical Board's Quality, Safety and Patient Experience Groups.	Clinical Boards will be provided with the monthly DToC report Clinical Board Directors of Operations will be reminded of the necessity to include in Quality and Governance agenda	Chief Operating Officer	4/1/2019
IA 1819	4/11/2019	Ward Nursing Staff Levels	Director of Nursing	Substantial	M	The Nurse Staffing Levels - Working Planning Template should be signed off by the approved personnel in line with the requirements of the Health Board's Operating Framework, as confirmation that they approve the staffing levels.	The completion of signing off the staffing templates has proved a challenge, given the timescales following validation of data and reporting to Board, due mainly to annual leave of key people during the time required. There have been instances where all signatures are present but have been placed in the incorrect boxes. We continue to learn from each staffing cycle (every 6 months) with an expected improvement.	Director of Nursing	5/1/2019
IA 1819	4/11/2019	Ward Nursing Staff Levels	Director of Nursing	Substantial	M	Management should ensure that all wards display the ward staffing levels to inform the patients of Nurse staffing levels for each ward. Management should ensure that the Nurse staffing levels being displayed are correct and up to date.	We have found that at times, there have been oversights in the ward displaying the information was not displayed at all. All ward Sisters therefore have been reminded on the importance and expectations to display the appropriate correct data	Director of Nursing	7/1/2019
IA 1819	4/11/2019	Ward Nursing Staff Levels	Director of Nursing	Substantial	L	Management should ensure that following the consistency check of the Operating Framework the document should be published on the Health Board Intranet.	The Operating framework is with the All Wales Group for final approval.	Director of Nursing	7/1/2019

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date
IA 1819	4/11/2019	Ward Nursing Staff Levels	Director of Nursing	Substantial	L	The Finance budgeted report for the WTE staff should be amended to align with the correct Nurse staffing levels and the number of beds on the ward.	It is proposed that the finance report will align to the correct Nurse establishment following the completion of the 3rd staffing calculation cycle currently being undertaken	Director of Nursing	7/1/2019
IA 1819	5/15/2019	Strategic Planning/IMTP	Director of Planning	Substantial	M	Management should ensure that the plans for Clinical Boards are produced on a timely basis to enable the Clinical Boards to report on their projects in a consistent manner and allow them to monitor them appropriately.	A revised monitoring process for reporting clinical board progress on IMTPs will be in place for 2019/20. This will utilise the Shaping Our Future Wellbeing- Annual Plan (X-Matrix) methodology to provide clarity on performance and accountability arrangements. Progress against key IMTP priorities as captured in the annual plan document will be reported to Management Executives on a monthly basis as agreed at Management Executives on 09/05/19.	Director of Planning	7/1/2019
IA 1819	7/2/2018	Annual Quality Statement	Director of Nursing	Substantial	L	Consideration should be given to the development of a tracker in the form of a spreadsheet or database that would record all planned developments within each AQS theme. This could be used to record progress during the year and to determine which planned developments should be updated in the following years AQS.	A database will be created to support the tracking of all improvement measures that are specified in the 2017/18 AQS	Director of Nursing	8/1/2018
IA 1819	7/2/2018	Annual Quality Statement	Director of Nursing	Substantial	L	A check on the accuracy of all data sets obtained from the Datix system should be undertaken to identify any significant variances from the data initially provided. This check should be incorporated into the AQS timetable and should be done as late as possible in the AQS process.	The specified data has been changed in line with the recommendation. Some of the data included in the AQS, in particular the reporting of patient safety incidents is generated from a dynamic reporting system and is subject to re-categorisation or change over time as investigations are ongoing, to ensure that the most accurate and up to date information is published the Patient Safety Incidents will be reviewed and checked immediately prior to presentation of the final draft to the Quality Safety and Experience Committee.	Director of Nursing	Closed
IA 1819	7/2/2018	Annual Quality Statement	Director of Nursing	Substantial	L	The UHB should consider the impact of the much earlier deadline for publishing the 2018/19 AQS and plan how each stage of the AQS process can be achieved by the deadline whilst ensuring that the quality and accuracy of the publication is maintained.	The development and coordination of the AQS is planned in advance with time scheduled for working with Media Resources and the Communication and Engagement team. Data including RTT, Patient Experience and Patient Safety cannot be generated until the new financial year but this is accommodated in the work plan for the document. This will be considered and reflected in a paper to the Quality, Safety and Experience Committee in December 2018, which will set out the time table for production of the 2018-2019 AQS in line with the requirements of the relevant WHC.	Director of Nursing	12/1/2018

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date
IA 1819	10/1/2018	Shaping Our Future Wellbeing	Director of Planning	Reasonable	M	Terms of Reference should be developed for the Programme Team and Project Teams to cover the all stages of the process after the submission and approval of the business cases, i.e. delivery of the capital projects and commissioning of the facilities. Responsibilities of the Teams should include overseeing programme and project budget management, as appropriate.	Terms of reference are reviewed at each stage of the project / Programme, so that they are relevant to the current stage of the process. We will review the current wording to ensure that the responsibility for budget monitoring is clear. Audit has now been provided with a revised structure document and terms of reference for the Delivery Group and the Penarth Project Team.	Director of Planning	11/30/2018
IA 1819	10/1/2018	Shaping Our Future Wellbeing	Director of Planning	Reasonable	L	Delivery of the required project business cases should be carefully performance monitored in-house to ensure that resources are adequate and that there are no unnecessary slippages in the target dates.	Supply Chain Partners have now been appointed for the Maelfa and Penarth schemes and their programmes confirm that the schemes can be delivered within the required timescales. The risks of delay have consequently been reduced. The risks of delay on the Park View scheme will continue to be monitored by the Project Team.	Director of Planning	10/8/2019
IA 1819	8/30/2018	Dental CB – Theatre Sessions	Chief Operating Officer	Reasonable	H	The Dental administration staff should ensure that Patient Dental files contain copies of all necessary documentation relating to the procedures undertaken.	Urgent meeting to be arranged with Clinical Lead and Peri-Operative Care Manager to define a process to manage documentation	Chief Operating Officer	9/1/2018
IA 1819	8/30/2018	Dental CB – Theatre Sessions	Chief Operating Officer	Reasonable	M	The majority of patients cancelled by Dental staff are due to oversubscribed and overrun lists. Therefore, list management should be monitored and improvements made where necessary.	Reviewed PasPlus regarding start and finish times. Clinical Lead to speak with Maxillofacial Consultants	Chief Operating Officer	9/1/2018
IA 1819	8/30/2018	Dental CB – Theatre Sessions	Chief Operating Officer	Reasonable	M	Dental management should ensure that cancelled operations are re-bookedwithin the required timescales.	Where possible this is always the case but many lists are held only on a monthly basis. Dental are limited in the number of lists that are dedicated to Dental Patients and therefore if a cancer patient requires theatre we have to utilise a dedicated list and cancelled patients will be re-listed at the next scheduled list.	Chief Operating Officer	9/1/2018
IA 1819	8/30/2018	Dental CB – Dental Nurse Pro	Chief Operating Officer	Reasonable	M	The Dental Nurse Management team should consider formalising ratios of Dental Nurse staff per operators /patients/procedures. This should include reevaluation of any ratios that are currently in place in agreement with the University. When these ratios have been produced they should ensure that weekly numbers allocations are adhering to these staffing levels.	To reduce duplication of lists, a meeting will be set up with Senior Dental Nurse's and colleagues working in medical records to review the current clinical staffing allocated to each department on PMS.Once complete work will begin on allocating core numbers of DN to each department.	Chief Operating Officer	10/1/2018
IA 1819	8/30/2018	Dental CB – Dental Nurse Pro	Chief Operating Officer	Reasonable	M	The Dental Nurse Management team should consider bringing forward the numbers allocation to mid-week. Consideration should be given to producing fortnightly numbers with weekly review once patient lists stabilise closer to the scheduled date.	To reduce duplication of lists, a meeting will be set up with Senior Dental Nurse's and colleagues working in medical records to review the current clinical staffing allocated to each department on PMS. Once complete work will begin on allocating core numbers of DN to each department.	Chief Operating Officer	10/1/2018

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date
IA 1819	8/30/2018	Dental CB – Dental Nurse Pro	Chief Operating Officer	Reasonable	M	Dental Nurse Management should attend the Clinical Staffing meeting and Performance Group meeting hosted by the Medical Records team.This forum should be used to escalate dental nurse staffing issues caused by changes to clinic schedules.	Dental Nurse Manager attends Clinical staffing meeting, at this meeting Dental Nurse Manager provides feedback on concerns raised by SDN	Chief Operating Officer	Closed
IA 1819	8/30/2018	Dental CB – Dental Nurse Pro	Chief Operating Officer	Reasonable	L	It is recommended that the Senior Dental Nurses maintain a log that documents changes to schedules or nursing allocations as they occur and discuss these at the Senior Dental Nurse meeting to establish patterns or identify root causes. These can also be escalated to the weekly meetings with Medical records, ie. Clinical Staffing and Performance Group.	Implement feedback tool; that will be used to collect weekly changes that take place on each department. This information will form part of the weekly SDN staff discussion meeting	Chief Operating Officer	10/1/2018
IA 1819	8/30/2018	Dental CB – Dental Nurse Pro	Chief Operating Officer	Reasonable	L	The Senior Dental Nurse weekly meeting should continue to function in order to force justification of requested allocation by each clinic.	The weekly Senior Dental Nurse meeting will continue to function, chaired by the Dental Nurse manager /Deputy Dental Nurse Manager A records of attendance will also be kept.	Chief Operating Officer	9/1/2018
IA 1819	8/30/2018	Dental CB – Dental Nurse Pro	Chief Operating Officer	Reasonable	L	Consideration should be given to adding in the Senior Dental Nurses into the ESR hierarchy to delegate responsibility and distribute the administrative task of approving and recording annual leave. The use of ESR self-service by Dental Nurses should be enforced.	Where appropriate, work will begin on rolling out ESR hierarchy access to Senior Dental Nurses	Chief Operating Officer	12/1/2018
IA 1819	8/23/2018	Environmental Sustainability I	Director of Planning	Reasonable	M	Future Sustainability Reports should only report on water supply costs. This may be achieved by: using different subjective codes to pay water and sewerage charges; by maintaining a manual record of the split between water and sewerage charges; or by apportioning annual costs based on a sample of paid water and sewerage charges.	Future Sustainability reports will include water supply costs, but will be determined on an apportionment basis from the invoices we receive from Welsh Water. The calculations will be determined from a limited sample of Welsh Water invoices.	Director of Planning	4/1/2019

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date
IA 1819	8/23/2018	Environmental Sustainability	Director of Planning	Reasonable	M	A requirement to draw up a timetable annually to cover the preparation of the Sustainability Report should be incorporated into the documented sustainability reporting procedure. The timetable should ensure that the draft report is signed off by the Director of Capital Estates and Facilities prior to publication in line with the required deadline. The timetable should also specify the date that the report will be approved by the Environmental Management Steering Group (EMSG) / Health & Safety Group. Where possible this should also be prior to publication, although it is acknowledged that to ensure compliance with the Welsh Government submission deadline it may sometimes be necessary to obtain retrospective approval from the EMSG / H & S Group.	A timetable will be developed in April 2019 detailing key milestones. Where possible approval will be granted prior to publication, but depending on the timing of the meetings to present the report and obtain approval, retrospective approval may also have to be considered.	Director of Planning	4/1/2019
IA 1819	8/23/2018	Environmental Sustainability	Director of Planning	Reasonable	L	The sustainability reporting procedure notes should be supplemented with detailed information on how to prepare each of the 3 mandatory tables included in the report. The procedure should detail where the source data for each entry in the table should be obtained.	The sustainability reporting procedure now includes detailed information on how to prepare each of the 3 mandatory tables included in the report. The Energy manager has completed this exercise. This action is therefore complete.	Director of Planning	Closed
IA 1819	8/23/2018	Environmental Sustainability	Director of Planning	Reasonable	L	Future Sustainability Reports should include references / links to where further sustainability and estate management performance is published. For example this could include links to information such as the Estates Strategy, EMSG Terms of Reference and selected meeting minutes, ISO Certificate and audit reports / ISO website, Cost Reduction Programme, Re:fit programme, further information on CHP units and Solar PV Schemes and the Sustainable Travel Plan.	Consideration will be given to include references / links to where further sustainability and Estate management performance is published depending on its relevance.	Director of Planning	4/1/2019
IA 1819	9/10/2018	Electronic Staff Record	Director of Workforce and Organisatio	Reasonable	H	The Workforce Department need to ensure that where ESR has been rolled out to departments that it is utilised fully and consistently with requirements, and provide further support and advice to departments where utilisation levels are not satisfactory.	During rollout (now 100% completed) managers and staff were made aware of the facility to record and manage annual leave using ESR. The facility to manage annual leave using ESR has been made available to managers and supervisors. The responsibility for ensuring staff apply for annual leave via ESR lies with the manager/supervisor. It also must be noted that where the Rosterpro system is in place, annual leaveis recorded on this system instead of ESR The Workforce Team will send a reminder to all anagers/Supervisors to use the ESR Annual Leave Functionality or use the Rostering systems that interface with ESR. They will also offer any further training if this is needed and signposting to Guidelines which are available.	Director of Workforce and O	9/30/2018

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IA 1819	9/10/2018	Electronic Staff Record	Director of Workforce and Organisatio	Reasonable	M	Appropriate staff will be reminded that paperwork needs to be sent to Medical Recruitment on a timely basis, so that an accurate picture of compliance can be represented.	It is the responsibility of the Clinical Board Management team to identify problems area in relation to job plan compliance and send the completed/up to date job plan summaries to the generic Job Plan inbox for ESR entry by Medical Workforce. The Medical Director will write to remind all Clinical Board Directors to ensure that they comply with Job Plan reporting. The Workforce & OD Team will explore how to further automate the recording of job plan updates into ESR through Manager Self Service under the supervision of the Medical Workforce Team. It is hoped this should enable updates to be done at source by Clinical Boards and Directorate Management. It is hoped that any future investment in rostering systems will interface with ESR to automate job planning updates.	Director of Workforce and C	10/31/2018
IA 1819	9/10/2018	Electronic Staff Record	Director of Workforce and Organisatio	Reasonable	M	Management will ensure a singular and consistent approach to reporting compliance performance with the Health Board.	This has already been actioned as the Learning Education & Development team are no longer providing PADR compliance rates as individual managers/supervisors are able to easily identify the compliance rates of all staff within their ESR hierarchies. One source of statistics is now provided to formal Meetings and Committees e.g., LPF, HSMB by the Workforce Information Manager	Director of Workforce and C	Closed
IA 1819	9/10/2018	Electronic Staff Record	Director of Workforce and Organisatio	Reasonable	L	Workforce to ensure that Health Board staff are aware of the support and guidance that is available either through online documents or face to face to ensure staff can use ESR effectively and efficiently. Consideration should also be given to producing shortened management selfservice quick guides for wards and departments that can be easily accessed.	Contact details of the new All-Wales ESR Self-Service Support Hub (helpdesk) have been widely circulated to managers. The Hub will provide 'how-to' support for Self-Service users, and signpost to nline user guides. The C&V ESR Internet page also contains links to the same online user guides. Gong forward a survey will be undertaken with Departments to identify any further identified training needs. This will provide an opportunity to develop ocal, tailored support interventions for teams of users as the majority of helpdesk routine enquiries are covered off by the Helpdesk.	Director of Workforce and C	3/31/2019

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IA 1819	9/10/2018	Management of the Disciplina	Director of Workforce and Organisatio	Reasonable	M	A fully complete initial assessment should be on every case file, which provides the rationale for the disciplinary method. This will allow early consideration of the different disciplinary methods to drive efficient working.	The current initial assessment process has been reviewed and a more robust process will be introduced in September 2018. This new process will ensure that there is consistency in how we approach issues/concerns as an organisation. ▪ The fast track process is lways encouraged. The All Wales Policy states that all parties have to be in agreement, which has resulted in a few cases proceeding to formal investigation because the employee has not been in agreement. The HR Operations Team are currently reviewing cases that have progressed inappropriately previously and discussions are taking place with the managers and HR Practitioners who have been involved in commissioning the investigation to learn from this review. The new WOD restructure and ways of working within the HR team, will resultin higher levels of consistency.	Director of Workforce and O	9/30/2018
IA 1819	9/10/2018	Management of the Disciplina	Director of Workforce and Organisatio	Reasonable	H	Management will implement mechanisms, i.e. a root cause analysis, to highlight the main constraints to timescales not being met and implement enhancements to enable an increased level of compliance with the target timescales.	The Director of Workforce & OD is leading the challenge and engagement with Trade Union Colleagues support to speed up the disciplinary process. A review has been undertaken by the Head of Operational HR to identify the main constraints in regard to unacceptable delays and the following actions have been agreed/implemented: ▪ Assistant Heads of Workforce (AHWODs) are now responsible for case management; ▪ Monthly monitoring/performance meetings are being held with the AHWODs; ▪ Monthly case review meetings are being held with the Deputy Executive Nurse Director to support progress and blockages; ▪ The previous system for coaching IO's has been changed as it often created delays in the process; The team are working with Disciplining Officers and Investigating Officers to ensure they understand their responsibilities; We are seeking commitment from the organisation to release IO's so that they can undertake investigations in an efficiently and effective manner.	Director of Workforce and O	3/31/2019

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IA 1819	9/10/2018	Management of the Disciplina	Director of Workforce and Organisatio	Reasonable	M	Management will put processes in place to enhance file management for both fast track and full investigation methods e.g. chronology. Management should explore and consider the use of electronic file management and digitising of files in order to drive efficient and effective working.	The HR team have revised the Guidance and Information Pack for Investigating Officer's which will be implemented in September; The format of the investigation report has been revised and streamlined for consistency and will be implemented in September 2018. ▪ The HR team are piloting electronic hearing packs for all grievances and some of the appropriate disciplinary cases; ▪ HR are currently working with the Head of IT to determine how we can implement an electronic file storage system so that documents can be shared securely. This will stop the need to photocopy disciplinary sharing packs.	Director of Workforce and C	3/31/2019
IA 1819	9/10/2018	Management of the Disciplina	Director of Workforce and Organisatio	Reasonable	M	Management will identify trends in delays and take appropriate action in order that performance improves.	The organisation of Appeals will be centralised within the HR Operations Centre in the Autumn with the ongoing support of the HR Governance Team; ▪ Greater focus has been placed on arranging appeal hearings in the last 2 months which has resulted in an improvement in timescales; ▪ The new HR Case Manager system will improve the Appeal process and ensure consistency and follow through. ▪ The way in which the HR administrator arrange both appeal and disciplinary hearings has been streamlined and we anticipate that this will result in timescale improvements.	Director of Workforce and C	10/30/2018
IA 1819	9/10/2018	Management of the Disciplina	Director of Workforce and Organisatio	Reasonable	M	Training will be undertaken by all investigators to help v	The HR team are currently reviewing the UHB list of IO's to ascertain their status, i.e. have they been trained, how experienced are they, have they completed an investigation recently, etc. This will ensure that we have an accurate list of both trained and xperienced IO's to choose from; ▪ The IO training is currently being enhanced to ensure that following the training IO's are capable to undertake investigations; ▪ It was evident following the review that HR practitioners are too involved in the investigation process. This has been rectified and roles have been clarified.	Director of Workforce and C	11/30/2018

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IA 1819	9/10/2018	Management of the Disciplina	Director of Workforce and Organisatio	Reasonable	M	Management should review their performance/ summary documents to ensure all information is included appropriately and a focus on outcomes.	The main ER tracker is being updated to ensure that we capture the performance data in a more streamlined way; Employee Relations reports will be reviewed to ensure that they are meaningful and outcome focused; The appeals monitoring spreadsheet has een amended and now captures the timescales; The department are currently exploring the implementation of an ER Tracker. There will be a system demonstration on 26th September, following which we will determine whether the system can deliver significant efficiency improvements and proceed to a business case proposal.	Director of Workforce and O	10/30/2018
IA 1819	11/21/2018	National Standards for Cleani	Director of Planning	Reasonable	M	The Health Board should ensure that there is a Multi-Disciplinary Group in place in line with the requirements of the 'National Standards for Cleaning in NHS Wales' or that the Healthcare Environment Steering Group referred to in the Cleaning Strategy is reconvened.	Formerly add the Cleaning Standards requirement into one of the existing forums described above into the same agenda. This will save additional meetings and labour resources.	Director of Planning	1/1/2018
IA 1819	11/21/2018	National Standards for Cleani	Director of Planning	Reasonable	M	The Health Board should ensure that a consistent approach is used for reporting the technical audit scores across the 2 sites and that accurate scores are reported for all completed audits.	On checking with C4C both approaches were in accordance with the system and standards, however Facilities will review their approach and standardise when and if appropriate.	Director of Planning	1/1/2018
IA 1819	11/21/2018	National Standards for Cleani	Director of Planning	Reasonable	H	An appropriate member of the Ward staff should sign off the technical audits undertaken by the domestic supervisor.	Facilities to coordinate and request clinical support on audit. Ward Sisters and Charge Nurses will be reminded of their responsibility to, when requested check the validity of the audit and sign off.	Director of Planning	11/1/2017
IA 1819	11/21/2018	National Standards for Cleani	Director of Planning	Reasonable	H	The Health Board should carry out managerial audits on a quarterly basis in line with the requirements of the Standards.	Facilities Staff to arrange audit schedule and invite ward staff to participate with good prior arrangements in place.	Director of Planning	1/1/2018
IA 1819	11/21/2018	National Standards for Cleani	Director of Planning	Reasonable	M	Management should update the Cleaning Strategy and develop an Operational Cleaning Plan in line with the requirements of the Standards.	Facilities Senior Management to develop and disseminate to the Cleaning Group for sign off and approval.	Director of Planning	3/1/2018
IA 1819	11/21/2018	National Standards for Cleani	Director of Planning	Reasonable	M	nagement should ensure that technical audits are completed on all high / very high risk areas as per required timescales.	Facilities to review audit schedule and make clear programme to Senior Management, stating UHB priorities.	Director of Planning	1/1/2018
IA 1819	10/25/2018	CRC Energy Efficiency Scheme	Director of Planning	Reasonable	M	Bureau data will be compared at meter level with supplier statements (on a like for like basis) to better inform review and compilation of the annual report.	For sites with multiple meters, the bureau data in the 2018/19 CRC reporting spreadsheet will be presented on a meter by meter basis. If there are instances where this cannot be achieved an alternative approach will be developed and adopted.	Director of Planning	2018/2019
IA 1819	10/25/2018	CRC Energy Efficiency Scheme	Director of Planning	Reasonable	L	The CRC working paper summary page should clearly show those figures that are to be uploaded to the CRC register, including on-site electricity generation and net of the 10% estimation uplifts.	For 2018/19 the CRC working summary page will show the figures that are to be uploaded to the CRC Register, including on site electricity generation and net of the 10% estimation uplifts.	Director of Planning	2018/2019

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IA 1819	11/19/2018	PCIC CB – District Nursing Rot	Chief Operating Officer	Reasonable	M	The District Nurses should ensure they are enforcing rules over how many staff can take annual leave on the same day. This should be reviewed periodically to ensure compliance. They should also ensure that Annual Leave requests are fully complete, updated when changes are made and authorised.	A local annual leave procedure has been developed since the audit to ensure that staff understand how the annual leave can be requested approved and rostered.	Chief Operating Officer	Closed
IA 1819	11/21/2018	PCIC CB – District Nursing Rot	Chief Operating Officer	Reasonable	L	District Nurses should work in conjunction with the Rosterpro team to ensure details in Rosterpro are correct to enable use of the automated generation of rotas. Rotas should be entered into Rosterpro prior to shifts being worked.	District Nursing sisters will be expected to use Rosterpro to roster all staff, this will be reviewed through regular 1-1's with them and the Locality senior nurse.	Chief Operating Officer	11/28/2019
IA 1819	11/21/2018	PCIC CB – District Nursing Rot	Chief Operating Officer	Reasonable	L	District Nurse Sisters should ensure rotas are prepared on a timely basis. Where rotas are prepared manually, these should be formally signed and the date of preparation recorded.	District Nursing sisters will be expected to use Rosterpro to roster all staff, rosters will be audited quarterly to ensure that rosters are provided 4-6 weeks in advance, and signed off, this will be reviewed through regular 1-1's with them and the Locality senior nurse	Chief Operating Officer	11/28/2019
IA 1819	11/21/2018	PCIC CB – District Nursing Rot	Chief Operating Officer	Reasonable	L	District Nurse Sisters should verify rotas weekly, within 72 hours of the last shift worked. This should be reviewed periodically to ensure compliance.	District Nursing sisters will be required to verify rosters weekly and this will bemonitored through regular 1-1's with the Locality Senior nurse	Chief Operating Officer	11/28/2019
IA 1819	11/21/2018	PCIC CB – District Nursing Rot	Chief Operating Officer	Reasonable	L	District Nurse Sisters should be reminded of the importance of recording shortfalls on the rota. Compliance should be reviewed periodically.	A revised process for recording gaps in staffing is to be developed	Chief Operating Officer	1/1/2019
IA 1819	11/16/2018	Mental Health Clinical Board -	Chief Operating Officer	Reasonable	M	The Guideline for Section 17 Leave of Absence Mental Health Act 1983 should be approved as soon as possible.	The Guideline for Section 17 Leave of Absence Mental Health Act 1983 will be presented for approval at the Clinical Board Quality and Safety Committee in December 2018.	Chief Operating Officer	12/13/2018
IA 1819	11/16/2018	Mental Health Clinical Board -	Chief Operating Officer	Reasonable	M	The Health Board should clarify if there is a requirement for specific risk assessments and intervention plans to be produced before patients go on leave. The Guideline should then be updated to reflect the clarified requirements and management should ensure that these are followed in all instances. Risk assessments and intervention plans should be updated and reviewed on a regular basis.	Consideration of the risk assessment and care and treatment plan will have taken place during a review with the Responsible Clinician prior to any Section 17 leave being granted. This is documented on the CPA 3 Review record and in the relevant case note entry. The Guideline for Section 17 Leave will be updated to remove the requirement for a specific Section 17 risk assessment and care plan. Wards have been reminded to ensure current contact details are correct prior to a patient commencing Section 17 leave.	Chief Operating Officer	12/1/2018
IA 1819	11/16/2018	Mental Health Clinical Board -	Chief Operating Officer	Reasonable	M	Management should consider updating the Section 17 Leave of Absence form to record the reason why leave has been granted to the patient.	The recording of the reason why leave has been granted is not a requirement of the MHA or Code of Practice. The conditions attached to the leave that are documented on the form, is the record if the leave is granted for a specific reason. The form does not therefore require updating.	Chief Operating Officer	Closed

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IA 1819	11/16/2018	Mental Health Clinical Board -	Chief Operating Officer	Reasonable	L	Staff should ensure that they complete all sections of the signing in and out book when patients leave and return to the wards.		Chief Operating Officer	Closed
IA 1819	12/1/2018	Renal IT system	Chief Operating Officer	Reasonable	H	Both UNIX and MySQL should updated to a more recent, supported version.	Early investigations have taken place between Vitalpulse and Summerside. Monies will need to be found to either see how viable the MySQL version 5.7 is with a more recent AIX version. It may not be compatible and a Windows or Linux infrastructure (Live and DR) will need to be considered. Whilst the appropriate Hardware and Software vendor companies, who are contractually obliged to support and maintain the renal IT infrastructure (Summerside Computers Ltd and Vitalpulse Ltd respectively) review and consider the viable options available, we are unable to action any immediate change, either as a HB or as part of the WRCN. We will continue to monitor and review until a suitable solution is identified and can be implemented.	Chief Operating Officer	6/1/2019
IA 1819	12/1/2018	Renal IT system	Chief Operating Officer	Reasonable	M	The minimum password length should be set to 8 and all users have a forced password change enacted.	The minimum length has now been amended to 8. With regard to forced change, this will be required when VitalData v1.7 is implemented across Wales this financial year. v1.7 has Active Directory authentication, which will mean Users will be required (and forced) to change their VitalData password every 90 days – the same as is required with User's everyday NADEX domain login.	Chief Operating Officer	6/1/2019
IA 1819	12/1/2018	Renal IT system	Chief Operating Officer	Reasonable	M	Recommendation: The backups should be subject to periodic testing.	This has been brought to the attention of the IT Server Team but is outside of the Directorate's direct control. We will continue to seek an appropriate response	Chief Operating Officer	4/1/2019
IA 1819	12/1/2018	Renal IT system	Chief Operating Officer	Reasonable	M	The DR plan should be revised to include contact details of support organisations, user departments and management. The DR plan should be tested and subject to subsequent review.	Dialogue with the Vendor parties has already started regarding the failback process. Action is underway to test and resolve, and identify an appropriate timetable for follow-up to ensure regular review. The BCP will be revised with immediate attention	Chief Operating Officer	4/1/2019
IA 1819	12/1/2018	Renal IT system	Chief Operating Officer	Reasonable	M	A review of users should be undertaken to ensures that leavers access is revoked.	Action has been taken as identified and a process implemented to regularly review leavers. This will ensure access is revoked at the earliest opportunity.	Chief Operating Officer	4/1/2019
IA 1819	12/1/2018	Renal IT system	Chief Operating Officer	Reasonable	M	Generic accounts should not be used for data entry.	Agreed, On request, Auditor provided a list of affected accounts and these have been reviewed.	Chief Operating Officer	Closed

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IA 1819	12/1/2018	Renal IT system	Chief Operating Officer	Reasonable	M	The local user group should seek to identify fields which could benefit from improved entry controls.	Communication with users is ongoing and agreed changes will be actioned where appropriate.	Chief Operating Officer	6/1/2019
IA 1819	12/1/2018	Renal IT system	Chief Operating Officer	Reasonable	M	A local user group should be established with leads from each of the user departments with the remit to: - Share knowledge over how departments use the system; - Identify areas where improvements to design or functionality could be made; - Identify areas where additional training should be provided to users. - identify areas where poor or late data entry has impacts on downstream departments.	Partially agree. There is an all Wales VitalData Group to which Users can feed into via their Renal IT lead or via each Health Board Clinical IT Lead. As the VitalData system is use within four out of the five Renal Units in Wales any developments or suggestions to change are to benefit all the renal community and a Request for Change process is in place in relation to any system improvements. In Cardiff, local drop-in How-To sessions were established but with little buy-in; they were soon disbanded.	Chief Operating Officer	6/1/2019
IA 1819	12/1/2018	Renal IT system	Chief Operating Officer	Reasonable	L	The ROOT account should be renamed and the anonymous account deleted.	Management Response The anonymous account was deleted Oct 2018. The ROOT account will be kept as such to maintain consistency in the database.	Chief Operating Officer	Closed
IA 1819	12/1/2018	Renal IT system	Chief Operating Officer	Reasonable	L	The UHB should consider enabling logging	Database enables logging of every action, be it viewing, editing, deleting etc. all stored in an Activity	Chief Operating Officer	Closed
IA 1819	2/14/2019	Contract Compliance	Director of Finance	Reasonable	H	Capital & Estates staff should be formally reminded of the requirement to comply with Procurement procedures and ensure all work awarded achieves value for money and contractors are able to compete for work on a fair and equal basis. Identified non-compliance with the above requirement should be reported to the Audit Committee through the Procurement Compliance Report.	Procurement Services has put in place a system to identify additional expenditure sub £5k, and are working with Estates Services to tender a Framework for these services to ensure competition and governance is managed. Capital & Estates staff are reminded to comply with Procurement Procedures. All non-compliance is reported to Audit Committee.	Director of Finance	8/1/2019
IA 1819	2/14/2019	Contract Compliance	Director of Finance	Reasonable	M	Staff raising purchase orders should be reminded of the requirement to obtain quotations and retain evidence of such, prior to raising orders in accordance with procurement procedures. The uploading of catalogue items to Oracle for new contracts should be undertaken on a timely basis.	Procurement Services will continue to support, provide training, guidance and reinforce SFI's to all departments.	Director of Finance	9/21/2019
IA 1819	2/14/2019	Contract Compliance	Director of Finance	Reasonable	L	An overview of the procurement process should be included in the Corporate staff induction programme. This could take the form of a summary guidance sheet that could be handed out to new employees and / or a presentation to new employees by the procurement team.	Procurement Services will provide a summary guidance sheet to the Induction	Director of Finance	4/1/2019

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IA 1819	2/14/2019	Contract Compliance	Director of Finance	Reasonable	L	The Procurement Guide should be reviewed and updated as necessary. The current year's Procurement Services Business Plan should be posted to theintranet if available. An up to date Procurement Services Business Plan should be drawn up for 2019/20 and made available to all staff via the procurement section of the C & V UHB intranet.	Since the C&V intranet was tested, the revised Business Plan has been approved by NWSSP and updated on the C&V website in January.	Director of Finance	1/1/2019
IA 1819	2/15/2019	Clinical Diagnostic and Therap	Director of Operations	Reasonable	H	The Clinical Board should develop a process to ensure that all overtime sessions worked in excess of 6 hours include a clearly documented 30 minute unpaid break. This process should then be communicated to all relevant managers and consistently implemented in the future.	All departments have received a communication instructing them to amend their current processes to include a documented 30 min break. This was done in advance of the production of a new Standard operating procedure which will include this guidance and elevant recording mechanisms as per finding 2	Chief Operating Officer	Closed
IA 1819	2/15/2019	Clinical Diagnostic and Therap	Director of Operations	Reasonable	M	The Clinical Board should consider producing a Standard Operating Procedure detailing the process to follow when booking bank, agency and utilisation of overtime, in order to ensure that there is a consistent approach throughout the clinical Board. As a minimum, Individual directorates should ensure that their own processes are formally documented in order to ensure consistent application and effective continuity in the event of staff changes / absence.	CD+T will review the current processes in place across departments to produce an overarching SOP to be utilised across departments. Where there are individual practices in place that are necessarily bespoke they can remain and will be referenced within the procedure	Chief Operating Officer	3/1/2019
IA 1819	2/15/2019	Clinical Diagnostic and Therap	Director of Operations	Reasonable	M	The department should ensure that all agency shifts worked are appropriately authorise prior to payment and evidence of authorisation should be retained.	The management team associated with this department has been requested to provide the relevant recording to the clinical board for review and the need for this on an ongoing basis will for part of the SOP.	Chief Operating Officer	3/15/2019
IA 1819	2/15/2019	Clinical Diagnostic and Therap	Director of Operations	Reasonable	L	Where staff work less than the Agenda for Change hours of 37.5 hours any additional hours worked must be recorded as 'Additional Hours' on the Pay Card returned to Payroll Delegated Budget Holders should review the pay-cards submitted to Payroll to establish whether additional hours have been incorrectly classed as overtime.	This will form part of the SOP, and a reminder email will be sent to all departments	Chief Operating Officer	Closed
IA 1819	2/15/2019	Kronos Time Recording Syster	Director of Planning	Reasonable	H	Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system.	Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system.	Director of Planning	6/1/2019

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IA 1819	2/15/2019	Kronos Time Recording Syster	Director of Planning	Reasonable	M	Management should review the current M & E Rotas to establish if the practice of paying staff for their breaks can be stopped.	The Estates Department is currently in the process of consultation with staff on modernisation of the department including changes to the shift patterns which would eliminate the need to pay staff for breaks. However until this is resolved the risk associated with enforcing an unpaid meal break for shifts outside normal hours is considered high. In so much that if an emergency (eg electrical failure) occurs when the shift electrician is on an unpaid break they could refuse to respond and put the service at risk.	Director of Planning	
IA 1819	2/15/2019	Kronos Time Recording Syster	Director of Planning	Reasonable	M	The development of an automatic interface between Kronos and ESR is a key factor in determining whether Kronos should be rolled out across Estates. A timetable and deadline should therefore be set for the development and introduction of a suitable interface between Kronos and ESR.	Refer to Management Response to Finding 1; which includes investigating the interface with ESR. Interface has now been developed and is currently being tested.	Director of Planning	6/1/2019
IA 1819	2/15/2019	Kronos Time Recording Syster	Director of Planning	Reasonable	M	Where overtime has been worked this should be reflected in the start and finish times recorded in Kronos, and should be authorised on the timesheets. Management should investigate the feasibility of including a 'reason for overtime' or Notes field on timesheets with the system providers so that in future all overtime can be claimed and authorised on individual timesheets	The issue will be considered as part of the system review although all overtime is authorised and recorded therefore the risk is low. Kronos has been updated to include overtime reasons.	Director of Planning	6/1/2019
IA 1819	2/15/2019	Kronos Time Recording Syster	Director of Planning	Reasonable	M	Staff should be instructed to clock in no more than 27 minutes before the start of their shift. Where staff do clock in more than 27 minutes before the start of their shift, supervisors should amend the timesheet start time to the scheduled start time if the additional time is not to be paid as overtime. Supervisors should update timesheets with reasons why staff have not clocked in or out of the system prior to authorising them, for example annual leave, special leave, unpaid leave, working off site, system down etc. Supervisors should amend shift start and finish times on Kronos where it has been agreed that staff can work alternative shift patterns. Disciplinary action should be taken against staff that are persistently late and fail to work their assigned shift pattern.	Staff clock in on arrival on site but are not paid from this point, unless authorisation is given for overtime. Staff will be advised not to clock in as suggested and this will be monitored but the risk associated with this practice is considered low.	Director of Planning	6/1/2019

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IA 1819	2/15/2019	Kronos Time Recording Syste	Director of Planning	Reasonable	L	Estates Admin staff should be instructed to only input hours for enhancements into Rosterpro, i.e. overtime, standby and callout, plus any adjustments to basic pay. The Kronos WFR system is being used primarily as a time and attendance recording system. Supervisors should therefore be instructed to ensure that timesheets accurately record the attendance and absences of all staff under their control.	Supervisors are fully aware of their responsibilities in respect of recording absence and attendance. Senior Managers will reiterate the process.	Director of Planning	6/1/2019
IA 1819	5/10/2018	Specialist Neuro & Spinal Reh	Director of Planning	Reasonable	M	The Procurement Strategy will be defined, within the FBC and consider all of the advantages / disadvantages if utilising the chosen framework and the options therein (D)	Other contractual options available in the SCAPE Framework were not considered so as to align the contract with Designed for Life parameters i.e. the use of NEC Option C. The contract option adopted is indicated in the FBC. **ACTIONED SINCE FIELDWORK**	Director of Planning	Closed
IA 1819	5/10/2018	Specialist Neuro & Spinal Reh	Director of Planning	Reasonable	L	At future schemes contract documentation will be signed prior to the commencement of the respective commissions/works (O)	At future schemes contract documentation will be signed prior to the commencement of the respective commissions/works (O)	Director of Planning	5/17/2019
IA 1819	5/10/2018	Specialist Neuro & Spinal Reh	Director of Planning	Reasonable	M	Appropriate, timely internal approval will be sought for the change in capital cost and supporting assumptions, prior to submission to the WG (O)	After completion of the audit fieldwork, Chair's Action approved the FBC prior to submission to the WG. **ACTIONED SINCE FIELDWORK**	Director of Planning	Closed
IA 1819	4/1/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable	H	Plan should be devsed for the proposed roll out of Datix to GPs, this should include, but not be limited to: Establishing realist timescales for implementation · Engagement with GPs · Communication with other Health Boards who have already rolled out Datix to their Primary Care providers · Developing a training and education plan for use fo the system; and · Consideration of access leveels and role assignments	The patient safety team (PST) have already carried out some preparatory work which has include: · Work with IT to explore Firewall issues · Visits to AMBUHB and BCUHB to share learning from their experiences of rolling this out · Consultation with All Wales Datix administrators group November 2018 - the Patient Safety Team is currently recruiting to a key vacancy in the Datix team Once the vacancy has been filled, the PST can review the current Datix workplan and re-commence an implementation plan for the roll out of the incident reporting module of Datix to GPs by December 2020	Chief Operating Officer	3/1/2019
IA 1819	4/1/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable	M	There should be continued engagement and education with GPs to ensure they are categorising issues correctly within the interface incidents remit and are highlighting those reports that contain a major risk or potential harm	In July 2018 the PST in partnership with PCIC have undertaken work to develop an incident trigger list, to improve the quality of and the appropriateness of what is reported on the system. Regular contact is made with practices and the LMC relating to patient safety issues	Chief Operating Officer	Closed

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IA 1819	4/1/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable	L	PCIC should communicate the importance of reporting interface incidents in a timely manner	Practices already deal with serious issues relating to interface incidents by contacting the secondary care dept themselves and dealing with the matter direct, this is supported by the LMC and GMC in their guidance for independent contracts working within the GMS contract	Chief Operating Officer	Closed
IA 1819	4/1/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable	L	In addition to the recommendation to consider future workplans, a Standard Operating Procedure should be writen that encompasses the entire Q&S Officer role in relation to Interface Incidents	An agreed pathway is already in place that has been supported by the LMC, staffing pressures sometimes result in delays inputting the information into Datix from PCIC staff, however the risk of the delay affecitng patient care or patient outcomes is extremely low as practices will have already dealt with the incident and are sending the information to PCIC for informtion and recording to the Interface incident process	Chief Operating Officer	Closed
IA 1819	4/1/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable	M	The Patient Safety Team should remind Clinical Boards a	This would not be the role fo the PST. The UHB incident, Hazard and near miss reporting procedure clarifies the roles and responsibilities of the Clinical Boards: `The Clinical / Service Board Management teams are responsible for ensuring that staff within their Board are briefed on their indiidual and collective responsibilities within the incidnet reporing process. They must ensure that all incidents are reported, investigated and analysed, so that learning and improvements can be embedded in practice. The Patient Safety Team and Health, Safety and Environment Unit are responsible for supporting and implementation of this procedure. They will also undertake to raise staff awareness and training on incident reporting and investigaiton.	Chief Operating Officer	Closed
IA 1819	4/1/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable	M	Efforts should be made to engage with all GP practices, especially those that do not regularly report interface incidents Consideration should be given to developing a training and education plan to improve the quality, timeliness and completeness of reporting from GPs	The Patient Safety Team will work with PCIC as part of the Datix implementation plan to provide an appropriate training and education programme ot GPs and other practice staff	Chief Operating Officer	9/1/2019
IA 1819	4/1/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable	M	The Q&S Officer should review the list of Datix Reports opened by themselves, paying particular attention to those with overdue flags, to monitor that interface incidents are being progressed and closed. Engagement with Secondary Care directorates to ensure they are aware of the benefit of feeding back investigation results to Primary Care	PST - the way that permissions and profiles are set up in Datix means that once the incident is assigned to another user (eg if an incident which involves the laboratories is passed on to the laboratory manager) it remains visible to staff within the reporting area but also to those who need to respond and investigate the issue	Chief Operating Officer	Closed

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IA 1819	4/1/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable	L	Regular communicatoin with GPs should be undertaken to make them aware of the actions taken following their reporting of interface incidents. This will inform them of improvements ot processes as a result and encourage future engagement	A paragraph in relation to the interface process was included in the winter Patient Safety and Quality newsletter. The UHB Medical Director and LMC are kept up to date with the interface incident process through the regular Primary / Secondary Care interface meetings.	Chief Operating Officer	Closed
IA 1819	4/1/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable	L	Consideration should be given to how feedback and incident reporting can be made a two way process with continued engagement between primary and secondary care. This will need to include training of secondary care professionals in the current process of interface incidents reporting	PCIC does not receive incident notification from internal depts within the UHB which are managed in line with the agreed UHB process for incident management/ PST - this issue has also been presented at the Datix Super User Gropu. Further information will be included on the Datix Intranet page.	Chief Operating Officer	Closed
IA 1819	4/9/2019	Medicine CB - Sickness Absen	Chief Operating Officer	Reasonable	H	Management must ensure that all future sickness episodes are managed and documentation is completed in accordance with the requirements of the All Wales Managing Attendance at Work Policy. Management should ensure that a self-certificate is completed correctly and a return to work interview is held with the employee including the completion of the return to work form. Clinical Board management should consider introducing further periodic training on the sickness management process in order to increase awareness and compliance levels.	Re-circulate the All Wales Managing Attendance at Work Policy. Support and appraises have been set up for A6 South to ensure consistency in completing Self-certification. Review Ward Base sickness processes to ensure that they reflect current policy and provide efficiency to complete necessary actions.	Chief Operating Officer	3/12/2019
IA 1819	4/9/2019	Medicine CB - Sickness Absen	Chief Operating Officer	Reasonable	M	Management should ensure that the sickness triggers are being managed correctly and all future required informal discussions and formal sickness interviews are carried out in accordance with the requirements of the All Wales Managing Attendance at Work Policy.	Support and appraises have been set up for A6 South to ensure consistency in completing Self-certification. Confirm management expectations with Ward Managers in following the All Wales Managing Attendance at Work Policy. Review Ward Base sickness processes to ensure that they reflect current policy and provide efficiency to complete necessary actions.	Chief Operating Officer	4/1/2019
IA 1819	4/9/2019	Medicine CB - Sickness Absen	Chief Operating Officer	Reasonable	M	Management should ensure that the sickness triggers are being managed correctly and all future required informal discussions and formal sickness interviews are carried out in accordance with the requirements of the All Wales Managing Attendance at Work Policy.	Support and appraises have been set up for A6 South to ensure consistency in completing Self-certification. Confirm management expectations with Ward Managers in following the All Wales Managing Attendance at Work Policy. Review Ward Base sickness processes to ensure that they reflect current policy and provide efficiency to complete necessary actions.	Chief Operating Officer	4/1/2019

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IA 1819	4/9/2019	Medicine CB - Sickness Absen	Chief Operating Officer	Reasonable	M	Management should ensure that all current ward managers are provided with appropriate training to enable them to effectively manage sickness absence. A robust process should also be implemented to ensure that timely training is provided to any new ward managers. Regular information on sickness absence levels should be consistently provided to all ward managers.	▪ Within Stroke Services, engaged with Human resources to provide further training for all members of the Leadership team. ▪ Discussed with HR and now regularly circulating sickness data. ▪ HR currently undertaking deep dives with high rate areas to provide useful supportive information about absence.	Chief Operating Officer	4/1/2019
IA 1819	4/9/2019	Medicine CB - Sickness Absen	Chief Operating Officer	Reasonable	L	Management should remind ward staff that the recording of sickness dates should reconcile between sickness documentation and ESR, and all sickness dates should be accurately and consistently recorded.	Within Stroke Services, engaged with Human resources to provide further training for all members of the Leadership team. ▪ Through Support and appraise, challenge can be placed upon the ward staff to ensure that appropriate input of data is reconciled.	Chief Operating Officer	5/1/2019
IA 1819	2/15/2019	CRI Safeguarding Works	Director of Planning	Reasonable	M	Progression at risk should be fully documented, approved and recorded at the risk register (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Planning	5/22/2020
IA 1819	2/15/2019	CRI Safeguarding Works	Director of Planning	Reasonable	L	A Project Execution Plan should be prepared at the outset of a project, in accordance with the Capital Projects Manual and best practice (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Planning	5/22/2020
IA 1819	2/15/2019	CRI Safeguarding Works	Director of Planning	Reasonable	M	Sufficient contractual arrangements should be in place to safeguard the Health Board interests (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Planning	5/22/2020
IA 1819	2/15/2019	CRI Safeguarding Works	Director of Planning	Reasonable	L	4) Project benefits should be clearly identified and documented in the business case, including: ▪ Baseline value; ▪ Method of measurement; ▪ Target improvement; ▪ Timing of when the benefit would be achieved; and ▪ Lead responsibility for the benefit (D). (This recommendation being for implementation at future projects). Post project evaluations should be delivered in accordance with agreed Business Case requirements, or a revised approach should be appropriately approved (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Planning	5/22/2019
IA 1819	2/15/2019	CRI Safeguarding Works	Director of Planning	Reasonable	L	5) The required approach to post project evaluation and benefits assessment should be agreed with the Welsh Government, in relation to the CRI afeguarding project and wider investment at the CRI site (O).	Agreed.	Director of Planning	6/1/2019

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IA 1819	4/11/2019	Commissioning	Director of Transformation, Improvem	Reasonable	H	Strategic Commissioning Group Terms of Reference document should be revised and updated to state the quorate attendance level and its current membership. Additionally, its membership should include representation from the Clinical Boards to ensure a broad contribution and as such an improved strategic approach in full alignment with the Group's Terms of Reference.	The Strategic Commissioning Groups Terms of Reference, including membership was reviewed at a facilitated workshop on 20th Feb 2019. The first draft of a refreshed Terms of reference is scheduled for discussion at the May 2019 meeting of the Strategic Commissioning and Finance Group. Clinical Board representation will be fully considered.	Director of Transformation	5/1/2019
IA 1819	4/11/2019	Commissioning	Director of Transformation, Improvem	Reasonable	M	The Commissioning Team should as part of its ongoing programme of work publicise their presence via their intranet pages and create an internet page thereby promoting the Commissioning Framework and Commissioning Intentions so as to maximise awareness of content to both internal/external stakeholders and the wider general public.	The development of the commissioning intranet pages, alongside commissioning toolkits, and awareness raising remains on the Commissioning Team's work plan. These actions were not progressed following publication of the Framework due to capacity of the team, and other urgent priorities. Progression of these actions will be included in the team's work plan for 2019-20, but capacity to implement remains an issue.	Director of Transformation	4/1/2020
IA 1819	4/11/2019	Commissioning	Director of Transformation, Improvem	Reasonable	L	The Commissioning Framework document should be updated to reflect its creation date and should be subject to version control stating a timescale of applicability and use.	The Commissioning Framework has been amended, and now includes version control, and timescale of applicability, which is 5 years. The Framework will be reviewed for currency and accuracy on an annual basis.	Director of Transformation	4/1/2019
IA 1819	4/12/2019	E IT Training	Director of Transformation, Improvem	Reasonable	M	An assessment of the impact of these measures should be carried out and procedures developed for actions in similar circumstances in the future.	An assessment of the reduced course duration is to be undertaken by the PARIS training senior officer at the point the team regain their second training staff member (long term sick, meant the two person PARIS training complement was reduced by half). The PARIS programme has service representation embedded in its 'change structure'. These staff have been asked for concerns and feedback regularly (to the fortnightly MHCS team meetings) since this 'new training model' was made necessary (due to long term loss of staff). No operational risks or concerns have been raised from scoped services to date.	Director of Transformation	9/1/2019

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IA 1819	4/12/2019	E IT Training	Director of Transformation, Improvem	Reasonable	M	Relevant policies and procedures should be put in place to set out the circumstances under which this kind of drift can be allowed (if at all), any mitigation measures, how many versions the training system can be allowed to be behind and any other provisions to ensure adequate quality levels of training are preserved.	The 'relevance' of the PARIS training system is under constant review through both the fortnightly PARIS team meeting and the fortnightly PARIS Technical Design Team (TDT). The functionality that is 'trained' upon is a hugely limited subset of all the capability of PARIS 'live' (as there are, for example, c400 assessment types on PARIS LIVE, and c50 casenote types etc…). As such the Health Board trains on one or two examples, thus negating the necessity for 'LIVE' and 'TRAIN' systems to be 'identical'. Approximately 6000 changes have been made to the PARIS 'live' system over a decade, including c20 PARIS 'version' changes. An assessed evaluation is constantly undertaken by the PARIS senior trainer to assure that what we 'train' upon, is 'suitably reflective' of what is currently (or sometimes due) to be on the LIVE system. As an example, in any 'version' change to PARIS there will be a range of changes. These changes may have no bearing upon what is 'trained' upon, and as such there would be no purpose in upgrading the training system. Further, doing so would reduce delivery capacity, leading to a greater wait for training, and inducing unnecessary 'training issues'.	Director of Transformation	Closed
IA 1819	4/12/2019	E IT Training	Director of Transformation, Improvem	Reasonable	L	To introduce a relevant pre-assessment process and procedures to ensure that staff with learning difficulties are able to learn the systems to the required level.	The Health Board will: 1. Agree a process for ensuring any LD is captured. 2. Develop the Training Booking system to include a mandatory Learning Difficulties field within the user profile screen. The LD will automatically display against the user when booking them in for training sessions. Initially the LD field will default to NONE however the IT Trainers are to check/update the LD field when requests for training received.	Director of Transformation	6/30/2019
IA 1819	4/12/2019	E IT Training	Director of Transformation, Improvem	Reasonable	L	Document control information to be standardised and completed in full on training documents.	Training documents are currently version controlled but not standardised. Standardising them would be a very low priority within the current resource.	Director of Transformation	9/1/2019
IA 1819	4/12/2019	E IT Training	Director of Transformation, Improvem	Reasonable	L	A sign off process should be introduced involving training customers for the Welsh Clinical Portal	A review and sign off procedure for the Welsh Clinical Portal involving the service coordinators who represent the training customers (attendants) will be considered and discussed with the WCP trainer on return to work from Work Life Balance absence. This could take the form of a WCP 'super user' group who review and comment on new versions of the training package before they are made available for general use.	Director of Transformation	9/1/2019

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IA 1819	4/12/2019	E IT Training	Director of Transformation, Improvem	Reasonable	L	An impact assessment process should be introduced in order to gather and evaluate the feedback from training attendants after they have had the opportunity to use the relevant systems. The feedback emails should be reviewed on a regular basis.	An impact assessment process is in draft but has been suspended due to the Work Life Balance absence of the WCP trainer. This and the regular review of feedback emails will recommence once the trainer has returned to post.	Director of Transformation	9/1/2019
IA 1819	4/12/2019	E IT Training	Director of Transformation, Improvem	Reasonable	L	The training material should be updated to include a range of options for post learning support other than just helpdesk contact information. The need for refresher sessions should be reviewed in conjunction with service customers.	It would not be appropriate to provide Service Coordinator details since these will be subject to change at effectively no notice. Training materials include contact information for the “IT User Support” team which is managed by the IT Trainers and Implementation Officer. Both e-mail and telephone contact details are included. Users are able to contact for advice, refresh and support to meet their requirements. If e-learning material is available the link to the learning is also included. As such full support is demonstrably available post training from the user's perspective. Refresh sessions have previously been included into a rolling schedule however take up from end users (and support from managers to ensure attendance) was so poor that it was deemed a waste of the limited resource within the training team. Refresh sessions can be (and are) delivered on request by the service customers.	Director of Transformation	Closed
IA 1819	5/15/2019	Water Safety	Director of Planning	Reasonable	M	Attendances of the Water Safety Group should be reviewed, with staff reminded of their responsibilities to attend, to ensure key groups are appropriately represented (O).	Agreed	Director of Planning	6/30/2019
IA 1819	5/15/2019	Water Safety	Director of Planning	Reasonable	M	The current position in respect of the backlog of remedial jobs, should be routinely reported to the Water Safety Group (O).	Agreed	Director of Planning	6/30/2019
IA 1819	5/15/2019	Water Safety	Director of Planning	Reasonable	M	Training should be updated for all key staff with assigned water management responsibilities (O).	Agreed	Director of Planning	7/30/2019

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IA 1819	5/15/2019	Water Safety	Director of Planning	Reasonable	M	a) An audit trail should be maintained where routine checks are not completed, in cases where risk-based decisions dictate alternative monitoring/testing schedules will be applied. b) Key person dependency should be reviewed and removed, where possible, to facilitate the timely identification and completion of remedial work (O). See also recommendation 2 in relation to assessment and reporting of the backlog of remedial jobs.	Agreed	Director of Planning	6/30/2019
IA 1819	5/15/2019	Water Safety	Director of Planning	Reasonable	H	a) For those clinical boards identified in this audit as being non-compliant with required flushing practices, the Chair of the WSG should request assurance from the clinical boards that practices have been improved. b) The Chair of the Water Safety Group should ensure that flushing guidance is re-issued to all clinical boards for full circulation to relevant staff (O).	Agreed	Director of Planning	7/30/2019
IA 1819	5/15/2019	Water Safety	Director of Planning	Reasonable	H	The risk assessment process, including preparation of appropriate prioritised action plans to address the identified risks, should be completed as soon as possible (D).	Agreed	Director of Planning	11/1/2019
IA 1819	5/15/2019	Water Safety	Director of Planning	Reasonable	M	Progress, including highlighting of any delays, should be regularly reported to the Water Safety Group (O).	Agreed	Director of Planning	11/1/2019
IA 1819	5/15/2019	UHB Core Financial Systems	Director of Finance	Reasonable	M	Management should ensure that the main Asset Register is updated to reflect the correct position and steps are undertaken to ensure the required follow up is commenced as soon as possible on all applicable assets.	Agreed and accepted. The follow up visits with clinical gerontology will be completed by the week ending May 24th 2019. The remaining transfers will be actioned by the end of July 2019.	Director of Finance	7/30/2019
IA 1819	5/15/2019	UHB Core Financial Systems	Director of Finance	Reasonable	L	Management should ensure departments are aware that all assets should have asset numbers, where this is not the case Finance should be informed. Management should advice Departments that where assets are to be disposed or no longer in use a disposal form should be completed and passed to Finance as soon as possible. The asset register should also be updated with asset serial numbers.	The Director of Finance will again write to departments during 2019/20 emphasising the need to place the asset identification labels provided onto new capital assets purchased and to ask for replacement labels where necessary. Departments will also be reminded of the need to inform finance of asset disposals on a timely basis and to provide details of missing serial numbers when they respond to the annual asset verification request. This will once again be supported with training sessions for directorate managers.	Director of Finance	10/31/2019

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IA 1819	5/15/2019	UHB Core Financial Systems	Director of Finance	Reasonable	M	Management should inform responsible staff to promptly notify eEnablement of changes to the Purchasing Oracle hierarchy list. The required forms should be completed to process updates.	Recommendation Accepted. The UHB's current procedure will be updated to clarify the responsibility to review approvers at the Clinical Board level and within Corporate Finance.	Director of Finance	7/31/2019
IA 1819	5/15/2019	UHB Core Financial Systems	Director of Finance	Reasonable	M	Management should ensure that a standard procedural guide is produced to support staff in the maintenance of the Oracle Purchasing hierarchy. The guide should also state an appropriate agreed period for the review of the hierarchy.	Recommendation accepted. The UHB's current procedure will be updated to clarify respective responsibilities at the Clinical Board level and within Corporate Finance. The minimum expectation is that purchasing hierarchies will be reviewed quarterly.	Director of Finance	7/31/2019
IA 1819	5/15/2019	UHB Core Financial Systems	Director of Finance	Reasonable	M	Management should ensure that the required forms are completed, signed and forwarded to eEnablement for all additions to the Oracle Hierarchy. Management should also liaise with eEnablement to ensure there is an organised system for storing the Financial limit forms so they can be easily retrieved here an audit trail is required.	Recommendation accepted. The UHB's revised procedure will be updated to clarify respective responsibilities for establishing approvers and maintaining appropriate records for additions to the Oracle Hierarchy.	Director of Finance	7/31/2019
IA 1819	5/15/2019	Health and Care Standards	Director of Nursing	Reasonable	N/A	N/A	N/A	N/A	
IA 1819	7/2/2018	Annual Quality Statement	Director of Nursing	Substantial	L	Consideration should be given to the development of a tracker in the form of a spreadsheet or database that would record all planned developments within each AQS theme. This could be used to record progress during the year and todetermine which planned developments should be updated in the following years AQS.	A database will be created to support the tracking of all improvement measuresthat are specified in the 2017/18 AQS	Director of Nursing	8/1/2018
IA 1819	7/2/2018	Annual Quality Statement	Director of Nursing	Substantial	L	A check on the accuracy of all data sets obtained from the Datix system should be undertaken to identify any significant variances from the data initially provided. This check should be incorporated into the AQS timetable and should be done as late as possible in the AQS process.	The specified data has been changed in line with the recommendation. Some of the data included in the AQS, in particular the reporting of patient safety incidents is generated from a dynamic reporting system and is subject to re-categorisation or change over time as investigations are ongoing, to ensure that the most accurate and up to date information is published the Patient Safety Incidents will be reviewed and checked immediately prior to presentation of the final draft to the Quality Safety and Experience Committee.	Director of Nursing	Completed

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IA 1819	7/2/2018	Annual Quality Statement	Director of Nursing	Substantial	L	The UHB should consider the impact of the much earlier deadline for publishing the 2018/19 AQS and plan how each stage of the AQS process can be achieved by the deadline whilst ensuring that the quality and accuracy of the publication is maintained.	The development and coordination of the AQS is planned in advance with timescheduled for working with Media Resources and the Communication and Engagement team. Data including RTT, Patient Experience and Patient Safety cannot be generated until the new financial year but this is accommodated in the work plan for the document. This will be considered and reflected in a paper to the Quality, Safety and Experience Committee in December 2018, which will set out the time table for production of the 2018-2019 AQS in line with the requirements of the relevant WHC.	Director of Nursing	12/1/2018
IA 1819	5/17/2019	Specialist Services Clinical Boa	Chief Operating Officer	Reasonable	H	Management should carry out a comprehensive review of the current and future consultant staffing levels to ensure that the Critical Care service can be sustainably delivered in the future. This should include review of the current service model.		Chief Operating Officer	4/1/2020
IA 1819	5/17/2019	Specialist Services Clinical Boa	Chief Operating Officer	Reasonable	L	Each 20 week Consultant rota should be subject to formal approval by the Clinical Director and evidence of this approval should be retained on file.	A process to sign off the rota by the Clinical Director will be developed by the Directorate Management Team, and a record of which will be retained on file along with existing job planning information.	Chief Operating Officer	8/31/2019
IA 1819	10/30/2018	Mental Health Clinical Board -	Chief Operating Officer	Limited	H	Management should ensure that all sickness episodes are managed and documentation is completed in accordance with the All Wales Sickness Policy. Management should ensure that a self-certificate is completed correctly and a return to work interview is held with the employee including the completion of the return to work form. Clinical Board management should consider introducing periodic training on the sickness management process in order to increase awareness and compliance levels.	Directorates to send all managers a link to the sickness policy /NHS Wales Managing Attendance at Work Policy, reminding them of the importance of sending timely letters, conducting interviews and checking self-certification notes. All Band 6 and 7 managers to attend refresher sickness training. Further sickness surgeries have been scheduled and sickness rates have fallen.	Chief Operating Officer	5/1/2019
IA 1819	10/30/2018	Mental Health Clinical Board -	Chief Operating Officer	Limited	H	Management should ensure that the sickness triggers are being managed correctly with informal discussions and formal sickness interviews being carried out in accordance with the All Wales Sickness Policy.	Directorates to send “trigger table” out to all managers, reminding them to check with line managers if they have any doubt or queries with individual cases. Senior Nurse Managers to conduct random sickness file checks as part of 1:1 with managers.	Chief Operating Officer	4/1/2019
IA 1819	10/30/2018	Mental Health Clinical Board -	Chief Operating Officer	Limited	L	Long term sickness meetings should be held as required to ensure that the employee is receiving support and help.	Directorates to send all managers a general reminder of the need for formal sickness letters to be sent and for LTS forms to be signed and copied. Managers to be asked to ensure that where conversations have been held with HR / OH re: additional triggers, these are to be more clearly noted in sickness files	Chief Operating Officer	4/1/2019

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IA 1819	10/30/2018	Mental Health Clinical Board -	Chief Operating Officer	Limited	L	Management should remind ward staff that the recording of sickness dates should reconcile between sickness documentation and ESR, and all sickness dates should be accurately and consistently recorded.	All band 6 / 7 managers to attend refresher sickness training.	Chief Operating Officer	5/1/2019
IA 1819	11/15/2018	Standards of Business Conduc	Director of Corporate Governanace	Limited	H	A system is introduced that will ensure that declarations are received from all required staff at the appropriate intervals as set out in the policy. The process will also ensure that missing returns are chased up and that the register is complete and accurate.	Recommendation Agreed – a process will be developed to ensure that key staff groups listed within the policy complete declarations as set out in the policy and that those who do not are chased up.	Director of Corporate Governance	12/31/2018
IA 1819	11/15/2018	Standards of Business Conduc	Director of Corporate Governanace	Limited	H	The Corporate Team must put processes in place to help raise awareness of the policy to ensure that all employees within the UHB are complying with the required standards of behaviour. Enhancements should be made to the intranet page to improve the avigation to the policy and associated forms and guidance.	Recommendation agreed. Review of the information available on the intranet will be undertaken to ensure that the information is easy to access. A programme of awareness raising will also be developed alongside the process detailed in recommendation 1 which will be continual and not a one off awareness raising programme.	Director of Corporate Governance	12/31/2018
IA 1819	11/15/2018	Standards of Business Conduc	Director of Corporate Governanace	Limited	H	The Corporate Team should ensure that all forms are compliant with the SoB Policy and completed appropriately. The current format of the register needs to be reviewed, updated and amalgamated into a single register.	Recommendation agreed – all submitted forms to be reviewed in line with the Policy to ensure compliance and appropriately completed. Register will be reviewed and updated and amalgamated into an appropriate format including recording in chronological order, whether the declaration has been accepted and also signed off.	Director of Corporate Governance	5/15/2020
IA 1819	11/15/2018	Standards of Business Conduc	Director of Corporate Governanace	Limited	M	The directorate should ensure that the policy is reviewed and updated accordingly with the appropriate approval for changes sought where necessary.	Recommendation Agreed – policy to be reviewed and updated in line with best practice and up to date guidance.	Director of Corporate Governance	12/31/2018
IA 1819	11/15/2018	Standards of Business Conduc	Director of Corporate Governanace	Limited	M	The Corporate Team should ensure that all forms are compliant with the SOB Policy and completed appropriately.	Recommendation Agreed – Forms will be reviewed for compliance with the new policy once reviewed and up until then forms will be reviewed for compliance with the current policy.	Director of Corporate Governance	8/15/2019
IA 1819	11/15/2018	Standards of Business Conduc	Director of Corporate Governanace	Limited	M	The Corporate Governance department must ensure that the information provided to the Audit Committee contains a full picture of the level and nature of declarations received and information on declarations not received.	Recommendation Agreed – Future reporting to the Committee will ensure that the report is complete and in a suitable format to allow challenge and assurance of the registers.	Director of Corporate Governance	2/1/2019
IA 1819	1/18/2019	Legislative/Regulatory Compl	Director of Corporate Governance	Limited	H	The Corporate Governance Team should re-evaluate the processes in place for identifying the activities associated with statutory, regulatory and licencing bodies so that there are robust systems in place to capture this information more effectively and completely.	Agreed this is an essential responsibility of the Corporate Governance Team which to date has not been undertaken effectively. This piece of work needs to be undertaken as a matter of urgency due to the risks it imposes with non-compliance with statutory and regulatory activities by not having adequate processes in place.	Director of Corporate Gover	2/1/2019

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IA 1819	1/18/2019	Legislative/Regulatory Compl	Director of Corporate Governance	Limited		A full list of Regulators that are relevant to the UHB needs to be established to ensure that the register is capturing all the required information.	Agreed this should be in place and the fact that it is not places the organisation at risk.	Director of Corporate Gover	2/1/2019
IA 1819	1/18/2019	Legislative/Regulatory Compl	Director of Corporate Governance	Limited		The Corporate Governance Team should ensure that all the relevant information that is required for the completion of the Tracking Report is obtained and up to date.	Agreed the information should be up to date and accurate	Director of Corporate Gover	2/1/2019
IA 1819	1/18/2019	Legislative/Regulatory Compl	Director of Corporate Governance	Limited		The Corporate Governance department must ensure that the information provided to the Audit Committee is supported by a covering paper, is legible and contains a comprehensive list of the compliance requirements relating to licensed, statutory and regulated activities.	It has already been agreed at the last Audit Committee that this report would be reviewed to ensure that it provided the Committee with a comprehensive list of compliance requirements relating to the statutory and regulated activities A sample of eight notices for the South Wales Fire Service (SWFS) was chosen from the Tracking Report. All 8 were recorded as complete and evidence to support their completion was requested from the Senior Fire Safety Officer. The following issues were identified; • 1/8 no evidence was provided to support its completion. The Senior Fire Safety Officer felt that the original findings from SWFS were unjust and both management actions had been dismissed by him. • 1/8 unable to provide evidence to support that the work had been completed. The work was carried out by a private company which would have been requested by the Clinical Board or Estates. Completion of works carried out by Estates that relates to enforcement notices are not fed back to the Senior Fire Safety Officer. • 2/8 both notices from SWFS had three actions identified. Evidence could only be found to support the completion of three out the six actions.	Director of Corporate Gover	2/1/2019
IA 1819	1/18/2019	Legislative/Regulatory Compl	Director of Corporate Governance	Limited		The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Agreed	Director of Corporate Gover	2/1/2019
IA 1819	1/18/2019	Legislative/Regulatory Compl	Director of Corporate Governance	Limited		The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers.	Agreed	Director of Corporate Gover	2/1/2019

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IA 1819	1/18/2019	Legislative/Regulatory Compl	Director of Corporate Governance	Limited		The Corporate Team should re-evaluate the Report to ensure that all the necessary information required to maintain a comprehensive list is in place. The Corporate Team should also review the standard email that is sent out to ensure that all the required information is requested. They should also pursue those who have not provided the relevant information.	Recommendation agreed	Director of Corporate Gover	2/1/2019
IA 1819	2/1/2019	Information Governance: Ger	Director of Transformation and Inform	Limited	H	The UHB should consider establishing a GDPR group with representation from all clinical boards. The function of the group should be to ensure appropriate compliance actions are taken and to provide assurance that the UHB has good processes to ensure compliance with the GDPR.	The UHB has adapted the all Wales IG policy. As part of the process to formal adoption, consultation and impact assessment will be taking place through which we anticipate identification of all clinical board requirements and prioritised action. The UHB sees placing responsibility and accountability as close as possible to the operational front line as the key to having an empowered and engaged workforce. Thus we see that the role of the corporate IG department is to design delivery of compliance and to provide specialist advice, rather than co-ordinate and deliver. It is accepted that as resources and expertise accumulate in line with expectation, there is more the central team can do on communication and engagement including the creation of a virtual mutually supporting networking of IAOs / IAAs. As recommended this will include setting up a GDPR group for a year.	Director of Transformation a	6/30/2019

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IA 1819	2/1/2019	Information Governance: Ger	Director of Transformation and Inform	Limited	H	The resource requirement for the Information Governance team should be fully assessed and resource provided appropriately.	In the context of the UK wide economy growing at a lower rate than: patient expectation, demand and health care cost inflation, the UHB has had to take business decisions in order to deliver a financially balanced plan. We recognise these have had significant consequences on many of our staff and resulted in high levels of sickness which have only made the position harder for all. We fully appreciate that a once in a generational change to IG legislation coincided with difficult financial circumstances has presented us with a challenge, but we would contend that this was a short sharp shock to the system which is now being adopted into routine ways of working as knowledge and awareness builds from experiential learning. As such we anticipate that by the end of Q1 2019/20 we will have increased the number of whole time equivalents in place and working by a whole time equivalent, taking the operational staffing levels to 4.8 wte, which will continue to be complimented by specialist advice from both Welsh Health Legal and Risk and a local legal firm. To confirm the financial resource for this external support is available within the UHB's budget.	Director of Transformation a	6/30/2019
IA 1819	2/1/2019	Information Governance: Ger	Director of Transformation and Inform	Limited	H	A revised Subject Access Procedure should be completed, placed on the intranet and flagged to all staff.	Accepted	Director of Transformation and Informatics	3/1/2019
IA 1819	2/1/2019	Information Governance: Ger	Director of Transformation and Inform	Limited	M	The IG webpages should be updated to ensure they present current, accurate information.	The contact details will be updated shortly. As noted above the department has been short staffed and there has needed to be a prioritisation between designing and mitigating significant risks to noncompliance and making general information available. The UHB has engaged widely on the DPA 2018 and is intending to use the consultation on the IG policy as a further vehicle for promoting awareness and setting out expectations. As identified above we anticipate that a further whole time equivalent will be available and contributing to delivery of the UHB's plan in Q1 2019/20 and that at this time we can speed up delivery of our comprehensive IG action plan.	Director of Transformation and Informatics	9/30/2019
IA 1819	2/1/2019	Information Governance: Ger	Director of Transformation and Inform	Limited	M	The UHB should seek to ensure all staff complete the IG training module.	Management Response Accept – The UHB is engaged nationally in the development of the e-learning package and has licenses for its use. We intend to make use of this national initiative in line with its roll out plan.	Director of Transformation and Informatics	ational Implementatic

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IA 1819	2/1/2019	Information Governance: Ger	Director of Transformation and Inform	Limited	M	Training on GDPR should be enhanced and provided to all staff acting in an IAO or IAA role. Further information should be passed to Directorates on the specific actions to be undertaken following GDPR.	Training is via the mandatory training route described in recommendation 5. The UHB will take actions to ensure we have asset registers and awareness of GDPR within dermatology and across the medicine clinical board as an early priority. Within clinical boards there will be further emphasis and engagement on the responsibilities and requirements for IAO/IAA roles, in order to enable appropriate senior staff to be allocated/trained, following implementation of enhanced training programme "Dojo" training which is designed to help staff understand cyber security threats is available on ESR.	Director of Transformation and Informatics	3/1/2019
IA 1819	2/1/2019	Information Governance: Ger	Director of Transformation and Inform	Limited	M	All areas should be asked to complete an IAR or feed into an IAR. Further guidance should be issued over what information to collect and how to record it using the standard template.	All areas have been asked on numerous occasions to complete asset registers and this was being reported into UHB committees. We acknowledge that the readiness is varied across service areas, which is a reflection on the operational challenges and the wider level of performance with other deliverables and risks requiring prioritisation. The UHB will take actions to ensure we have asset registers and awareness of GDPR within dermatology and across the medicine clinical board as an early priority.	Director of Transformation and Informatics	9/30/2019
IA 1819	2/1/2019	Information Governance: Ger	Director of Transformation and Inform	Limited	M	A reminder should be sent to all staff to ensure that all IG breaches are entered onto Datix immediately.	National policy is being discussed at IGMAG and Medical Directors (Caldicott Guardians) groups. Given the advent of digital and the opportunities presented by 'big data' analysis the proposal is that digital records containing the core clinical record will be kept for 100 years. The UHB is an advocate of this position The paper record is being retained on instruction of the NHS Wales Chief Executive for the reasons stated in the findings.	Director of Transformation and Informatics	9/30/2019
IA 1819	2/1/2019	Information Governance: Ger	Director of Transformation and Inform	Limited	M	This issue should be raised with WG to confirm that the requirement to keep overrides the stated retention guidelines. This issue should be entered onto the UHB risk registers.	National policy is being discussed at IGMAG and Medical Directors (Caldicott Guardians) groups. Given the advent of digital and the opportunities presented by 'big data' analysis the proposal is that digital records containing the core clinical record will be kept for 100 years. The UHB is an advocate of this position The paper record is being retained on instruction of the NHS Wales Chief Executive for the reasons stated in the findings. **NO ACTION REQUIRED**	Director of Transformation and Informatics	

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IA 1819	2/1/2019	Information Governance: Ger	Director of Transformation and Inform	Limited	M	The IAR process should pick up information flows and also consider the basis for processing.	In line with the approach taken across NHS Wales which has been discussed openly with the ICO's office a phased approach to the development of IARs has been adopted. Presently the UHB is in the process of mapping flows, with the initial focus having been on mapping new flows, those concerning R&D (potentially higher risk) and those into NWIS. The legal basis for processing in the majority of cases is patient care as set out in our privacy notice. The UHB is using the requirement to get the documentation right for all new flows as a tool for increasing knowledge of what is required.	Director of Transformation and Informatics	9/30/2019
IA 1819	2/1/2019	Information Governance: Ger	Director of Transformation and Inform	Limited	M	The UHB should make clear the requirement to gain explicit consent for these transfers.	As above – there is no requirement for consent where the data processing by a non EEA 3rd party has a EEA 'kitemark'. Information around this is being shared and informed by work reporting into IG MAG **Continuation of existing practice**	Director of Transformation and Informatics	
IA 1819	2/1/2019	Information Governance: Ger	Director of Transformation and Inform	Limited	L	Directorates should be reminded to display the GDPR information.	Accept – SIRO will write to Directorate Managers & CDs to remind them of this requirement	Director of Transformation and Informatics	2/26/2019
IA 1819	2/12/2019	Surgery Clinical Board – Medi	Chief Operating Officer	Limited	H	The Directorate should ensure that consultants carry out all planned sessions wherever possible and appropriate reasons are recorded for the cancellation of clinics and theatres. Colorectal Consultants should ensure that they cover and backfill the other Consultants lists if they are unable to carry out the planned session.	A new system to accurately record consultant activity in theatre is being developed with a clear desktop procedure. Through job planning each consultants expected activity will be agreed in weeks and monitored accordingly by the Directorate Expectation around backfill sessions will be agreed and signed by consultants and a system to monitor this will be managed by the Directorate team Systems will be put in place by end of March 2019	Chief Operating Officer	3/30/2019
IA 1819	2/12/2019	Surgery Clinical Board – Medi	Chief Operating Officer	Limited	H	The Directorates should ensure that any displaced SPA sessions are appropriately recorded and agreed on the WLI form, in accordance with the policy.	Systems will be put in place to ensure that the governance for displaced SPA will be aligned to health board policy and audited within Directorates. Job plans will have clear timetables to ensure it is simple to follow WLI against working week Key responsible officers will be allocated to this task	Chief Operating Officer	
IA 1819	2/12/2019	Surgery Clinical Board – Medi	Chief Operating Officer	Limited	H	General Surgery should ensure that they follow the correct procedure for recruiting and authorising Locum Consultants.	Ensure CD signs off paperwork for locum highlighting rationale for locum Create SOP/DTP so all staff can follow clear process Review paperwork to ensure it is up to date These actions will be put in place by end of March 2019	Chief Operating Officer	3/30/2019

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IA 1819	2/12/2019	Surgery Clinical Board – Medi	Chief Operating Officer	Limited	M	Management should produce desk top procedures to ensure that Consultants medical staff time and costs are being managed appropriately and consistently	Standardised procedure notes to be created and shared with key personnel (March 2019)	Chief Operating Officer	3/30/2019
IA 1819	2/12/2019	Surgery Clinical Board – Medi	Chief Operating Officer	Limited	M	In conjunction with the actions already being taken following the Consultant Job Planning Audit, the Directorate should ensure that all consultants have an up to date, agreed job plan in place that accurately reflects the current required sessions.	All job plans will be completed and recorded appropriately (March 2019)	Chief Operating Officer	3/30/2019
IA 1819	2/12/2019	Surgery Clinical Board – Medi	Chief Operating Officer	Limited	M	Management should ensure that request for Locum cover documentation is fully completed prior to the cover required.	SOP/DTP will be developed and standardised for all Directorates to record adherence to agree protocols (March 2019)	Chief Operating Officer	3/30/2019
IA 1819	2/14/2019	Internal Medicine Directorate	Chief Operating Offier	Limited	H	Management should ensure that all staff within Internal Medicine undertake a PADR, which is completed in full with both organisational and personal objectives agreed by the reviewing manager and employee. Management should create a personal development plan for each employee to help achieve each objective set. Management must ensure that when completing the annual review with staff they are completing the latest and most up to date version of the PADR format.	All PADRs are signed by the employee prior to them leaving the room at the end	Chief Operating Officer	6/1/2019
IA 1819	2/14/2019	Internal Medicine Directorate	Chief Operating Offier	Limited	H	Management should ensure that all members of staff within the directorate are fully compliant and up to date with their mandatory training. If staff members believe that ESR is not tracking when a module is completed, staff should print out the certificate available to provide proof and store it within their personal file.	Improved compliance for 85% of staff with completion of 100% mandatory and statutory training modules (44% improvement over 6 months). Staff to be allocated onto study leave planner and compliance monitored monthly via ESR and discussed with ward managers at 121s.	Chief Operating Officer	9/1/2019
IA 1819	2/14/2019	Internal Medicine Directorate	Chief Operating Offier	Limited	H	Management should ensure that workforce runs monthly reports that highlight the current PADR compliance rate and also separate reports highlighting the current compliance rate for Statutory & Mandatory Training. These reports should be fed back and reported on during the Directorate Performance Review as and when they are held.	Monthly Performance Meetings with the MCB to be undertaken monthly (avoid cancellation) and PADR compliance reported and discussed, and progress monitored against 6 month improvement trajectory.	Chief Operating Officer	3/1/2019
IA 1819	2/14/2019	Internal Medicine Directorate	Chief Operating Offier	Limited	M	Management should ensure that any completed PADRs are retained in employees personal files and recorded onto ESR as evidence the PADR has been completed. PADRs should be retained to support the reviewer when establishing progress against agreed objectives during the year and on a year on year basis.	TCopies of all completed PADRs must be placed in personal files. Record of a completed PADR must be recorded on ESR.	Chief Operating Officer	4/1/2019

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IA 1819	2/14/2019	Internal Medicine Directorate	Chief Operating Offier	Limited	M	Management must ensure that the staff database is regularly maintained, with the deletion of staff that have left the directorate and the inclusion of new employees. Management must look to tie in the mandatory training dates with the ESR matrices to ensure they tie back to LED.	No Longer Applicable No database is maintained by the directorate office. They are now reliant on reports from ESR therefore consistent figures are being used and reported.	Chief Operating Officer	N/A
IA 1819	2/14/2019	Internal Medicine Directorate	Chief Operating Offier	Limited	L	Management should ensure that all staff using ESR attends the training courses provided by LED/Workforce on how to use and utilise the ESR function. All ward managers and the senior nurse should check to see that there is a hierarchy in place within their area and that the hierarchy is correct and includes all members of staff under their management. The directorate should start uploading the review dates for individuals PADRs into ESR once they have been complete. This will assist Workforce when running compliance reports and also aid ward managers as it provides reminders when the next PADR review is approaching.	Timely changes made by ESR when staff or hierarchies change.	Chief Operating Officer	3/1/2019
IA 1819	5/1/2019	Cyber Security	Director of Transformation and Inform	Limited	H	A review of the resources available within IM&T and the requirements of the organisation should be undertaken to ensure that the department can appropriately meet the demands. Additional investment should be considered in order to provide a cyber security function.	A review of the current IT and Information departments has been completed and a restructure proposal created. This includes additional cyber security resources to manage and deliver the NESSUS and SIEM requirements, utilising the additional funding being made available by Welsh Government.	Director of Transformation a	7/1/2019
IA 1819	5/1/2019	Cyber Security	Director of Transformation and Inform	Limited	H	An active monitoring process which feeds into KPI reporting should be developed and maintained within IM&T.	The restructure of the directorate includes additional resource to manage cyber security issues. A key role for this function will be the development of a monitoring system that supports the KPI reporting against cyber security.	Director of Transformation a	9/1/2019
IA 1819	5/1/2019	Cyber Security	Director of Transformation and Inform	Limited	H	Resources should be provided to allow for a cyber security role to be properly defined and operating appropriately.	The restructure of the IT and information functions being proposed will result in the establishment of cyber security roles which will monitor and respond to cyber incidents and will develop policy, processes and procedures to reduce the likelihood of a cyber security incident	Director of Transformation a	9/1/2019
IA 1819	5/1/2019	Cyber Security	Director of Transformation and Inform	Limited	H	Active monitoring should be established. A Cyber response plan should be developed.	The creation of new cyber security roles in the restructured directorate will mean that a proactive stance on monitoring of cyber security is created as part of a wider Cyber response plan, which will also incorporate use of the NESSUS and SIEM solutions.	Director of Transformation a	9/1/2019
IA 1819	5/1/2019	Cyber Security	Director of Transformation and Inform	Limited	M	A formal, resourced plan for the removal of old software and devices should be established.	A formal plan is in the early stages of production and will address removal of aged and insecure software as well as devices. This will be implemented by the cyber security team proposed in the new directorate structure.	Director of Transformation a	9/1/2019

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IA 1819	5/1/2019	Cyber Security	Director of Transformation and Inform	Limited	M	A formal patch management procedure should be developed that sets out the mechanisms for patching / updating all items within the Health Board.	Patching of PCs is being investigated as time allows to identify the scale of the risk. A patch management procedure will be developed to address patching of all devices. This procedure will describe how patches and updates will be managed, with reference to the national standards and alerts managed through NWIS.	Director of Transformation a	9/1/2019
IA 1819	5/1/2019	Cyber Security	Director of Transformation and Inform	Limited	M	Regular cyber security "bulletins" should be published via the intranet, with reminders of good practice.	The profile of cyber security will be raised via the creation of regular proactive bulletins, available to all staff via the intranet, which will remind staff of good practice.	Director of Transformation a	7/1/2019
IA 1819	5/1/2019	Cyber Security	Director of Transformation and Inform	Limited	M	The IT Security Policy should be reviewed and updated.	The current IT security policy is scheduled to be reviewed to reflect changes in legislation, IT architecture and national policy.	Director of Transformation a	9/1/2019

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

Audit Title	Rec No.	Executive Lead for Report	Recommendation Narrative	Management Response	Status of Report Overall
			The Health Board should ensure that the Action Plan details realistic timesca		
Action plan on Deloitte Financial Governance Review	R1/2	Director of Finance		A further progress report will be taken to the April meeting of the Finance Committe	Audit open for more than 12-months
	R2/2	Director of Finance	The Health Board should ensure that the reported status recorded on the actionplan accurately reflects the actual progress made towards implementing theagreed actions.		
Action plan on WAO Audit of RKC Associates	R1/3	Director of Corporate Governance	Action timescales should be reasonably considered and further updates to tl	Accepted.We will continue to emphasise the importance of realistic timescales wher	Audit Closed as Complete
	R2/3	Director of Corporate Governance	Further updates to the audit committee should include Conclusion 3, Action	Accepted.ActionUpdate report for the February Audit Committee will contain this in	Audit Closed as Complete
	R3/3	Director of Corporate Governance	Action timescales should be reasonably considered and realistic and achieva	Accepted.We will continue to emphasise the importance of realistic timescales wher	Audit Closed as Complete
Annual Quality Statement	R1/1	Director of Nursing	Consideration should be given to how the UHB plans to satisfy the requirem	The QSI Framework did not include Staying Healthy and Our Staff as domains, as the	Superseded
	R1/3	Director of Nursing	Consideration should be given to the development of a tracker in the form o	A database will be created to support the tracking of all improvement measures that	Audit open for over 6 months
	R2/3	Director of Nursing	A check on the accuracy of all data sets obtained from the Datix system shou	The specified data has been changed in line with the recommendation. Some of the	Audit open for over 6 months
	R3/3	Director of Nursing	The UHB should consider the impact of the much earlier deadline for publish	The development and coordination of the AQS is planned in advance with time sche	Audit open for over 6 months
	(blank)	Director of Nursing	A check on the accuracy of all data sets obtained from the Datix system shou	The specified data has been changed in line with the recommendation. Some of the	Audit Closed as actions complete
			Consideration should be given to the development of a tracker in the form o	A database will be created to support the tracking of all improvement measuresthat	Audit Closed as actions complete
			The UHB should consider the impact of the much earlier deadline for publish	The development and coordination of the AQS is planned in advance with timesched	Audit Closed as actions complete
Business Continuity Planning Follow-Up	R1/1	Director of Planning	The significant, high priority, issue that remains from the original review can	Not Provided	Audit open for more than 12-months
Charitable Funds	R1/2	Director of Finance	The Finance Department should undertake a regular review of dormant Chai	Agreed	Audit open for over 6 months
	R1/4	Director of Finance	Management will review the appropriateness of this expenditure items and	Professional Fees should be paid by the individual members of staff. Clinical Boards t	Superseded
	R2/2	Director of Finance	Dormant Fund balances should be periodically reported to the Charitable Fu	Agreed	Audit open for over 6 months
	R2/4	Director of Finance	The Health Board need to further review the monitoring arrangements of dc	Finance department to continue working with Clinical Boards to deliver appropriate	expenditure plans. The 8 funds are not part of the Clinical Boards and these have n
	R3/4	Director of Finance	Management will ensure that there are wider representation from Clinical B	The Fundraising team will continue to engage with the Clinical Boards to ensure appı	Superseded
	R4/4	Director of Finance	Documentation surrounding the governance of charitable funds will be revie	Fundraising Policy to be reviewed as per governance arrangements.	Superseded
Children & Women Clinical Board – Medical Staff Rotas	R1/7	Chief Operating Officer	The Clinical Board will monitor the number of study days taken by medical st	Directorate Management Teams will be reminded to monitor the requests and apprc	Audit open for more than 12-months
	R2/7	Chief Operating Officer	The profile and accountabilities in relation to study leave requirements neec	Updated study leave procedures will be circulated to DMT and onwards to all medic	Audit open for more than 12-months
	R3/7	Chief Operating Officer	Staff will be reminded of their responsibilities when requesting and approvir	Updated study leave procedures will be circulated to DMT and onwards to all medic	Audit open for more than 12-months
	R4/7	Chief Operating Officer	Proactive monitoring will be undertaken to ensure all appropriate staff are u	Assurance to be provided through Directorate Performance Reviews from each DMT	Audit open for more than 12-months
	R5/7	Chief Operating Officer	Staff will be reminded of the procedural requirements and updates to stand	A review of the format of the claims forms used within C&W Clinical Board will be ur	Audit open for more than 12-months
	R6/7	Chief Operating Officer	Guidance should be produced and made available throughout the Clinical Bc	The current document will be reviewed and consideration given to broadening its sc	Audit open for more than 12-months
	R7/7	Chief Operating Officer	Management should remind staff around the requirements of the working ti	The current requirements of the working time policy will be shared with all DMT and	Audit open for more than 12-months
Claims Reimbursement	N/A	Director of Finance	N/A	N/A	Superseded
	R1/2	Director of Nursing	Management should ensure that staff members complete the status section	This will be audited through regular peer datix reviews of files by each claims manag	Audit Closed as actions complete
	R2/2	Director of Nursing	Signatories should ensure that all documents are appropriately dated.Manag	There was no problem with any authorities in signing off the Appendix forms; these	Audit Closed as actions complete
Clinical Diagnostic and Therapeutic Clinical Board – Ban	R1/4	Director of Operations	The Clinical Board should develop a process to ensure that all overtime sessi	All departments have received a communication instructing them to amend their cu	Audit open under 6 months and some dates breached
	R2/4	Director of Operations	The Clinical Board should consider producing a Standard Operating Procedur	CD+T will review the current processes in place across departments to produce an o	Audit open under 6 months and some dates breached
	R3/4	Director of Operations	The department should ensure that all agency shifts worked are appropriate	The management team associated with this department has been requested toprovi	Audit open under 6 months and some dates breached
	R4/4	Director of Operations	Where staff work less than the Agenda for Change hours of 37.5 hours any a	This will form part of the SOP, and a reminder email will be sent to all departments	Audit open under 6 months and some dates breached
Commissioning	R1/3	Director of Transformation, Improvements and Informatics	Strategic Commissioning Group Terms of Reference document should be rev	The Strategic Commissioning Groups Terms of Reference, including membership wa	Audit open under 6 months and some dates breached
	R2/3	Director of Transformation, Improvements and Informatics	The Commissioning Team should as part of its ongoing programme of work p	The development of the commissioning intranet pages, alongside commissioning toc	Audit open under 6 months and some dates breached
	R3/3	Director of Transformation, Improvements and Informatics	The Commissioning Framework document should be updated to reflect itscr	The Commissioning Framework has been amended, and now includes version contrc	Audit open under 6 months and some dates breached
Consultant Job Planning	R1/6	Medical Director	Clinical Boards must ensure that all consultants complete a job plan or have	Processes are in place to support the completion and reporting of job planning activi	Audit open for more than 12-months
	R2/6	Medical Director	The UHB job planning guidance should require consultants to use the standa	Clinical Board Directors and Clinical Directors should ensure that summary job plans	Audit open for more than 12-months
	R3/6	Medical Director	Clinical Board management must ensure that all consultants complete the o	Review of job planning guidance with regard to job plan template and re-issue to Clir	Audit open for more than 12-months
	R4/6	Medical Director	In accordance with the guidance, Clinical Board management should ensure	Review of job planning guidance with regard to job plan template and re-issue to Clir	Audit open for more than 12-months
	R5/6	Medical Director	The UHB should consider developing additional methods of communication	A planned schedule for training should be refreshed and communicated, including sc	Audit open for more than 12-months
	R6/6	Medical Director	All completed job plans must be signed by the Consultant and the clinical ma	The job plan review does not require an actual signature but there does need to be a	Audit open for more than 12-months
Continuing Health Care (CHC)	R1/8	Chief Operating Officer	The UHB should accept the residual risk relating to these changes in care rec	A recent Ombudsman ruling in 2015 has expressly advised the UHB when triggers be	COMPLETE
	R2/8	Chief Operating Officer	A timescale should be set to ensure the Head of Service Agreement is agree	The Heads of Service agreement is being reviewed following the Operation Jasmin w	PARTIALLY COMPLETE
	R3/8	Chief Operating Officer	PCIC should ensure an annual review is carried out on existing CHC placemer	A schedule is in place to meet statutory requirements for review which is monitored	COMPLETE
	R4/8	Chief Operating Officer	The Children CHC team should develop a local procedure that sets out how t	The Community Child Health Directorate will develop a local Operational Policy base	Audit open for more than 12-months
	R5/8	Chief Operating Officer	Individual Service User Agreements should be produced to cover health aspe	The Community Child Health Directorate will agree a process for KPI's to be measur	Audit open for more than 12-months
	R6/8	Chief Operating Officer	All new placements should have a placement agreement in place and be pro	This is in place	COMPLETE
	R7/8	Chief Operating Officer	A list of QA dates should be maintained with corresponding patients reviewe	QA is held every Tuesday each week for 52 weeks (Whitchurch Locality Meeting roor	COMPLETE
	R8/8	Chief Operating Officer	PCIC should ensure an initial 3 month review is carried out on new CHC placı	Agreed – this will be undertaken if the staffing resource is available.	COMPLETE
Contract Compliance	R1/4	Director of Finance	Capital & Estates staff should be formally reminded of the requirement to cc	Procurement Services has put in place a system to identify additional expendituresul	Audit open under 6 months and some dates breached
	R2/4	Director of Finance	Staff raising purchase orders should be reminded of the requirement to obt	Procurement Services will continue to support, provide training, guidance and reinfo	Audit open under 6 months and some dates breached
	R3/4	Director of Finance	An overview of the procurement process should be included in the Corporat	Procurement Services will provide a summary guidance sheet to the Induction	Audit open under 6 months and some dates breached
	R4/4	Director of Finance	The Procurement Guide should be reviewed and updated as necessary. The	Since the C&V intranet was tested, the revised Business Plan has been approved by	Audit open under 6 months and some dates breached
Core Financial Systems	R1/6	Director of Finance	Management should issue a reminder to all departments that debtor reques	The Financial Services Manager will write to All Heads of Finance emphasising the ne	Superseded
	R2/6	Director of Finance	Management should issue a reminder that credit note requests should not b	The Financial Services Manager will write to All Heads of Finance emphasising the ne	Superseded
	R3/6	Director of Finance	Management should remind staff that all debts referred for write off should	The Financial Services Manager will write to All Heads of Finance emphasising the ne	Superseded
	R4/6	Director of Finance	Management should review all reconciliations where there are a large numb	Finding agreed and understood. The department has been one member of staff dow	Superseded
	R5/6	Director of Finance	Management should ensure that a review is undertaken for all staff that hav	Discussions with the NWSSP E-enablement team have taken place to request the dis	Superseded
	R6/6	Director of Finance	Management should ensure that a review is undertaken on the PO approval	A list of UHB authorised signatories is produced on a quarterly basis (last done Janua	Superseded
Cost Improvement Programme	R1/3	Director of Finance	Management should ensure that sufficient detailed supporting documentati	CIP Impact statements have been developed and filtered through Clinical Boards for	Audit open for over 6 months
	R2/3	Director of Finance	Where it is identified that actual savings are higher or lower than originally a	Actual savings delivered are reported on a monthly basis as part of the monthly acco	Audit open for over 6 months
	R3/3	Director of Finance	NHS Wales Audit & Assurance Services Page 11 of 12 Recommendation 3 Pri	A process merging pay and non-pay elements of savings schemes will be put in place	Audit open for over 6 months
Costing Review	R1/6	Director of Finance	Management will look to increase the level of clinical engagement throughc	The PCB platform provides the UHB with an effective dashboard for analysing costin	Audit open for more than 12-months
	R2/6	Director of Finance	The concerns highlighted will be further investigated to ensure appropriate	Agreed.Costing is an exercise of mass data linkage reliant on basic administrative fur	Audit open for more than 12-months
	R3/6	Director of Finance	The Welsh Government returns should be subject to formal scrutiny by the F	Agreed. The costing returns will be reported to the Finance Committee to provide su	Audit open for more than 12-months
	R4/6	Director of Finance	Management will ensure the future accuracy of costing return.	We agree that the statement was misleading as submitted, indicating that aspecific i	Audit open for more than 12-months
	R5/6	Director of Finance	Wider verification should be sought to ensure accuracy and increaseengager	Agreed.There is an ongoing engagement with Clinical Boards to better understand cc	Audit open for more than 12-months
	R6/6	Director of Finance	Mechanisms will be established to monitor and report more widely on costir	This point is noted and it is accepted that the relationship between the UHB IMTP an	Audit open for more than 12-months
CRC Energy Efficiency Scheme	R1/2	Director of Planning	Bureau data will be compared at meter level with supplier statements (on a	For sites with multiple meters, the bureau data in the 2018/19 CRC reporting spread	Audit open for over 6 months
	R1/3	Director of Planning	Approval will be sought in advance of all future purchases being made. Shou	Future carbon credit purchases will only be required for the final year of the scheme	Superseded
			Management will amend the evidence pack for the errors / anomalies identi	The evidence pack was amended for the errors / anomalies at the date of the audit.	Superseded
			Management will work with the Estates team to determine the ownership o	The ownership of the Lansdowne gas meter will be progressed with our current UHB	Superseded
	R2/2	Director of Planning	The CRC working paper summary page should clearly show those figures tha	For 2018/19 the CRC working summary page will show the figures that are to be uplc	Audit open for over 6 months
CRI Safeguarding Works	R1/5	Director of Planning	Progression at risk should be fully documented, approved and recorded at tl	Agreed.	Audit open under 6 months and some dates breached
	R2/5	Director of Planning	A Project Execution Plan should be prepared at the outset of a project, in acc	Agreed.	Audit open under 6 months and some dates breached
	R3/5	Director of Planning	Sufficient contractual arrangements should be in place to safeguard the Hea	Agreed.	Audit open under 6 months and some dates breached
	R4/5	Director of Planning	4) Project benefits should be clearly identified and documented in the busin	Agreed.	Audit open under 6 months and some dates breached
	R5/5	Director of Planning	5) The required approach to post project evaluation and benefits assessmen	Agreed.	Audit open under 6 months and some dates breached
Cyber Security	R1/8	Director of Transformation and Informatics	A review of the resources available within IM&T and the requirements of tha	A review of the current IT and Information departments has been completed and a r	Audit open under 6 months and no dates breached
	R2/8	Director of Transformation and Informatics	An active monitoring process which feeds into KPI reporting should be devel	The restructure of the directorate includes additional resource to manage cyber secu	Audit open under 6 months and no dates breached
	R3/8	Director of Transformation and Informatics	Resources should be provided to allow for a cyber security role to be proper	The restructure of the IT and information functions being proposed will result inthe e	Audit open under 6 months and no dates breached
	R4/8	Director of Transformation and Informatics	Active monitoring should be established.A Cyber response plan should be de	The creation of new cyber security roles in the restructured directorate will mean th	Audit open under 6 months and no dates breached
	R5/8	Director of Transformation and Informatics	A formal, resourced plan for the removal of old software and devices should	A formal plan is in the early stages of production and will address removal of aged ar	Audit open under 6 months and no dates breached
	R6/8	Director of Transformation and Informatics	A formal patch management procedure should be developed that sets out tl	Patching of PCs is being investigated as time allows to identify the scale of the risk. A	Audit open under 6 months and no dates breached
	R7/8	Director of Transformation and Informatics	Regular cyber security "bulletins" should be published via the intranet, with	The profile of cyber security will be raised via the creation of regular proactive bullet	Audit open under 6 months and no dates breached
	R8/8	Director of Transformation and Informatics	The IT Security Policy should be reviewed and updated.	The current IT security policy is scheduled to be reviewed to reflect changes in legisl	Audit open under 6 months and no dates breached

Delayed Transfers of Care Reporting	R2/2	Chief Operating Officer	Due to the patient impact of delayed discharge, it would be beneficial to incl	Clinical Boards will be provided with the monthly DToC reportClinical Board Director:	Audit open under 6 months and some dates breached
Delayed Transfers of Care Reporting	R1/2	Chief Operating Officer	The Medically Fit spreadsheet used to identify DToCs weekly is updated usin	The date of referral and compliance with time scales is checked verbally within the w	Audit open under 6 months and some dates breached
Dental CB – Dental Nurse Provision	R1/6	Chief Operating Officer	The Dental Nurse Management team should consider formalising ratios of D	To reduce duplication of lists, a meeting will be set up with Senior Dental Nurse's an	Audit open for over 6 months
	R2/6	Chief Operating Officer	The Dental Nurse Management team should consider bringing forward the r	To reduce duplication of lists, a meeting will be set up with Senior Dental Nurse's an	Audit open for over 6 months
	R3/6	Chief Operating Officer	Dental Nurse Management should attend the Clinical Staffing meeting and P	Dental Nurse Manager attends Clinical staffing meeting, at this meeting Dental Nurs	Audit open for over 6 months
	R4/6	Chief Operating Officer	It is recommended that the Senior Dental Nurses maintain a log that docum	Implement feedback tool; that will be used to collect weekly changes that take place	Audit open for over 6 months
	R5/6	Chief Operating Officer	The Senior Dental Nurse weekly meeting should continue to function in orde	The weekly Senior Dental Nurse meeting will continue to function, chaired by the De	Audit open for over 6 months
	R6/6	Chief Operating Officer	Consideration should be given to adding in the Senior Dental Nurses into the	Where appropriate, work will begin on rolling out ESR hierarchy access to Senior Der	Audit open for over 6 months
Dental CB – Theatre Sessions	R1/2	Chief Operating Officer	The Dental administration staff should ensure that Patient Dental files conta	Urgent meeting to be arranged with Clinical Lead and Peri-Operative Care Manager t	Audit open for over 6 months
	R2/3	Chief Operating Officer	The majority of patients cancelled by Dental staff are due to oversubscribed	Reviewed PasPlus regarding start and finish times. Clinical Lead to speak with Maxill	Audit open for over 6 months
	R3/3	Chief Operating Officer	Dental management should ensure that cancelled operations are re-booked	Where possible this is always the case but many lists are held only on a monthly basi	Audit open for over 6 months
Deprivation of Liberties Safeguards Follow-Up	R1/2	Medical Director	There is still a low uptake with the number of staff having DoLS training.139	The Medical Director has provided the following additional information about some	Audit open for more than 12-months
	R2/2	Medical Director	The number of DoLS requests have increased but there has been no corresp	See above	Audit open for more than 12-months
E IT Training	R1/7	Director of Transformation, Improvements and Informatics	An assessment of the impact of these measures should be carried out andpr	An assessment of the reduced course duration is to be undertaken by the PARIS trair	Audit open under 6 months and no dates breached
	R2/7	Director of Transformation, Improvements and Informatics	Relevant policies and procedures should be put in place to set out the circun	The 'relevance' of the PARIS training system is under constant review through both t	Audit open under 6 months and no dates breached
	R3/7	Director of Transformation, Improvements and Informatics	To introduce a relevant pre-assessment process and procedures to ensure th	The Health Board will:1. Agree a process for ensuring any LD is captured.2. Develop t	Audit open under 6 months and no dates breached
	R4/7	Director of Transformation, Improvements and Informatics	Document control information to be standardised and completed in full onto	Training documents are currently version controlled but not standardised.Standardis	Audit open under 6 months and no dates breached
	R5/7	Director of Transformation, Improvements and Informatics	A sign off process should be introduced involving training customers for the	A review and sign off procedure for the Welsh Clinical Portal involving the service co	Audit open under 6 months and no dates breached
	R6/7	Director of Transformation, Improvements and Informatics	An impact assessment process should be introduced in order to gather and e	An impact assessment process is in draft but has been suspended due to the Work Li	Audit open under 6 months and no dates breached
	R7/7	Director of Transformation, Improvements and Informatics	The training material should be updated to include a range of options for po	It would not be appropriate to provide Service Coordinator details since these will be	Audit open under 6 months and no dates breached
Electronic Staff Record	R1/4	Director of Workforce and Organisational Development	The Workforce Department need to ensure that where ESR has been rolled o	During rollout (now 100% completed) managers and staff were made aware of the fa	Audit open for over 6 months
	R2/4	Director of Workforce and Organisational Development	Appropriate staff will be reminded that paperwork needs to be sent to Medi	It is the responsibility of the Clinical Board Management team to identify problems a	Audit open for over 6 months
	R3/4	Director of Workforce and Organisational Development	Management will ensure a singular and consistent approach to reportingcon	This has already been actioned as the Learning Education & Development team are r	Audit open for over 6 months
	R4/4	Director of Workforce and Organisational Development	Workforce to ensure that Health Board staff are aware of the support and gu	Contact details of the new All-Wales ESR Self-Service Support Hub (helpdesk) have b	Audit open for over 6 months
Emergency Unit - 12 Hour Target	R1/2	Chief Operating Officer	Management will remind staff around the importance of timely and correct	Reminder sent to all staff in Emergency Medicine.	Audit Closed as Complete
	R2/2	Chief Operating Officer	Management will ensure that the results of the internal monitoring process	A report on the monitoring of the application of Stop Clocks will be a standing item c	Audit Closed as Complete
Environmental Sustainability Report	R1/4	Director of Planning	Future Sustainability Reports should only report on water supply costs. This	Future Sustainability reports will include water supply costs, but will be determined	Audit open for over 6 months
	R2/4	Director of Planning	A requirement to draw up a timetable annually to cover the preparation of t	A timetable will be developed in April 2019 detailing key milestones. Where possible	Audit open for over 6 months
	R3/4	Director of Planning	The sustainability reporting procedure notes should be supplemented withd	The sustainability reporting procedure now includes detailed information on how to	Audit open for over 6 months
	R4/4	Director of Planning	Future Sustainability Reports should include references / links to where furtl	Consideration will be given to include references / links to where further sustainabili	Audit open for over 6 months
Health and Care Standards	N/A	Director of Nursing	N/A	N/A	Audit closed as no recommendations
					No Action Required - complete
IM&T Server Virtualisation	R1/5	Director of Therapies and Health Science	The UHB should consider widening the pool of staff with the skills to manage	The IT Department will review potential opportunities for recruitment and training a	Audit open for more than 12-months
	R2/5	Director of Therapies and Health Science	A formal SOP should be developed setting out the basis for patching / updat	Agreed	Audit open for more than 12-months
	R3/5	Director of Therapies and Health Science	A SOP for VM creation should be developed, setting out the process and the	Agreed	Audit open for more than 12-months
	R4/5	Director of Therapies and Health Science	A separate network adapter should be installed for the management netwo	The documented recommendation for a separate Management Network dates back	Audit open for more than 12-months
	R5/5	Director of Therapies and Health Science	The UHB should fully investigate the possibility of datacentre licencing.Shoul	The UHB has investigated the licence requirements and costs associated with VMotic	Audit open for more than 12-months
IM&TMTeD Deployment	R1/2	Director of Therapies and Health Science	Repeat the benefits measurements (MBPM described above) which was carr	The benefits measurements carried out as part of the MTED Pilot Project and set out	Audit open for more than 12-months
	R2/2	Director of Therapies and Health Science	The membership of ISEC should be reviewed to ensure it is still valid. Subseq	The membership of ISEC has been recently reviewed to ensure validity.	Audit open for more than 12-months
IM&TWelsh Patient Referral System	R1/2	Director of Therapies and Health Science	The membership of ISEC should be reviewed to ensure it is still valid. Subseq	Agreed.The membership of ISEC has been recently reviewed to ensure validity.	Audit open for more than 12-months
	R2/2	Director of Therapies and Health Science	Encryption should be applied to all data transfers.	The feasibility of applying encryption to this data transfer will be raised /discussed w	Audit open for more than 12-months
Information Governance: General Data Protection Regul	R1/12	Director of Transformation and Informatics	The UHB should consider establishing a GDPR group with representation fro	The UHB has adapted the all Wales IG policy. As part of the process to formal adopti	Audit open under 6 months and some dates breached
	R10/12	Director of Transformation and Informatics	The IAR process should pick up information flows and also consider the basis	In line with the approach taken across NHS Wales which has been discussed openly v	Audit open under 6 months and some dates breached
	R11/12	Director of Transformation and Informatics	The UHB should make clear the requirement to gain explicit consent for thes	As above – there is no requirement for consent where the data processing by a non l	Audit open under 6 months and some dates breached
	R12/12	Director of Transformation and Informatics	Directorates should be reminded to display the GDPR information.	Accept – SIRO will write to Directorate Managers & CDs to remind them of this requi	Audit open under 6 months and some dates breached
	R2/12	Director of Transformation and Informatics	The resource requirement for the Information Governance team should be f	In the context of the UK wide economy growing at a lower rate than: patient expecta	Audit open under 6 months and some dates breached
	R3/12	Director of Transformation and Informatics	A revised Subject Access Procedure should be completed, placed on the intr	Accepted	Audit open under 6 months and some dates breached
	R4/12	Director of Transformation and Informatics	The IG webpages should be updated to ensure they present current, accurat	The contact details will be updated shortly.As noted above the department has beer	Audit open under 6 months and some dates breached
	R5/12	Director of Transformation and Informatics	The UHB should seek to ensure all staff complete the IG training module.	Management Response Accept – The UHB is engaged nationally in the development	Audit open under 6 months and some dates breached
	R6/12	Director of Transformation and Informatics	Training on GDPR should be enhanced and provided to all staff acting in an I	Training is via the mandatory training route described in recommendation 5.The UHI	Audit open under 6 months and some dates breached
	R7/12	Director of Transformation and Informatics	All areas should be asked to complete an IAR or feed into an IAR.Further gui	All areas have been asked on numerous occasions to complete asset registers and th	Audit open under 6 months and some dates breached
	R8/12	Director of Transformation and Informatics	A reminder should be sent to all staff to ensure that all IG breaches are ente	National policy is being discussed at IGMAG and Medical Directors (Caldicott Guardia	Audit open under 6 months and some dates breached
	R9/12	Director of Transformation and Informatics	This issue should be raised with WG to confirm that the requirement to keej	National policy is being discussed at IGMAG and Medical Directors (Caldicott Guardia	Audit open under 6 months and some dates breached
Internal Medicine Directorate – Mandatory Training & P	R1/6	Chief Operating Offier	Management should ensure that all staff within Internal Medicine undertake	All PADRs are signed by the employee prior to them leaving the room at the end	COMPLETE
	R2/6	Chief Operating Officer	Management should ensure that all members of staff within the directorate	Improved compliance for 85% of staff with completion of 100% mandatory and statu	PC – will be completed by September 2019
	R3/6	Chief Operating Officer	Management should ensure that workforce runs monthly reports that highli	Monthly Performance Meetings with the MCB to be undertaken monthly (avoid canc	COMPLETE
	R4/6	Chief Operating Officer	Management should ensure that any completed PADRs are retained in empl	TCopies of all completed PADRs must be placed in personal files.Record of a complet	COMPLETE
	R5/6	Chief Operating Officer	Management must ensure that the staff database is regularly maintained, w	No Longer ApplicableNo database is maintained by the directorate office. They are n	Audit open under 6 months and some dates breached
	R6/6	Chief Operating Officer	Management should ensure that all staff using ESR attends the training cour	Timely changes made by ESR when staff or hierarchies change.	COMPLETE
Internal Medicine Directorate Mandatory Training and F	R1/6	Chief Operating Officer	Management should ensure that all staff within Internal Medicine undertake	The Directorate has developed a Project Outline Document to support ward areas to	Overdue
	R2/6	Chief Operating Officer	Management should ensure that all members of staff within the directorate	The Directorate has assigned a member of the team to improve the mandatory train	Superseded
	R3/6	Chief Operating Officer	Management should ensure that workforce runs monthly reports that highli	Key links with ESR team will be established and core reports determined, including cl	Superseded
	R4/6	Chief Operating Officer	Management should ensure that any completed PADRs are retained in empl	The Directorate has developed an POD to support ward areas to complete PADR. See	Superseded
	R5/6	Chief Operating Officer	Management should ensure that any completed PADRs are retained in empl	The Directorate has developed an POD to support ward areas to complete. PADR. Se	Superseded
	R6/6	Chief Operating Officer	Management should ensure that all staff using ESR attends the training cour	To be included in the reports for ESR to ensure all have access and training.	Superseded
Kronos Time Recording System - Estates	R1/6	Director of Planning	Suitably qualified and experienced staff should be assigned specific respons	Suitably qualified and experienced staff should be assigned specific responsibility for	Audit open under 6 months and no dates breached
	R2/6	Director of Planning	Management should review the current M & E Rotas to establish if the pract	The Estates Department is currently in the process of consultation with staff on mod	Audit open under 6 months and no dates breached
	R3/6	Director of Planning	The development of an automatic interface between Kronos and ESR is a ke	Refer to Management Response to Finding 1; which includes investigating the interfa	Audit open under 6 months and no dates breached
	R4/6	Director of Planning	Where overtime has been worked this should be reflected in the start and fi	The issue will be considered as part of the system review although all overtime is aut	Audit open under 6 months and no dates breached
	R5/6	Director of Planning	Staff should be instructed to clock in no more than 27 minutes before the st	Staff clock in on arrival on site but are not paid from this point, unless authorisation	Audit open under 6 months and no dates breached
	R6/6	Director of Planning	Estates Admin staff should be instructed to only input hours for enhanceme	Supervisors are fully aware of their responsibilities in respect of recording absence a	Audit open under 6 months and no dates breached
Legislative/Regulatory Complaince	R1/7	Director of Corporate Governance	The Corporate Governance Team should re-evaluate the processes in place f	Agreed this is an essential responsibility of the Corporate Governance Team which to	PARTIALLY COMPLETE
	R2/7	Director of Corporate Governance	A full list of Regulators that are relevant to the UHB needs to be established	Agreed this should be in place and the fact that it is not places the organisation at ris	COMPLETE
	R3/7	Director of Corporate Governance	The Corporate Governance Team should ensure that all the relevant informa	Agreed the information should be up to date and accurate	PARTIALLY COMPLETE
	R4/7	Director of Corporate Governance	The Corporate Governance department must ensure that the information pr	It has already been agreed at the last Audit Committee that this report would be rev	PARTIALLY COMPLETE
	R5/7	Director of Corporate Governance	The Senior Fire Safety Office should ensure that sufficient evidence is availat	Agreed	n/a
	R6/7	Director of Corporate Governance	The Senior Fire Safety Officer should ensure that there is appropriate attend	Agreed	n/a
	R7/7	Director of Corporate Governance	The Corporate Team should re-evaluate the Report to ensure that all the ne	Recommendation agreed	PARTIALLY COMPLETE
Management of the Disciplinary process.	R1/6	Director of Workforce and Organisational Development	A fully complete initial assessment should be on every case file, which provic	The current initial assessment process has been reviewed and a more robust process	Audit open for over 6 months
	R2/6	Director of Workforce and Organisational Development	Management will implement mechanisms, i.e. a root cause analysis, to highl	The Director of Workforce & OD is leading the challenge and engagement with Trade	Audit open for over 6 months
	R3/6	Director of Workforce and Organisational Development	Management will put processes in place to enhance file management for bo	The HR team have revised the Guidance and Information Pack for Investigating Offic	COMPLETE
	R4/6	Director of Workforce and Organisational Development	Management will identify trends in delays and take appropriate action in orc	The organisation of Appeals will be centralised within the HR Operations Centre in th	Audit open for over 6 months
	R5/6	Director of Workforce and Organisational Development	Training will be undertaken by all investigators to help with the efficient run	The HR team are currently reviewing the UHB list of IO's to ascertain their status, i.e.	COMPLETE
	R6/6	Director of Workforce and Organisational Development	Management should review their performance/ summary documents to ens	The main ER tracker is being updated to ensure that we capture the performance da	Audit open for over 6 months
Medicine CB - Sickness Absence Management	R1/5	Chief Operating Officer	Management must ensure that all future sickness episodes are managed an	Re-circulate the All Wales Managing Attendance at Work Policy. ▪ Support and appr	Audit open under 6 months and some dates breached
	R2/5	Chief Operating Officer	Management should ensure that the sickness triggers are being managed co	Support and appraises have been set up for A6 South to ensure consistency in compl	Audit open under 6 months and some dates breached
	R3/5	Chief Operating Officer	Management should ensure that the sickness triggers are being managed co	▪ Support and appraises have been set up for A6 South to ensure consistency in cor	Audit open under 6 months and some dates breached
	R4/5	Chief Operating Officer	Management should ensure that all current ward managers are provided wi	▪ Within Stroke Services, engaged with Human resources to provide furthertraining	Audit open under 6 months and some dates breached
	R5/5	Chief Operating Officer	Management should remind ward staff that the recording of sickness dates :	Within Stroke Services, engaged with Human resources to provide further training fc	Audit open under 6 months and some dates breached
Mental Health Clinical Board – Section 17 Leave	R1/4	Chief Operating Officer	The Guideline for Section 17 Leave of Absence Mental Health Act 1983 shou	The Guideline for Section 17 Leave of Absence Mental Health Act 1983 will be preser	Audit open for over 6 months
	R2/4	Chief Operating Officer	The Health Board should clarify if there is a requirement for specific risk asse	Consideration of the risk assessment and care and treatment plan will have taken pl	Audit open for over 6 months
	R3/4	Chief Operating Officer	Management should consider updating the Section 17 Leave of Absence forr	The recording of the reason why leave has been granted is not a requirement of the	Audit open for over 6 months
	R4/4	Chief Operating Officer	Staff should ensure that they complete all sections of the signing in and outt	(blank)	Audit open for over 6 months

Mental Health Clinical Board – Sickness Management	R1/4	Chief Operating Officer	Management should ensure that all sickness episodes are managed and doc	Directorates to send all managers a link to the sickness policy /NHS Wales Managing	COMPLETE
	R2/4	Chief Operating Officer	Management should ensure that the sickness triggers are being managed co	Directorates to send "trigger table" out to all managers, reminding them to check wi	COMPLETE
	R3/4	Chief Operating Officer	Long term sickness meetings should be held as required to ensure that the e	Directorates to send all managers a general reminder of the need for formal sickness	PARTIALLY COMPLETE
	R4/4	Chief Operating Officer	Management should remind ward staff that the recording of sickness dates :	All band 6 / 7 managers to attend refresher sickness training.	COMPLETE
Mental Health Sickness Management and Rostering	R1/5	Chief Operating Officer	Management should ensure that all sickness episodes are managed anddocu	The MHCB has seen significant changes to the inpatient ward management structure	Audit open for more than 12-months
	R2/5	Chief Operating Officer	Ward Managers should ensure that recommended breaks are factored in wh	The MHCB have been working alongside staff side colleagues to agree a process and	Audit open for more than 12-months
	R3/5	Chief Operating Officer	Magement need to ensure that the Medical Team are provided with training	The Clinical Directors support local medical managers in the management of sickness	Audit open for more than 12-months
	R4/5	Chief Operating Officer	Nursing staff should be reminded that all bank and agency time sheets shoul	It was evidenced from our testing that there were a number of inconsistencies acros	Audit open for more than 12-months
	R5/5	Chief Operating Officer	NHS Wales Audit & Assurance Services Page 16 of 17 Recommendation Prior	This issue will be monitored via the sickness surgeries.	Audit open for more than 12-months
Mortality Reviews	R1/3	Medical Director	Best practice would dictate that the UHB should introduce a mechanism of c	Work is underway to design an all-Wales Level 2 mortality screening tool. The UHB h	Audit open for more than 12-months
	R2/3	Medical Director	The Health Board must ensure that level 1 mortality reviews are completed i	A review of the current paper trail will be undertaken and improved as necessary. Cli	Audit open for more than 12-months
	R3/3	Medical Director	The Universal Mortality Review form question pertaining to the need to trig	The wording on the form and subsequent IT development was so that any 'yes' answ	Audit open for more than 12-months
National Standards for Cleaning in NHS Wales	R1/6	Director of Planning	The Health Board should ensure that there is a Multi-Disciplinary Group in pl	Formerly add the Cleaning Standards requirement into one of the existing forums de	Superseded
	R2/6	Director of Planning	The Health Board should ensure that a consistent approach is used for repor	On checking with C4C both approaches were in accordance with the system and star	Superseded
	R3/6	Director of Planning	An appropriate member of the Ward staff should sign off the technical audit	Facilities to coordinate and request clinical support on audit. Ward Sisters and Charg	Superseded
	R4/6	Director of Planning	The Health Board should carry out managerial audits on a quarterly basis in l	Facilities Staff to arrange audit schedule and invite ward staff to participate with goo	Superseded
	R5/6	Director of Planning	Management should update the Cleaning Strategy and develop an Operatio	Facilities Senior Management to develop and disseminate to the Cleaning Group for	Superseded
	R6/6	Director of Planning	Management should ensure that technical audits are completed on all high /	Facilities to review audit schedule and make clear programme to Senior Managemen	Superseded
National Standards for Cleaning in NHS Wales Follow-up	R1/6	Director of Planning	The Health Board should ensure that there is a Multi-Disciplinary Group in pl	Formerly add the Cleaning Standards requirement into one of the existing forums de	Overdue more than 12-months: Follow-up Audit confirmed not fully complete
	R2/6	Director of Planning	The Health Board should ensure that a consistent approach is used forrepor	On checking with C4C both approaches were in accordance with the system and star	Overdue more than 12-months: Follow-up Audit confirmed not fully complete
	R3/6	Director of Planning	An appropriate member of the Ward staff should sign off the technical audit	Facilities to coordinate and request clinical support on audit. Ward Sisters and Charg	Overdue more than 12-months: Follow-up Audit confirmed not fully complete
	R4/6	Director of Planning	The Health Board should carry out managerial audits on a quarterly basis in l	Facilities Staff to arrange audit schedule and invite ward staff to participate with goo	Overdue more than 12-months: Follow-up Audit confirmed not fully complete
	R5/6	Director of Planning	Management should update the Cleaning Strategy and develop an Operatio	Facilities Senior Management to develop and disseminate to the Cleaning Group for	Overdue more than 12-months: Follow-up Audit confirmed not fully complete
	R6/6	Director of Planning	nagement should ensure that technical audits are completed on all high /ver	Facilities to review audit schedule and make clear programme to Senior Managemen	Overdue more than 12-months: Follow-up Audit confirmed not fully complete
Neurosciences - Patient Care IT System	(blank)	(blank)	(blank)	(blank)	(blank)
Nurse Revalidation	R1/3	Director of Nursing	The All Wales policy should be adopted by the Health Board and adapted to	The All Wales Policy is currently under review by Welsh Government expected date f	Audit open for more than 12-months
	R2/3	Director of Nursing	The C&V UHB PADR form should be revised for Nursing Staff to include an aj	The Senior Nurse for Nurse Education will work with the lead for PADR to create a se	Audit open for more than 12-months
	R3/3	Director of Nursing	Where nurses are using their line manager as their confirmer, the confirmer:	An email via the Directors of Nursing will be issued to remind staff of ESR capability r	Audit open for more than 12-months
Ombudsman Report	N/A	Director of Nursing	N/A	N/A	Audit Closed as no action required
Organisational Values	R1/3	Director of Workforce and Organisational Development	Management should review the Communications Plan and revise the dates c	The communications and engagement plan has been revised and updated for 2018 w	Audit open for more than 12-months
	R2/3	Director of Workforce and Organisational Development	Management within the Health Board and Clinical Boards should ensure that	Chief Executive has signed the Formal Pledge and has publicised this via CAV-News ir	COMPLETE
	R3/3	Director of Workforce and Organisational Development	Management need to ensure that there are appropriate measures such as su	Some measure of the organisational values will be collected via the All Wales staff su	COMPLETE
PCIC CB – District Nursing Rotas	R1/5	Chief Operating Officer	The District Nurses should ensure they are enforcing rules over how many st	A local annual leave procedure has been developed since the audit to ensure that sta	Audit open for over 6 months
	R2/5	Chief Operating Officer	District Nurses should work in conjunction with the Rosterpro team to ensur	District Nursing sisters will be expected to use Rosterpro to roster all staff, this will b	Audit open for over 6 months
	R3/5	Chief Operating Officer	District Nurse Sisters should ensure rotas are prepared on a timely basis.Wh	District Nursing sisters will be expected to use Rosterpro to roster all staff, rosters wi	Audit open for over 6 months
	R4/5	Chief Operating Officer	District Nurse Sisters should verify rotas weekly, within 72 hours of the last s	District Nursing sisters will be required to verify rosters weekly and this will bemonit	Audit open for over 6 months
	R5/5	Chief Operating Officer	District Nurse Sisters should be reminded of the importance of recording sha	A revised process for recording gaps in staffing is to be developed	Audit open for over 6 months
PCIC Interface Incidents	R1/9	Chief Operating Officer	Plan should be devsed for the proposed roll out of Datix to GPs, this should i	The patient safety team (PST) have already carried out some preparatory work which	Audit open under 6 months and some dates breached
	R2/9	Chief Operating Officer	There should be continued engagement and education with GPs to ensure tl	In July 2018 the PST in partnership with PCIC have undertaken work to develop an in	Audit open under 6 months and some dates breached
	R3/9	Chief Operating Officer	PCIC should communicate the importance of reporting interface incidents in	Practices already deal with serious issues relating to interface incidents by contacting	Audit open under 6 months and some dates breached
	R4/9	Chief Operating Officer	In addition to the recommendation to consider future workplans, a Standarc	An agreed pathway is already in place that has been supported by the LMC, staffing	Audit open under 6 months and some dates breached
	R5/9	Chief Operating Officer	The Patient Safety Team should remind Clinical Boards and Directorates of tl	This would not be the role fo the PST. The UHB incident, Hazard and near miss repo	Audit open under 6 months and some dates breached
	R6/9	Chief Operating Officer	Efforts should be made to engage with all GP practices, especially those that	The Patient Safety Team will work with PCIC as part of the Datix implementation pla	Audit open under 6 months and some dates breached
	R7/9	Chief Operating Officer	The Q&S Officer should review the list of Datix Reports opened by themselv	PST - the way that permissions and profiles are set up in Datix means that once the i	Audit open under 6 months and some dates breached
	R8/9	Chief Operating Officer	Regular communicatoin with GPs should be undertaken to make them awar	A paragraph in relation to the interface process was included in the winter Patient Sa	Audit open under 6 months and some dates breached
	R9/9	Chief Operating Officer	Consideration should be given to how feedback and incident reporting can b	PCIC does not receive incident notification from internal depts within the UHB which	Audit open under 6 months and some dates breached
Performance Reporting Data Quality - Non RTT	R1/3	Director of Public Health	Consideration should be given to aligning the Performance Report and Tier 1	Discussions at a national level are happening between Welsh Government and the N	Audit open under 6 months and some dates breached
	R2/3	Director of Public Health	The Performance Report working spreadsheet should be linked to data sourc	As identified above – not all the data is available to achieve this.The UHB is actively c	Audit open under 6 months and some dates breached
	R3/3	Director of Public Health	Consideration should be given to re-formatting the Performance Report toin	Accept	Audit open under 6 months and some dates breached
Pilot Model Ward Review	R1/5	Director of Planning	The costing exercise for the potential roll out should be re-examined, agreec	As this was a clear pilot and proof of concept. Outcomes were genuinely not known.	Audit open for more than 12-months
	R2/5	Director of Planning	For future projects the plans for financial costing should be more detailed wi	As this was a clear pilot and proof of concept. Costings were genuinely not known. W	Audit open for more than 12-months
	R3/5	Director of Planning	For future projects a defined terms of reference that identifies membership,	Agreed for applicable future projects.	Audit open for more than 12-months
	R4/5	Director of Planning	For future projects of this nature the project plan should be scrutinised mor	Agreed for applicable future projects.	Audit open for more than 12-months
	R5/5	Director of Planning	If this project was to be expanded, a more structured approach to lessons le	The project took a 'lessons learned' and amendments were made 'live' to the projec	Audit open for more than 12-months
Primary, Community & Intermediate Care Clinical Board	N/A	Chief Operating Officer	N/A	N/A	No Action Required - complete
Progress against findings from the Human Tissue Author	R1/1	Chief Operating Officer	Management must ensure that the terms of reference of the HTA Licence Cc	The Human Tissue Authority compliance group is currently running in parallel to HTA	Audit open for more than 12-months
Renal IT system	R1/10	Chief Operating Officer	Both UNIX and MySQL should updated to a more recent, supported version.	Early investigations have taken place between Vitalpulse and Summerside. Monies v	Audit open for over 6 months
	R10/10	Chief Operating Officer	The UHB should consider enabling logging	Database enables logging of every action, be it viewing, editing, deleting etc. all store	Audit open for over 6 months
	R2/10	Chief Operating Officer	The minimum password length should be set to 8 and all users have a forcec	The minimum length has now been amended to 8. With regard to forced change, thi	Audit open for over 6 months
	R3/10	Chief Operating Officer	Recommendation The backups should be subject to periodic testing.	This has been brought to the attention of the IT Server Team but is outside of the Dir	Audit open for over 6 months
	R4/10	Chief Operating Officer	The DR plan should be revised to include contact details of support organisa	Dialogue with the Vendor parties has already started regarding the failback process.	Audit open for over 6 months
	R5/10	Chief Operating Officer	A review of users should be undertaken to ensures that leavers access is rev	Action has been taken as identified and a process implemented to regularly review le	Audit open for over 6 months
	R6/10	Chief Operating Officer	Generic accounts should not be used for data entry.	Agreed, On request, Auditor provided a list of affected accounts and these have beer	Audit open for over 6 months
	R7/10	Chief Operating Officer	The local user group should seek to identify fields which could benefit from i	Communication with users is ongoing and agreed changes will be actioned where ap	Audit open for over 6 months
	R8/10	Chief Operating Officer	A local user group should be established with leads from each of the user d	Partially agree. There is an all Wales VitalData Group to which Users can feed into vi	Audit open for over 6 months
	R9/10	Chief Operating Officer	The ROOT account should be renamed and the anonymous account deleted	Management Response The anonymous account was deleted Oct 2018.The ROOT ac	Audit open for over 6 months
Research & Development	R1/6	Medical Director	Lead officers will be required to provide an assessment of the research proje	The R&D Office accepts the concerns raised. There are several issues with the systen	Audit open for more than 12-months
	R2/6	Medical Director	Declarations of interest should be added as a standard agenda item andmin	A Declaration of Interest has been added as a standard agenda item to the Research	Audit open for more than 12-months
	R3/6	Medical Director	Management will ensure data protection checks are undertaken by appropri	A guidance document written by the R&D Office on how the data protection checks	Audit open for more than 12-months
	R4/6	Medical Director	(blank)	The Senior Management Team at C&V UHB has completed and submitted a Narrativ	Audit open for more than 12-months
	R5/6	Medical Director	Management will ensure that all clinical boards have appropriate leads for R	The Medical Director has written to the Children and Womens Clinical Board Directo	Audit open for more than 12-months
	R6/6	Medical Director	Policies and standard operating procedures surrounding research and devel	The R&D Office maintains its own Document Version Control System currently holdir	Audit open for more than 12-months
Residences	R1/10	Director of Planning	The new tenancy agreement should be finalised, approved and formally intr	Implementation of new tenancy agreement. Long term tenancy agreement to be rev	Audit open for more than 12-months
	R10/10	Director of Planning	The UHB should refer to the PFI contract/SLA to consider whether expectant	Currently being reviewed by PFI Manager.	Audit open for more than 12-months
	R2/10	Director of Planning	The UHB should prepare, approve and implement a formal pricing structure	The pricing structure is currently under review to simplify.	Audit open for more than 12-months
	R3/10	Director of Planning	The UHB should prepare Standard Operating Procedures to cover all admini:	Daily standard operating procedures is being further developed and cross cover by a	Audit open for more than 12-months
	R4/10	Director of Planning	The UHB should consider and document any risks relating to the provision ol	Risk Register for Residences to be developed. Estate compliance is already addressec	Audit open for more than 12-months
	R5/10	Director of Planning	The UHB should prepare, approve and implement a cancellation policy; this :	The priority will be focussed on the appropriate collection of bonds which will requir	Audit open for more than 12-months
	R6/10	Director of Planning	The UHB should document future plans for the provision and utilisation of re	The UHB is currently embarking on a significant master planning exercise for the UHI	Audit open for more than 12-months
	R7/10	Director of Planning	The UHB should ensure that all figures within the Commercial Services dashl	Dashboards to be updated via hotel perfect (accommodation database) on a monthl	Audit open for more than 12-months
	R8/10	Director of Planning	The UHB should discuss these drawbacks with the Hotel Perfect System own	Hotel Perfect are working with the Health Board to address any issues with thedatal	Audit open for more than 12-months
	R9/10	Director of Planning	The UHB should ensure all rents are paid in full within the agreed timescales	The process and management for the collection of rents will be addressed with imm	Audit open for more than 12-months
RTT Performance Reporting	R1/4	Director of Transformaiton and Informatics	The Health Board should ensure there is a formalised policy that encompass	We accept that there is a need to review the appropriateness of our RTT policy, ensu	Audit open for more than 12-months
	R2/4	Director of Transformaiton and Informatics	The Health Board should consider validating data of patients that are 'in targ	We accept the point made in the context that data quality audits should extend to re	Audit open for more than 12-months
	R3/4	Director of Transformaiton and Informatics	The Performance Report should include a note next to the SCP compliance fi	Accepted	Audit open for more than 12-months
	R4/4	Director of Transformaiton and Informatics	The Performance Report should include data on the related Cancer patientw	The reporting of volumes occurs infrequently. There is a balance to be had in the det	Audit open for more than 12-months
Serious Incidents Management	R1/5	Director of Nursing	Management must ensure that closure forms are submitted to WG within th	NHS Wales Audit & Assurance Services Page 11 of 17 Management Response Respor	Audit open for more than 12-months
	R2/5	Director of Nursing	Management must ensure that the policy is up to date and available to all th	The Incident Reporting Policy was approved at the July 2017 Health and Safety Comr	Audit open for more than 12-months
	R3/5	Director of Nursing	Management must ensure that the policy is up to date and available to all th	The Incident Reporting Policy was approved at the July 2017 Health and Safety Comr	Audit open for more than 12-months
	R4/5	Director of Nursing	The Patient Safety team should communicate the importance of uploading t	Action plans will have been developed and signed off as part of the investigation pro	Audit open for more than 12-months
	R5/5	Director of Nursing	Management should ensure that SIs are reported to WG within the required	Whenever possible the Patient Safety team will attempt to report within 24 hours. T	Audit open for more than 12-months
	(blank)	Director of Nursing	Management should ensure that SIs are reported to WG within the required	Whenever possible the Patient Safety team will attempt to report within 24 hours. T	Audit open for more than 12-months
			The Patient Safety Team should encourage management to use the feedbacl	It is well recognised that the success of a reporting system depends on the level of fe	Audit open for more than 12-months

Shaping Our Future Wellbeing – Capital Projects	R1/2	Director of Planning	Terms of Reference should be developed for the Programme Team and Proje	Terms of reference are reviewed at each stage of the project / Programme, so that t	Audit open for over 6 months
	R2/2	Director of Planning	Delivery of the required project business cases should be carefully performa	Supply Chain Partners have now been appointed for the Maelfa and Penarth scheme	Audit open for over 6 months
Specialist Neuro & Spinal Rehabilitation and Older Peop	R1/3	Director of Planning	The Procurement Strategy will be defined, within the FBC and consider all of	Other contractual options available in the SCAPE Framework were not considered so	COMPLETE
	R2/3	Director of Planning	At future schemes contract documentation will be signed prior to the comm	Noted and accepted.	COMPLETE
	R3/3	Director of Planning	Appropriate, timely internal approval will be sought for the change in capital	After completion of the audit fieldwork, Chair's Action approved the FBC prior to sub	COMPLETE
Specialist Neuro & Spinal Rehabilitation and Older Peop	R1/3	Director of Planning	The Procurement Strategy will be defined, within the FBC and consider all of	Other contractual options available in the SCAPE Framework were not considered so	Audit Closed as actions complete
	R2/3	Director of Planning	At future schemes contract documentation will be signed prior to the comm	At future schemes contract documentation will be signed prior to the commenceme	Audit Closed as actions complete
	R3/3	Director of Planning	Appropriate, timely internal approval will be sought for the change in capital	After completion of the audit fieldwork, Chair's Action approved the FBC prior to sub	Audit Closed as actions complete
Specialist Services Clinical Board – Medical Finance Gove	R1/2	Chief Operating Officer	Management should carry out a comprehensive review of the current and fu	(blank)	Audit open under 6 months and no dates breached
	R2/2	Chief Operating Officer	Each 20 week Consultant rota should be subject to formal approval by the Cl	A process to sign off the rota by the Clinical Director will be developed by the Directo	Audit open under 6 months and no dates breached
Specialist ServicesFollow up - Patientcare IT System	R1/1	Chief Operating Officer	A process should be established to periodically test the backups.	Discussions are underway with IM&T and a test of the backup is due to be scheduled	Audit open for over 6 months
Standards of Business Conduct (DoI & GH&S)	R1/6	Director of Corporate Governanace	A system is introduced that will ensure that declarations are received from a	Recommendation Agreed – a process will be developed to ensure that key staff grou	COMPLETE
	R2/6	Director of Corporate Governanace	The Corporate Team must put processes in place to help raise awareness of	Recommendation agreed. Review of the information available on the intranet will b	PARTIALLY COMPLETE
	R3/6	Director of Corporate Governanace	The Corporate Team should ensure that all forms are compliant with the SoI	Recommendation agreed – all submitted forms to be reviewed in line with the Policy	COMPLETE
	R4/6	Director of Corporate Governanace	The directorate should ensure that the policy is reviewed and updated accor	Recommendation Agreed – policy to be reviewed and updated in line with best prac	PARTIALLY COMPLETE
	R5/6	Director of Corporate Governanace	The Corporate Team should ensure that all forms are compliant with the SOI	Recommendation Agreed – Forms will be reviewed for compliance with the new poli	COMPLETE
	R6/6	Director of Corporate Governanace	The Corporate Governance department must ensure that the information pr	Recommendation Agreed – Future reporting to the Committee will ensure that the r	PARTIALLY COMPLETE
Statutory Compliance	R1/1	Director of Strategic Planning	Processes will be implemented to reduce the exposure to human/transposit	Agreed. As outlined, a software solution is presently being piloted through August ar	Audit open for more than 12-months
Strategic Planning/IMTP	R1/1	Director of Planning	Management should ensure that the plans for Clinical Boards are produced (	A revised monitoring process for reporting clinical board progress on IMTPs will be ir	Audit open under 6 months and no dates breached
	R1/2	Director of Planning	Management must ensure that the Ophthalmology Directorate produce thei	As identified the Ophthalmology IMTP was not completed for 17/18 due to particula	Superseded
	R2/2	Director of Planning	The Strategy Development and Delivery Group's terms of reference should b	We will review the functioning of the Strategy Development and Delivery Group as p	Superseded
Surgery Clinical Board - Anaesthetist Rota Management	R1/1	Chief Operating Officer	Standard Operating Procedure notes covering the administration of the CLW	It is accepted by the Directorate that there is no written SOP for staff, although all th	Audit open for more than 12-months
Surgery Clinical Board – Medical Finance Governance	R1/6	Chief Operating Officer	The Directorate should ensure that consultants carry out all planned session	A new system to accurately record consultant activity in theatre is being develop	PARTIALLY COMPLETE
	R2/6	Chief Operating Officer	The Directorates should ensure that any displaced SPA sessions are appropri	Systems will be put in place to ensure that the governance for displaced SPA will l	COMPLETE
	R3/6	Chief Operating Officer	General Surgery should ensure that they follow the correct procedure for re	Ensure CD signs off paperwork for locum highlighting rationale for locum Creat	COMPLETE
	R4/6	Chief Operating Officer	Management should produce desk top procedures to ensure that Consultan	Standardised procedure notes to be created and shared with key personnel (March 2	PARTIALLY COMPLETE
	R5/6	Chief Operating Officer	In conjunction with the actions already being taken following the Consultant	All job plans will be completed and recorded appropriately (March 2019)	PARTIALLY COMPLETE
	R6/6	Chief Operating Officer	Management should ensure that request for Locum cover documentation is	SOP/DTP will be developed and standardised for all Directorates to record adherenc	COMPLETE
Sustainability Reporting	R1/3	Director of Planning	The lead responsible for preparing the Sustainability Report should ensure tl	The preparation of future Sustainability reports will have deadlines for data submissi	Superseded
	R2/3	Director of Planning	The lead should ensure that an in-depth review of the report is completed p	The final report and data was reviewed however future reports will be further scruti	Superseded
	R3/3	Director of Planning	The UHB should ensure references are made to further sources of informati	Agreed, references shall be included in future reports where appropriate.	Superseded
UHB Core Financial Systems	R1/5	Director of Finance	Management should ensure that the main Asset Register is updated to reflec	Agreed and accepted. The follow up visits with clinical gerontology will be completed	Audit open under 6 months and no dates breached
	R2/5	Director of Finance	Management should ensure departments are aware that all assets should ha	The Director of Finance will again write to departments during 2019/20 emphasising	Audit open under 6 months and no dates breached
	R3/5	Director of Finance	Management should inform responsible staff to promptly notify eEnablemer	Recommendation Accepted. The UHB's current procedure will be updated to clarify t	Audit open under 6 months and no dates breached
	R4/5	Director of Finance	Management should ensure that a standard procedural guide is produced to	Recommendation accepted. The UHB's current procedure will be updated to clarify r	Audit open under 6 months and no dates breached
	R5/5	Director of Finance	Management should ensure that the required forms are completed, signed a	Recommendation accepted. The UHB's revised procedure will be updated to clarify r	Audit open under 6 months and no dates breached
University Hospital of Wales Neo Natal Development	R1/7	Director of Planning	The design for the MRI new build will be concluded and frozen as soon as po	The design solution has been informed, as far as is practicable, by considering the sp	Audit open for more than 12-months
	R2/7	Director of Planning	The value of identified risk will be included within the assessment of afforda	Whilst the recommendation is accepted regarding inclusion in the Cost Adviser repo	Audit open for more than 12-months
	R3/7	Director of Planning	An agreed timetable should be developed for design completion and validati	The design has been developed in conjunction with a design development programn	Audit open for more than 12-months
	R4/7	Director of Planning	A formal evaluation of the adequacy of the ground investigation reports will	The ability to carry out an extensive ground investigation survey was impeded by the	Audit open for more than 12-months
	R5/7	Director of Planning	Risk mitigation plans will continue to be actively managed by the UHB, contr	The finding is factually correct at time of compiling the report. Risk has been actively	Audit open for more than 12-months
	R6/7	Director of Planning	The Capital Procedures Manual should be revised to include the requiremen	Agreed	Audit open for more than 12-months
	R7/7	Director of Planning	Requests for 'Single Tender Action' should be approved and reported to the	Agreed	Audit open for more than 12-months
Ward Nursing Staff Levels	R1/4	Director of Nursing	The Nurse Staffing Levels - Working Planning Template should be signed off	The completion of signing off the staffing templates has proved a challenge, given th	Audit open under 6 months and some dates breached
	R2/4	Director of Nursing	Management should ensure that all wards display the ward staffing levels to	We have found that at times, there have been oversights in the ward displaying the i	Audit open under 6 months and some dates breached
	R3/4	Director of Nursing	Management should ensure that following the consistency check of the Ope	The Operating framework is with the All Wales Group for final approval.	Audit open under 6 months and some dates breached
	R4/4	Director of Nursing	The Finance budgeted report for the WTE staff should be amended to align v	It is proposed that the finance report will align to the correct Nurseestablishment fol	Audit open under 6 months and some dates breached
Water Safety	R1/7	Director of Planning	Attendances of the Water Safety Group should be reviewed, with staff remir	Agreed	Audit open under 6 months and no dates breached
	R2/7	Director of Planning	The current position in respect of the backlog of remedial jobs, should be ro	Agreed	Audit open under 6 months and no dates breached
	R3/7	Director of Planning	Training should be updated for all key staff with assigned water managemen	Agreed	Audit open under 6 months and no dates breached
	R4/7	Director of Planning	a) An audit trail should be maintained where routine checks are not complet	Agreed	Audit open under 6 months and no dates breached
	R5/7	Director of Planning	a) For those clinical boards identified in this audit as being non-compliant wi	Agreed	Audit open under 6 months and no dates breached
	R6/7	Director of Planning	The risk assessment process, including preparation of appropriate prioritisec	Agreed	Audit open under 6 months and no dates breached
	R7/7	Director of Planning	Progress, including highlighting of any delays, should be regularly reported t	Agreed	Audit open under 6 months and no dates breached
Wellbeing of Future Generations Act	R1/5	Director of Public Health	The Health Board/ Management should produce an Action Plan to provide a	The Steering Group agreed the need to develop an Action Plan at its meeting on 12 M	Audit open for more than 12-months
	R2/5	Director of Public Health	The Terms of Reference for the WFG Steering Group should be formalised ar	Draft Terms of Reference were discussed at the meeting of the Steering Groupon 12	Audit open for more than 12-months
	R3/5	Director of Public Health	The Health Board should formalise and approve the role and responsibility o	A draft WFG Champion role was discussed at the Steering Group on 12 March. Final v	Audit open for more than 12-months
	R4/5	Director of Public Health	The Health Board must ensure that its obligations in respect of the Act are a	The Chair of the Steering Group met with UHB Director Communications and the UH	Audit open for more than 12-months
	R5/5	Director of Public Health	The Health Board should update their WFG internet page to ensure that it pr	UHB WFG Internet page to be updated to reflect the recommendations.	Audit open for more than 12-months
WLI Payments Follow-Up	R1/2	Chief Operating Officer	The UHB has produced a WLI Payments Policy/Procedure and this has been r	Not Provided	Audit open for more than 12-months
	R2/2	Chief Operating Officer	Testing identified that whilst Cardiac Surgery make the appropriate checks a	Not Provided	Audit open for more than 12-months
(blank)	(blank)	(blank)	(blank)	(blank)	(blank)
Grand Total					

Audit	(All)

Audit Log Ref No.	Financial Year Fieldwork Under	Audit Title	Audit Rating	Executive Lead for Report	Status of Report Overall	Age Group
IA 01 1819	2018-19	Ombudsman Report	Substantial	Director of Nursing	Audit Closed as no action required	Closed/Not Open
IA 01_1718	2016-17	Core Financial Systems	Substantial	Director of Finance	Superseded	Closed/Not Open
IA 02 1819	2018-19	Charitable Funds	Substantial	Director of Finance	Audit open for over 6 months	Over 6 Months
IA 02_1718	2017-18	Claims Reimbursement	Substantial	Director of Finance	Superseded	Closed/Not Open
IA 03 1819	2018-19	Specialist ServicesFollow up - Patientcare IT System	Substantial	Chief Operating Officer	Audit open for over 6 months	Over 6 Months
IA 03_1718	2017-18	Action plan on Deloitte Financial Governance Review	Substantial	Director of Finance	Audit open for more than 12-months	Over One Year
IA 03_1718	2017-18	Progress against findings from the Human Tissue Authority (HTA) Inspection of UHW	Substantial	Chief Operating Officer	Audit open for more than 12-months	Over One Year
IA 04 1819	2018-19[deferred from 2017-18	Cost Improvement Programme	Substantial	Director of Finance	Audit open for over 6 months	Over 3 Months
IA 04 1819	2018-19[deferred from 2017-18	Cost Improvement Programme		Director of Finance	Audit open for over 6 months	Date not Specified
IA 05 1819	2018-19	Claims Reimbursement	Substantial	Director of Nursing	Audit Closed as actions complete	Closed/Not Open
IA 05_1718	2017-18	Action plan on WAO Audit of RKC Associates	Substantial	Director of Corporate Governance	Audit Closed as Complete	Closed/Not Open
IA 06 1819	2018-19	Performance Reporting Data Quality - Non RTT	Substantial	Director of Public Health	Audit open under 6 months and some dates breached	Date not Specified
IA 06_1718	2017-18	IM&TWelsh Patient Referral System	Substantial	Director of Therapies and Health Science	Audit open for more than 12-months	Closed/Not Open
IA 07 1819	2018-19	Delayed Transfers of Care Reporting	Substantial	Chief Operating Officer	Audit open under 6 months and some dates breached	Over 3 Months
IA 07 1819	2018-19	Delayed Transfers of Care Reporting	Substantial	Chief Operating Officer	Audit open under 6 months and some dates breached	Over 3 Months
IA 07_1718	2017-18	IM&TMTeD Deployment	Substantial	Director of Therapies and Health Science	Audit open for more than 12-months	Over One Year
IA 07_1718	2017-18	IM&TMTeD Deployment		Director of Therapies and Health Science	Audit open for more than 12-months	Closed/Not Open
IA 07_1718	2017-18	IM&TWelsh Patient Referral System	Substantial	Director of Therapies and Health Science	Audit open for more than 12-months	Over One Year
IA 08 1819	2018-19	Ward Nursing Staff Levels	Substantial	Director of Nursing	Audit open under 6 months and some dates breached	Over 3 Months
IA 08 1819	2018-19	Ward Nursing Staff Levels		Director of Nursing	Audit open under 6 months and some dates breached	Less Than 3 Months
IA 08_1718	2017-18	Charitable Funds	Substantial	Director of Finance	Superseded	Closed/Not Open
IA 09 1819	2018-19	Strategic Planning/IMTP	Substantial	Director of Planning	Audit open under 6 months and no dates breached	Less Than 3 Months
IA 09_1718	2016-17	Statutory Compliance	Substantial	Director of Strategic Planning	Audit open for more than 12-months	Over One Year
IA 10 1819	2018-19	Annual Quality Statement	Substantial	Director of Nursing	Audit open for over 6 months	Over 6 Months
IA 10 1819	2018-19	Annual Quality Statement		Director of Nursing	Audit open for over 6 months	Over One Year
IA 10 1819	2018-19	Annual Quality Statement		Director of Nursing	Audit open for over 6 months	Closed/Not Open
IA 10_1718	2017-18	Primary, Community & Intermediate Care Clinical BoardLocality Stock Follow-Up	Reasonable	Chief Operating Officer	No Action Required - complete	Closed/Not Open
IA 11 _1718	2017-18	WLI Payments Follow-Up	Reasonable	Chief Operating Officer	Audit open for more than 12-months	Over One Year
IA 11 _1718	2017-18	WLI Payments Follow-Up		Chief Operating Officer	Audit open for more than 12-months	Date not Specified
IA 11 1819	2017-18	Shaping Our Future Wellbeing – Capital Projects	Reasonable	Director of Planning	Audit open for over 6 months	Over 6 Months
IA 11 1819	2017-18	Shaping Our Future Wellbeing – Capital Projects		Director of Planning	Audit open for over 6 months	Date not Specified
IA 12 1819	2018-19	Dental CB – Theatre Sessions	Reasonable	Chief Operating Officer	Audit open for over 6 months	Over One Year
IA 12_1718	2017-18	Residences	Reasonable	Director of Planning	Audit open for more than 12-months	Over One Year
IA 12_1718	2017-18	Residences		Director of Planning	Audit open for more than 12-months	Date not Specified
IA 13 1819	2018-19	Dental CB – Dental Nurse Provision	Reasonable	Chief Operating Officer	Audit open for over 6 months	Over 6 Months
IA 13 1819	2018-19	Dental CB – Dental Nurse Provision		Chief Operating Officer	Audit open for over 6 months	Over One Year
IA 13 1819	2018-19	Dental CB – Dental Nurse Provision		Chief Operating Officer	Audit open for over 6 months	Closed/Not Open
IA 13_1718	2017-18	Surgery Clinical Board - Anaesthetist Rota Management	Reasonable	Chief Operating Officer	Audit open for more than 12-months	Date not Specified
IA 14 1819	2018-19	Environmental Sustainability Report	Reasonable	Director of Planning	Audit open for over 6 months	Over 3 Months
IA 14 1819	2018-19	Environmental Sustainability Report		Director of Planning	Audit open for over 6 months	Closed/Not Open
IA 14_1718	2017-18	Pilot Model Ward Review	Reasonable	Director of Planning	Audit open for more than 12-months	Over One Year
IA 14_1718	2017-18	Pilot Model Ward Review		Director of Planning	Audit open for more than 12-months	Date not Specified
IA 15 1819	2018-19	Electronic Staff Record	Reasonable	Director of Workforce and Organisational Development	Audit open for over 6 months	Over 3 Months
IA 15 1819	2018-19	Electronic Staff Record		Director of Workforce and Organisational Development	Audit open for over 6 months	Over 6 Months
IA 15 1819	2018-19	Electronic Staff Record		Director of Workforce and Organisational Development	Audit open for over 6 months	Closed/Not Open
IA 15_1718	2017-18	IM&T Server Virtualisation	Reasonable	Director of Therapies and Health Science	Audit open for more than 12-months	Closed/Not Open
IA 15_1718	2017-18	IM&T Server Virtualisation		Director of Therapies and Health Science	Audit open for more than 12-months	Date not Specified
IA 16 1819	2018-19	Management of the Disciplinary process.	Reasonable	Director of Workforce and Organisational Development	Audit open for over 6 months	Over 3 Months
IA 16 1819	2018-19	Management of the Disciplinary process.		Director of Workforce and Organisational Development	Audit open for over 6 months	Over 6 Months
IA 16 1819	2018-19	Management of the Disciplinary process.		Director of Workforce and Organisational Development	COMPLETE	Over 3 Months
IA 16 1819	2018-19	Management of the Disciplinary process.		Director of Workforce and Organisational Development	COMPLETE	Over 6 Months
IA 16_1718	2017-18	Organisational Values	Reasonable	Director of Workforce and Organisational Development	Audit open for more than 12-months	Closed/Not Open
IA 16_1718	2017-18	Organisational Values		Director of Workforce and Organisational Development	COMPLETE	Over 6 Months
IA 16_1718	2017-18	Organisational Values		Director of Workforce and Organisational Development	COMPLETE	Over One Year
IA 17 1819	2018-19	National Standards for Cleaning in NHS Wales Follow-up	Reasonable	Director of Planning	Overdue more than 12-months: Follow-up Audit confirmed not fully complete	Over One Year
IA 17 1819	2018-19	National Standards for Cleaning in NHS Wales Follow-up		Director of Planning	Overdue more than 12-months: Follow-up Audit confirmed not fully complete	Closed/Not Open
IA 17_1718	2017-18	Wellbeing of Future Generations Act	Reasonable	Director of Public Health	Audit open for more than 12-months	Over One Year
IA 17_1718	2017-18	Wellbeing of Future Generations Act		Director of Public Health	Audit open for more than 12-months	Date not Specified
IA 18 1819	2018-19	CRC Energy Efficiency Scheme	Reasonable	Director of Planning	Audit open for over 6 months	Date not Specified
IA 18_1718	2017-18	Children & Women Clinical Board – Medical Staff Rotas and Study	Reasonable	Chief Operating Officer	Audit open for more than 12-months	Over One Year
IA 18_1718	2017-18	Children & Women Clinical Board – Medical Staff Rotas and Study		Chief Operating Officer	Audit open for more than 12-months	Date not Specified
IA 19 1819	2018-19	PCIC CB – District Nursing Rotas	Reasonable	Chief Operating Officer	Audit open for over 6 months	Over 6 Months
IA 19 1819	2018-19	PCIC CB – District Nursing Rotas		Chief Operating Officer	Audit open for over 6 months	Closed/Not Open
IA 19 1819	2018-19	PCIC CB – District Nursing Rotas		Chief Operating Officer	Audit open for over 6 months	Date not Specified
IA 19_1718	2017-18	Serious Incidents Management	Reasonable	Director of Nursing	Audit open for more than 12-months	Over One Year
IA 19_1718	2017-18	Serious Incidents Management		Director of Nursing	Audit open for more than 12-months	Date not Specified
IA 20 1819	2018-19	Mental Health Clinical Board – Section 17 Leave	Reasonable	Chief Operating Officer	Audit open for over 6 months	Over 6 Months
IA 20 1819	2018-19	Mental Health Clinical Board – Section 17 Leave		Chief Operating Officer	Audit open for over 6 months	Closed/Not Open
IA 20_1718	2017-18	Research & Development	Reasonable	Medical Director	Audit open for more than 12-months	Over One Year
IA 20_1718	2017-18	Research & Development		Medical Director	Audit open for more than 12-months	Closed/Not Open
IA 20_1718	2017-18	Research & Development	(blank)	Medical Director	Audit open for more than 12-months	Date not Specified
IA 21 1819	2018-19	Renal IT system	Reasonable	Chief Operating Officer	Audit open for over 6 months	Over 3 Months

IA 21 1819	2018-19	Renal IT system		Chief Operating Officer	Audit open for over 6 months	Closed/Not Open
IA 21_1718	2017-18	Mental Health Sickness Management and Rostering	Reasonable	Chief Operating Officer	Audit open for more than 12-months	Over One Year
IA 21_1718	2017-18	Mental Health Sickness Management and Rostering		Chief Operating Officer	Audit open for more than 12-months	Closed/Not Open
IA 22 1819	2018-19	Contract Compliance	Reasonable	Director of Finance	Audit open under 6 months and some dates breached	Over 3 Months
IA 22 1819	2018-19	Contract Compliance		Director of Finance	Audit open under 6 months and some dates breached	Over 6 Months
IA 22 1819	2018-19	Contract Compliance		Director of Finance	Audit open under 6 months and some dates breached	Less Than 3 Months
IA 22 1819	2018-19	Contract Compliance		Director of Finance	Audit open under 6 months and some dates breached	Closed/Not Open
IA 22_1718	2017-18	Nurse Revalidation	Reasonable	Director of Nursing	Audit open for more than 12-months	Over One Year
IA 23 1718	2017-18	Sustainability Reporting	Reasonable	Director of Planning	Superseded	Closed/Not Open
IA 23 1819	2018-19	Clinical Diagnostic and Therapeutic Clinical Board – Bank, Agency & Overtime Spend	Reasonable	Director of Operations	Audit open under 6 months and some dates breached	Over 3 Months
IA 23 1819	2018-19	Clinical Diagnostic and Therapeutic Clinical Board – Bank, Agency & Overtime Spend		Director of Operations	Audit open under 6 months and some dates breached	Over 6 Months
IA 23 1819	2018-19	Clinical Diagnostic and Therapeutic Clinical Board – Bank, Agency & Overtime Spend		Director of Operations	Audit open under 6 months and some dates breached	Closed/Not Open
IA 24 1718	2017-18	CRC Energy Efficiency Scheme	Reasonable	Director of Planning	Superseded	Closed/Not Open
IA 24 1819	2018-19	Kronos Time Recording System - Estates	Reasonable	Director of Planning	Audit open under 6 months and no dates breached	Over 3 Months
IA 24 1819	2018-19	Kronos Time Recording System - Estates		Director of Planning	Audit open under 6 months and no dates breached	Date not Specified
IA 25 1718	2017-18	Strategic Planning/IMTP	Reasonable	Director of Planning	Superseded	Closed/Not Open
IA 25 1819	2018-19	Specialist Neuro & Spinal Rehabilitation and Older People's Services - (Rookwood Relocation)	Reasonable	Director of Planning	Audit Closed as actions complete	Closed/Not Open
IA 25 1819	2018-19	Specialist Neuro & Spinal Rehabilitation and Older People's Services - (Rookwood Relocation)		Director of Planning	Audit Closed as actions complete	Date not Specified
IA 26 1718	2017-18	Emergency Unit - 12 Hour Target	Reasonable	Chief Operating Officer	Audit Closed as Complete	Closed/Not Open
IA 26 1819	2018-19[deferred from 2017-18	PCIC Interface Incidents	Reasonable	Chief Operating Officer	Audit open under 6 months and some dates breached	Over 6 Months
IA 26 1819	2018-19[deferred from 2017-18	PCIC Interface Incidents		Chief Operating Officer	Audit open under 6 months and some dates breached	Closed/Not Open
IA 27 1718	2017-18	University Hospital of Wales Neo Natal Development	Reasonable	Director of Planning	Audit open for more than 12-months	Over One Year
IA 27 1718	2017-18	University Hospital of Wales Neo Natal Development		Director of Planning	Audit open for more than 12-months	Closed/Not Open
IA 27 1819	2018-19	Medicine CB - Sickness Absence Management	Reasonable	Chief Operating Officer	Audit open under 6 months and some dates breached	Over 3 Months
IA 28 1718	2017-18	Health and Care Standards	Reasonable	Director of Nursing	No Action Required - complete	Closed/Not Open
IA 28 1819	2018-19	CRI Safeguarding Works	Reasonable	Director of Planning	Audit open under 6 months and some dates breached	Over 3 Months
IA 28 1819	2018-19	CRI Safeguarding Works		Director of Planning	Audit open under 6 months and some dates breached	Date not Specified
IA 29 1718	2017-18	Business Continuity Planning Follow-Up	Reasonable	Director of Planning	Audit open for more than 12-months	Closed/Not Open
IA 29 1819	2018-19	Commissioning	Reasonable	Director of Transformation, Improvements and Informatics	Audit open under 6 months and some dates breached	Over 3 Months
IA 29 1819	2018-19	Commissioning		Director of Transformation, Improvements and Informatics	Audit open under 6 months and some dates breached	Due Date Not Reached
IA 30 1718	2017-18	Mortality Reviews	Reasonable	Medical Director	Audit open for more than 12-months	Over 6 Months
IA 30 1718	2017-18	Mortality Reviews		Medical Director	Audit open for more than 12-months	Over One Year
IA 30 1819	2018-19	E IT Training	Reasonable	Director of Transformation, Improvements and Informatics	Audit open under 6 months and no dates breached	Less Than 3 Months
IA 30 1819	2018-19	E IT Training		Director of Transformation, Improvements and Informatics	Audit open under 6 months and no dates breached	Closed/Not Open
IA 31 1718	2017-18	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Reasonable	Director of Planning	COMPLETE	Closed/Not Open
IA 31 1819	2018-19	Water Safety	Reasonable	Director of Planning	Audit open under 6 months and no dates breached	Less Than 3 Months
IA 31 1819	2018-19	Water Safety		Director of Planning	Audit open under 6 months and no dates breached	Date not Specified
IA 32 1718	2017-18	RTT Performance Reporting	Reasonable	Director of Transformaiton and Informatics	Audit open for more than 12-months	Over 6 Months
IA 32 1718	2017-18	RTT Performance Reporting		Director of Transformaiton and Informatics	Audit open for more than 12-months	Over One Year
IA 32 1718	2017-18	RTT Performance Reporting		Director of Transformaiton and Informatics	Audit open for more than 12-months	Date not Specified
IA 32 1819	2018-19	UHB Core Financial Systems	Reasonable	Director of Finance	Audit open under 6 months and no dates breached	Less Than 3 Months
IA 32 1819	2018-19	UHB Core Financial Systems		Director of Finance	Audit open under 6 months and no dates breached	Due Date Not Reached
IA 33 1718	2017-18	Costing Review	Reasonable	Director of Finance	Audit open for more than 12-months	Over 6 Months
IA 33 1718	2017-18	Costing Review		Director of Finance	Audit open for more than 12-months	Over One Year
IA 33 1819	2018-19	Health and Care Standards	Reasonable	Director of Nursing	Audit closed as no recommendations	Closed/Not Open
IA 34 1718	2017-18	National Standards for Cleaning in NHS Wales	Limited	Director of Planning	Superseded	Closed/Not Open
IA 34 1819	2018-19	Annual Quality Statement	Substantial	Director of Nursing	Audit Closed as actions complete	Closed/Not Open
IA 35 1718	2017-18	Internal Medicine Directorate Mandatory Training and PADRs	Limited	Chief Operating Officer	Overdue	Closed/Not Open
IA 35 1718	2017-18	Internal Medicine Directorate Mandatory Training and PADRs		Chief Operating Officer	Superseded	Closed/Not Open
IA 35 1819	2018-19	Specialist Services Clinical Board – Medical Finance Governance	Reasonable	Chief Operating Officer	Audit open under 6 months and no dates breached	Less Than 3 Months
IA 35 1819	2018-19	Specialist Services Clinical Board – Medical Finance Governance		Chief Operating Officer	Audit open under 6 months and no dates breached	Due Date Not Reached
IA 36 1718	2017-18	Neurosciences - Patient Care IT System	Limited	(blank)	(blank)	Closed/Not Open
IA 36 1819	2018-19	Mental Health Clinical Board – Sickness Management	Limited	Chief Operating Officer	COMPLETE	Over 3 Months
IA 36 1819	2018-19	Mental Health Clinical Board – Sickness Management		Chief Operating Officer	PARTIALLY COMPLETE	Over 3 Months
IA 37 1718	2017-18	Deprivation of Liberties Safeguards Follow-Up	Limited	Medical Director	Audit open for more than 12-months	Date not Specified
IA 37 1819	2018-19	Standards of Business Conduct (DoI & GH&S)	Limited	Director of Corporate Governanace	COMPLETE	Closed/Not Open
IA 37 1819	2018-19	Standards of Business Conduct (DoI & GH&S)		Director of Corporate Governanace	PARTIALLY COMPLETE	Over 6 Months
IA 38 1718	2016-17	Continuing Health Care (CHC)	Limited	Chief Operating Officer	Audit open for more than 12-months	Over One Year
IA 38 1718	2016-17	Continuing Health Care (CHC)		Chief Operating Officer	COMPLETE	Closed/Not Open
IA 38 1718	2016-17	Continuing Health Care (CHC)		Chief Operating Officer	COMPLETE	Date not Specified
IA 38 1718	2016-17	Continuing Health Care (CHC)		Chief Operating Officer	PARTIALLY COMPLETE	Date not Specified
IA 38 1819	2018-19	Legislative/Regulatory Complaince	Limited	Director of Corporate Governance	COMPLETE	Over 6 Months
IA 38 1819	2018-19	Legislative/Regulatory Complaince		Director of Corporate Governance	n/a	Over 6 Months
IA 38 1819	2018-19	Legislative/Regulatory Complaince		Director of Corporate Governance	PARTIALLY COMPLETE	Over 6 Months
IA 38 1819	(blank)	Legislative/Regulatory Complaince	Limited	Director of Corporate Governance	n/a	Over 6 Months
IA 39 1718	2017-18	Consultant Job Planning	Limited	Medical Director	Audit open for more than 12-months	Over One Year
IA 39 1718	2017-18	Consultant Job Planning		Medical Director	Audit open for more than 12-months	Date not Specified
IA 39 1819	2018-19	Information Governance: General Data Protection Regulation (GDPR)	Limited	Director of Transformation and Informatics	Audit open under 6 months and some dates breached	Over 6 Months
IA 39 1819	2018-19	Information Governance: General Data Protection Regulation (GDPR)		Director of Transformation and Informatics	Audit open under 6 months and some dates breached	Less Than 3 Months
IA 39 1819	2018-19	Information Governance: General Data Protection Regulation (GDPR)		Director of Transformation and Informatics	Audit open under 6 months and some dates breached	Closed/Not Open
IA 39 1819	2018-19	Information Governance: General Data Protection Regulation (GDPR)		Director of Transformation and Informatics	Audit open under 6 months and some dates breached	Date not Specified
IA 39 1819	2018-19	Information Governance: General Data Protection Regulation (GDPR)		Director of Transformation and Informatics	Audit open under 6 months and some dates breached	Due Date Not Reached
IA 40 1718	2016-17	Annual Quality Statement	Substantial	Director of Nursing	Superseded	Closed/Not Open
IA 40 1819	2018-19	Surgery Clinical Board – Medical Finance Governance	Limited	Chief Operating Officer	COMPLETE	Over 3 Months
IA 40 1819	2018-19	Surgery Clinical Board – Medical Finance Governance		Chief Operating Officer	COMPLETE	Date not Specified
IA 40 1819	2018-19	Surgery Clinical Board – Medical Finance Governance		Chief Operating Officer	PARTIALLY COMPLETE	Over 3 Months

IA 41 1819	**2018-19**	**Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up**	**Limited**	Chief Operating Offier	Audit open under 6 months and some dates breached	Closed/Not Open
IA 41 1819	**2018-19**	**Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up**		Chief Operating Offier	COMPLETE	Over 3 Months
IA 41 1819	**2018-19**	**Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up**		Chief Operating Offier	COMPLETE	Over 6 Months
IA 41 1819	**2018-19**	**Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up**		Chief Operating Offier	COMPLETE	Closed/Not Open
IA 41 1819	**2018-19**	**Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up**		Chief Operating Offier	PC – will be completed by September 2019	Less Than 3 Months
IA 42 1819	**2018-19[deferred from 2017-1**	**Cyber Security**	**Limited**	Director of Transformation and Informatics	Audit open under 6 months and no dates breached	Less Than 3 Months
(blank)	**(blank)**	**(blank)**	**(blank)**	(blank)	(blank)	(blank)
(blank)	**(blank)**	**(blank)**		(blank)	(blank)	Closed/Not Open
Grand Total						

Status	Open

Count of Audit Log Ref No.	Age Group						
Audit	**Date not Specified**	**Due Date Not Reached**	**Less Than 3 Months**	**Over 3 Months**	**Over 6 Months**	**Over One Year**	**Grand Total**
IA 1718	30				8	51	89
IA 1819	22	7	31	42	36	7	145
Grand Total	**52**	**7**	**31**	**42**	**44**	**58**	**234**

Report Title:	**Legislative and Regulatory Tracker Report**						
Meeting:	Audit Committee				**Meeting Date:**	30.09.19	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	**Director of Corporate Governance**						
Report Author (Title):	**Director of Corporate Governance**						

SITUATION

This report provides Members of the Audit Committee with information on Legislation and Regulatory Compliance at Cardiff and Vale Local University Health Board by means of a Regulatory Tracking Report (attached at Appendix 1).

BACKGROUND

In January 2019 the organisation received a report on Legislative and Regulatory Compliance which provided a 'limited' assurance rating and made seven recommendations. These recommendations were all accepted by the Director of Corporate Governance. Four of the ratings were classed as high priority and three were rated as medium priority.

ASSESSMENT

Good progress has been made on the development of a Legislative and Regulatory Tracker and the follow up internal audit report now gives an assurance rating of 'reasonable' so there is still some work to be done to ensure that the tracker is fit for purpose in providing assurance to the Audit Committee and the Board. The tracker now provides the following details:

- All Regulatory Bodies which inspect Cardiff and Vale UHB are listed
- The Regulatory Standard which is being inspected is listed
- The Lead Executive in each case is detailed
- The Assurance Committee where any inspection reports will be presented along with any action plans as a result of inspection is detailed
- The accountable individual is detailed and where there is a gap this will be the lead Executive
- Where we have been informed what the inspection cycle is we have detailed it where we have not been informed or simply don't know we have put 'ad hoc'.
- The last inspection date is detailed and also detailed is where Cardiff and Vale have not been inspected in the last 10 years.
- Where we know the inspection date it is detailed. Where we know the inspection cycle and the last time it was inspected we have put in a predicted date so we don't completely lose sight of it. Where the cycle time is ad hoc we have stated that no inspection has been notified and when we are notified via the central inbox, which has been set up, this will be added to the tracker. Hence we have called this column 'expected date of inspection'. Where there is an * it means an inspection was expected

but never took place.

- Where we know the outcome of the inspection we have included it. Where there were no issues picked up we have put this column to 'action complete' this links to the final column which is a binary complete or not complete. The reason for this is that it will link to the dials in due course.

Clearly the Legislative and Regulatory tracker will continue to develop and improve through the quarterly follow up process which has been put in place. The next steps in the development of the tracker will be the completion of the dials which show the level of compliance and predicted next inspection date which then gives an indication and assurance on whether the area being inspected is likely to be compliant or not.

A new policy has been developed and approved by the Management Executives it is also due to be approved by HSMB at the beginning of October.

The tracker will now be updated on a quarterly basis throughout the organisation and also reported to the Audit Committee on a quarterly basis after been presented to HSMB.
Based on the information currently contained within the tracker there are six inspections due in relation to Regulatory Compliance for the remainder for 2019. These are as follows:

1. An inspection by the **All Wales Quality Assurance Pharmacist** is due in October 2019 on **Pharmacy SMPU**. This is currently classed as high risk and not yet compliant due to the fact the there is an issue resourcing an accountable pharmacist. This is an annual inspection. The outcome will be reported to the QSE Committee and then at a higher level to the Audit Committee.

2. An inspections by the **Health and Safety Executive** on **Violence and Aggression** is due in November 2019. The inspection is ad hoc and there is no data on previous inspections in this area. The outcome will be reported to Health and Safety Committee and then at a higher level to the Audit Committee.

3. An inspection by the **Medicines and Healthcare products Regulatory Agency** (MRHA) on **Blood Transfusion** is due in December 2019. They last inspected 12 months ago in December 2018 and found 2 major issues and 1 other issue. These issues are on track for compliance by the next inspection. The outcome will be reported to the QSE Committee and then at a higher level to the Audit Committee.

4. An inspection by **Natural Resources Wales** is due to take place on **Medical Physics** at the University Hospital Llandough. It was last inspected in January 2018 and due for another inspection in November 2019. This is an annual inspection. From the last inspection there was 1 action and 1 recommendation and these issues are on track for compliance by the next inspection. The outcome will be reported to Health and Safety Committee and then at a higher level to the Audit Committee.

5. An inspection by **Quality in Primary Immunodeficiency Services (QPIDS)** is due in October 2019 on **Immunology**. There is currently no further detail on this inspection but the outcome will be reported to QSE Committee and then at a higher level to the Audit Committee.

6. An inspection by **SGS/UKAS** is due to take place in September 2019 in SSSU on M**edical Devices**. It is an annual inspection and was last inspected in January 2019 where three minor issues were highlighted. These issues are on track for compliance. The outcome will be reported to the QSE Committee and then at a higher level to the Audit Committee.

RECOMMENDATION

For Members of the Audit Committee to:

(a) Note the development of the Legislative and Regulatory Tracker and 'reasonable' assurance rating provided by internal audit;

(b) Note the next steps required to complete all of the recommendations made within the Internal Audit Report and so provide further assurance to the Audit Committee and the Board on compliance with Legislation and Regulatory Standards.

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

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

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

REGULATORY BODY REVIEW TRACKER - September 2019

Clinical Board	Directorate	Regulatory body/inspector	Service area	Regulation/Standards	Lead Executive	Assurance Committee	Accountable individual	Inspection cycle time	last inspection date	Next inspection date	Inspection outcome	inspection closure due by	inspection closure complete/ontrack? 1=Y 2=N	Document review compliance	Audit compliance	Audit overdue by (days)	Overdue CAPA	CAPA overdue by (days)	Number of overdue incidents	incidents overdue by (days)	Critical Issue1=y 2=n	Critical Comment
	Pharmacy	All Wales Quality Assurance Pharmacist	Pharmacy SMPU	Medicines Act 1968 (c.67) specific review of section 10	Stuart Walker		Darrell Baker	annual	Nov-18	Oct-19	High Risk - resourcing of an accountable pharmacist	Nov-19	2									
	Pharmacy	All Wales Quality Assurance Pharmacist	Pharmacy UHL	Medicines Act 1968 (c.67) specific review of section 10	Stuart Walker		Darrell Baker	annual	7/16/2019		High Risk - estate and PQS defciencies - link to MHRA inspection	Jan-19	1									
		British Standards Institute																				
		Cardiff and Vale of Glamorgan Food Hygiene Ratings	Teddy Bear Nursery	Food Safety Act 1990 (the Act),	Abigail Harris				9/4/2019		Food rating 4	9/30/2019										
	Pharmacy			Falsifying Medicines Directive	Stuart Walker		Darrell Baker	n/a	n/a	n/a	no inspection data as yet											
		Fire and Rescue Services		Health and Safety at Work Act 1974	Abigail Harris																	
		Health and Safety Executive		Health and Safety at Work Act 1974	Martin Driscoll																	
		Health Education and Improvement Wales																				
	Radiology	HIW	Radiology	The Ionising Radiation (Medical Exposure) Regulations 2017	Ruth Walker		Andrew Wood/Kathy Ikin	ad hoc	10/4/2017		3 non conformances	2/28/2018	1									Entitlement process for duty holders completed. Increased number of CT incidents (themed review 19/1/17). Medical Physics Experts in place in some areas. HIW inspection Cardiology/Radiology 2017 New legislation Feb 18 - IR(ME)R18
	Medical Physics	HIW - MARS associated with IR(ME)R	Medical Physics	The Medicines (Administration of Radioactive Substances) Regulations 1978	Ruth Walker		Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years		n/a	n/a										Practitioners hold ARSAC certificates. ARSAC licence in place for UHW. Application in progress for UHL
	Radiology	HSE	Radiology	The Ionising Radiations Regulations 2017	Martin Driscoll		Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years		last inspections pre 2004, no inspeciton data currently available											RPAs and RPSs appointed, Local Rules written etc etc. UHB Ionising Radiation Risk Management Policy and Procedures to be completed. RPA audits complete. Radiation risk assessments complete. New legislation Feb 18 - IRR18. Registration complete.
	Medical Physics	HSE	Medical Physics	Control of Artificial Optical Radiation at Work Regulations 2010	Martin Driscoll		Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years		last inspections pre 2004, no inspeciton data currently available											Need to review the state of implementation in the UHB.
	Medical Physics	HSE	Medical Physics	The Control of Electromagnetic Fields at Work Regulations 2016	Martin Driscoll		Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years		last inspections pre 2004, no inspeciton data currently available											Need to review the state of implementation in the UHB. Includes MRI.
	Haematology	HTA	Stem Cell processing Unit (HTA)	Human Tissue Act	Fiona Jenkins		Alun Roderick/Sarah Phillips	730	1/22/2019		1 major 4 minors	9/6/2019	1	97%	72%	138	22	288	0	0	2	
	Cellular Pathology	HTA	Mortuary (Cell Path - HTA)	Human Tissue Act	Fiona Jenkins		Adam Christian/Scott Gable	730	11/22/2018		3 criticals, 14 majors, 9 minor	1/31/2019	1	97%	96%	31	13	213	0	0	2	SI - datix with WG since January 2018 Oldest CAPA NC-18-123 - associated with audit MOR-18-71 (document control)
		Joint Education Accreditation Committee		Stuart Walker																		
	Lab Med	MHRA	Blood transfusion (BSQR)	Blood and Safety Quality Regulations	Fiona Jenkins		Andrew Gorringe/Alun Roderick	365	12/13/2018		2 majors 1 other	2/28/2019	1	97%	92%	32	4	22	15	88	2	BTL's bimonthly MHRA monitoring has now finished.
	Pharmacy	MHRA	Pharmacy SMPU	Good manufacturing practice (GMP) and good distribution practice (GDP)	Stuart Walker		Darrel Baker	365	7/23/2019		3 majors 2 others	12/3/2019	1	75%	95%	46	54	517	9	53	2	Gold command in place to address findings of MHRA inspection
	Pharmacy	MHRA	Pharmacy UHL	Good manufacturing practice (GMP) and good distribution practice (GDP)	Stuart Walker		Darrel Baker	730	1/21/2015		2 majors 6 minors	6/30/2015	1	75%	86%	15	8	380	0	0	2	Gold command in place to address findings of MHRA inspection
	Medical Physics	MHRA	radiopharmacy	Good manufacturing practice (GMP) and good distribution practice (GDP)	Fiona Jenkins		Andrew Wood/Kathy Ikin	730	7/23/2019		5 majors, 2 others	tbc with regulator	1	0%	0%	0	0	0	0	0	0	Radiopharmacy, facilities which need replacement. Inspection completed awaiting final report. Under MHRA compliance team for new facilities.
	Medical Physics	MHRA	Medical Physics	Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices 2015.	Fiona Jenkins		Andrew Wood/Kathy Ikin	ad hoc	1/2/2011	no inspection notified	No inspection to date in this area	n/a	n/a									LPAs appointed and laser safety audits performed.
	Medical Physics	MHRA	Medical Physics	Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use 2015.	Fiona Jenkins		Andrew Wood/Kathy Ikin	ad hoc	1/3/2011	no inspeciton notified	no inspection to date in this area	n/a	n/a									Need to review the state of implementation in the UHB. No MR Safety Expert appointed.
	Medical Physics	MHRA	Medical Physics	Managing Medical Devices 2015	Fiona Jenkins		Andrew Wood/Kathy Ikin	ad hoc	1/5/2011	no inspeciton notified	no inspection to date in this area	n/a	n/a									UHB generally compliant, mainly through Clinical Engineering.
	Haematology	Natural Resources Wales	Medical Physics UHL	The Environmental Permitting (England and Wales) Regulations 2010 (EPR 2010)	Fiona Jenkins		Andrew Wood/Kathy Ikin	annual	1/26/2018	11/1/2019	1 action, 1 reccomendation	2/28/2018	1									
	Medical Physics UHW	Natural Resources Wales	Medical Physics UHW	The Environmental Permitting (England and Wales) Regulations 2010 (EPR 2010)	Fiona Jenkins		Andrew Wood/Kathy Ikin	annual	4/30/2019		0	n/a	1									No local RWA. RWA audits complete. Support being given from Velindre NHS Trust
	Medical Physics	Office for Nuclear regulation	Medical Physics	The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009	Fiona Jenkins		Andrew Wood/Kathy Ikin	biannual	3/17/2017		4 non conformances, 3 reccomendaitons	5/1/2017	1									DGSA appointed. DGSA audits performed.
	Haematology	Research and Development			Stuart Walker																	
	Haematology	UKAS	Haematology/Blood Transfusion (UKAS)	ISO 15189			Andrew Gorringe/Alun Roderick	365	5/2/2019		25 findings	5/5/2019	1	97%	99%	1	6	10	0	0	2	
	Haematology	UKAS	Phlebotomy (UKAS)	ISO 15189			Andrew Gorringe/Alun Roderick	365	5/2/2019		included in Heamatology findings above	5/5/2019	1	97%	100%	0	0	0	0	0	2	
	Cellular Pathology	UKAS	Cellular Patholgy/ (Mortuary - UKAS)	ISO 15189	Fiona Jenkins		Adam Christian/Scott Gable	365	2/27/2019		14 findings	3/27/2019	1	98%	88%	95	49	247	3	122	2	

REGULATORY BODY REVIEW TRACKER - September 2019

	Biochemistry	UKAS	Biochemistry (UKAS)	ISO 15189	Fiona Jenkins		Carol Evans/Nigel Roberts	365	1/14/2019		25 findings	2/16/2019	1	93%	97%	2	12	68	20	60	2	**Incident In89824** - the issue sits outside of the departments control with NWIS, there is a service point call and Toxicology have a work around. **In91954** waiting for RCA report(USEP). **In92732** waiting RCA report (RLU issue Alinity analyser) In95843 – Investigation/corrective action sits with Estates as another exception on the spreadsheet
	Biochemistry	UKAS	Specimen Reception (UKAS)	ISO 15189			Carol Evans/Nigel Roberts	365	1/14/2019		2 findings and 1 reccomendation Included in findings of Biochemistry UKAS	2/16/2019	1	99%	100%	0	1	39	0	0	2	
		Welsh Water			Abigail Harris																	
	audiology	WSAC	audiology - adults	audiology quality standards			lorraine Lewis	3 yearly	Jun-19	Jun-22	compliant with 8 of 9 standards and meeting 85% target	2020	1									
	audiology	WSAC	Newborn hearing screeing wales	audiology quality standards			Jackie Harding	2 yearly	Jun-18	Jun-20	80% target met in all standards and 85% overall target met	Jan-19	1									
	audiology	WSAC	audiology - paediatrics	audiology quality standards			Jackie Harding/Rhian Hughes	2 yearly	Jun-18	Jun-20	80% target met in all standards and 85% overall target met	2020	1									
Specialist Services	Haematology	JACIE	South Wales BMT Programme	6th edition of JACIE standards	Stuart Walker		Keith Wilson	Every 4 years	4-5/02/2019	Feb-23	Minor deficiencies noted	Oct-19	1									
Specialist Services	Haematology	HTA	South Wales BMT Programme	Human Tissue Act	Fiona Jenkins		Xiujie Zhao	730	22-23/01/2019		1 minor	9/6/2019	1	97%	0%	0	0	0	0	0	2	
Specialist Services	Immunology	QPIDS	Immunology	Quality in Primary Immunodeficiency Services Standards	Stuart Walker		Stephen Jolles/Richard Cousins	365		10/1/2019												
Specialist Services	N&T	HTA	South Wales Transplant and NORS programme	Human Tissue Act	Fiona Jenkins		Rafael Chavez	Every 2 years	S-6/12/2016	self reported compliance due by 18/10/2019	Number of areas of good practice noted	2/7/2017	1		100%	0			0	0	2	
Specialist Services	ALAS	MHRA	ALAS (CAV)	Managing Medical Devices 2015	Fiona Jenkins		Paul Rogers	ad hoc														Awaiting to hear the inspection regime from MHRA to confirm with changes in the Medical Devices Regulations due to come into force in May 2020.
Specialist Services	ALAS	SGS/UKAS	ALAS (CAV)	ISO 9001:2015	Fiona Jenkins		Paul Rogers	185 (Twice Yearly)	19/20 June 2019	Jan-20	2 x Major Corrective Actiions, 1 X Minor Corrective Action, Several Opportunities for Improvement	6-Sep-19	1		100%	0			0	0		
Surgical Services	Perioperative	SGS/UKAS	SSSU	ISO 13485:2016			Clare Jacobs	annually	Jan-19	Sep-19	3 minors	1-Jan-20	1									
Surgical Services	Perioperative	SGS/UKAS	HSDU	ISO 13485:2017			Mark Campbell	annually	Aug-19	Aug-20	2 minors	1-Aug-20	1									

Regulatory and Accreditation Dashboard

Biochemistry ISO15189 inspection readiness

Improvement required on time of longest incident and CAPA.

Low likelihood of inspection

Haematology ISO15189 inspection readiness

Significant delays in capa management

Last inspections held on 3 - 5th April and 1 - 2 May 2019

Cellular Pathology ISO15189 inspection readiness

Overdue CAPA and incident is of concern.

ISO inspection arranged for March 2020.

Radiopharmacy MHRA inspection readiness

Good improvement on audit and Capa closure

Without clear estates plan closure is likley

High likelihood of inspection

Cellular Pathology/Mortuary HTA inspection readiness

Whilst the previous inspection has been closed successfully, the current performance on timeliness of closing CAPA and incidents needs continued improvement

SMPU Pharmacy production MHRA

significnatly overdue incidents and capa, reflects current escalation postion with the regulator

UHL Pharmacy MHRA inspection readiness

significantly overdue incidents and CAPA

High likelihood of inspection

BLood Transfusion Laboratory MHRA inspection

Inspection outcomes recently closed, MHRA on bimonthly monitoring to test sustainability
Improvement required on time of longest incident
Low likelihood of inspection

Stem Cell Processing Unit HTA

long standing capa closure related to change controls

Report Title:	**Declarations of Interest, Gifts, Hospitality & Sponsorship**								
Meeting:	**Audit & Assurance Committee**						**Meeting Date:**	**30.09.19**	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**	**X**	
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Corporate Governance Officer**								

SITUATION

Following a 'Limited Assurance' rating for Internal Audit, the Governance team have taken steps to strengthen and improve the Declarations of Interest, Gifts, Hospitality & Sponsorship (GH&S) Register, it's reporting and monitoring, whilst also raising more awareness around Standards of Behaviour across Cardiff & Vale UHB.

BACKGROUND

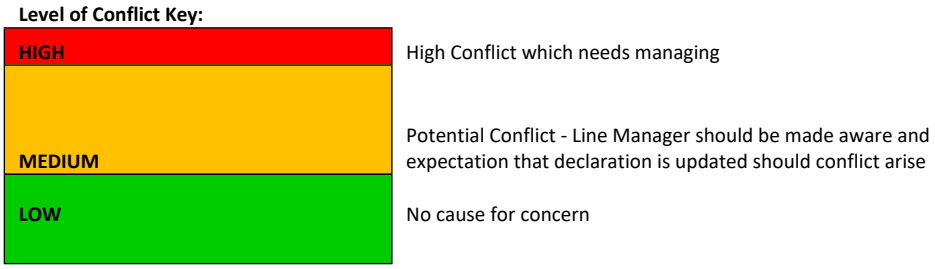
Following a number of recommendations outlined in a Limited Assurance Internal Report, the Governance team have:

- Implemented a specific email address, cav.declarations@wales.nhs.uk for Declarations of Interests G,H&S, to ensure forms are sent in centrally and to avoid them getting lost in the system
- Developed a comprehensive DOI register with a RAG rating system and also amalgamated the Gifts, Hospitality & Sponsorship register with this so there is one, single register held centrally
- Arranged an awareness campaign to be rolled out across the UHB with guidance directed at both staff and service users on information screens, social media campaigns and also an updated intranet page
- Implemented a monthly Declaration of Interest alert on the ESR system on or around the 21st of each month as this reaches approximately 11,000 staff logging on for payday
- Arranged to have a Governance stand at the monthly Corporate Induction Day reaching 100 new staff members per session to educate and advise them on Declarations of Interests G,H&S
- Developed a revised Standards of Behaviour Policy which is currently out for consultation before going to the Board for approval before the end of 2019
- Ensuring the Audit & Assurance Committee receive regular updates on Declarations of Interests, G,H&S.

ASSESSMENT

Since the Governance team have implemented the above steps the following number of Declarations have been received to date (20/09/2019)

- 707 Declarations of Interests, Gifts, Hospitality & Sponsorship Forms
- Cardiff & Vale UHB has 648 staff members banded 8a and above, out of these 20.4% of staff have returned their declaration forms. Where forms have not been received, a tracking and chase system is in place and monitored by the Corporate Governance Officer
- All Declarations of Interests G,H&S are reviewed before going onto the register to ensure they are compliant and completed correctly, when they are not compliant they are sent back with guidance to be resubmitted
- The Declarations of Interests G, H&S received are RAG rated by the Corporate Governance Officer to ensure appropriate action and monitoring. The RAG rating system is as follows:



To date, 76.67% of Declarations received are rated **Green**. These require no action and the individual is asked to complete a new form on a yearly basis and should circumstances change, a new form is to be submitted.

To date, 23.05% of Declarations received are rated **Orange**. These outline potential conflicts, eg, Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies, the individuals are made aware of their responsibility and importance to declare should a potential conflict arise, eg. Associated business tendering for a UHB contract. Line Managers are made aware of staff member's conflict to ensure they are managed appropriately.

To date. 0.28% of Declarations are rated **Red.** These are escalated to the Director of Corporate Governance for relevant action eg. Conflicts with the Blood Inquiry, the individual in question is asked to leave meetings when related discussions are taking place, arrangements are made to ensure the individual does not have sight of papers relating to the Inquiry etc.

- Where Declarations of G, H&S are received but not signed off by the appropriate Clinical Board Directors they are returned to the individual with guidance to be resubmitted.
- Declarations of Interests, G,H&S are now incorporated into the Workforce Organisational

Development Carousel to ensure they are incorporated into the Induction and PADR process

- Work with the Procurement Department is ongoing to develop to ensure the procurement team have sight of the Corporate Governance Declaration of Interest Register.

ASSURANCE is provided by:

Strong governance arrangements and the recent 'Substantial Assurance' rating for Internal Audit report.

RECOMMENDATION

The Audit & Assurance Committee is asked to:

- **NOTE** progress made by the Corporate Governance team to date
- **NOTE** the strengthened governance procedures implemented by the Corporate Governance team
- Be **ASSURED** that the new arrangements are sufficient following the recent 'Substantial Assurance' rating for Internal Audit Report

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

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

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

Cardiff and Vale University Health Board

Medicines and Healthcare products Regulatory Agency - Compliance

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Review reference:	C&V-1819-22
Report status:	Final Internal Audit Report
Fieldwork commencement:	11th April 2019
Fieldwork completion:	20th May 2019
Draft report issued:	22nd May 2019
Management response received:	2nd July 2019
Final report issued:	9th July 2019
Auditor/s:	Ian Virgil - Head of Internal Audit.
	Murray Gard – Principal Auditor.
Executive sign off:	Steve Curry – Chief Operating Officer.
Distribution:	Darrell Baker - Director of Pharmacy and Medicines Management.
	Matthew Temby - Director of Operations.
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.

1. Introduction and Background

The review of Legislative Compliance: Medicines and Healthcare products Regulatory Agency (MHRA) was completed in line with the Internal Audit Plan. The review provides the Health Board with assurance that compliance with MHRA requirements is being achieved.

The MHRA is the UK's regulator of medicines, medical devices and blood components for transfusion, responsible for ensuring their safety, quality and effectiveness. The scope of the current review will focus on the MHRA compliance requirements relating to medicines within Pharmacy.

The Health Board is required to have MHRA licences in place for all areas that make, assemble, import or distribute human medicines. The MHRA carry out inspections to establish the level of compliance with required practice and will report any identified failures to comply. The Health Board is then required to submit a response to the MHRA detailing the proposed corrective actions and implementation timescales to address the issues.

The relevant lead Executive Director for the assignment is the Chief Operating Officer

2. Scope and Objectives

The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of MHRA compliance, 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 establish if adequate processes are in place within Pharmacy to ensure compliance with MHRA requirements.

The main areas that the review sought to provide assurance on are:

- Current MHRA licences are in place for Pharmacy;
- Issues raised through MHRA inspections are appropriately addressed within the required timescales;
- Appropriate processes are in place for monitoring, reporting and escalating any issues relating to MHRA compliance; and
- Key risks relating to MHRA compliance are included on departmental risks registers and escalated for inclusion on the Health Board risk register as required.

3. Associated Risks

Reputational / patient safety risk due to non-compliance with MHRA regulations.

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 MHRA Compliance is **Reasonable assurance**.

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.

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.

The audit has confirmed that MHRA licences are currently in place at SMPU and University Hospital Llandough (UHL).

The controls in place within the Pharmacy and Medicine Management Directorate to manage the risks associated with MHRA compliance are of a reasonable standard. The audit did however note issues relating to tracking MHRA recommendations, attendance at scrutiny meetings and also risk management.

There is one high priority finding noted within this report relating to the absence of an effective tracker at the UHL site.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Current MHRA licences are in place for Pharmacy.				✓
2	Issues raised through MHRA inspections are appropriately addressed within the required timescales			✓	
3	Appropriate processes are in place for monitoring, reporting and escalating any issues relating to MHRA compliance			✓	
4	Key risks relating to MHRA compliance are included on departmental risks registers and escalated for inclusion on the Health Board risk register as required.			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as weaknesses in the control design for MHRA compliance.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the operation of the designed control for MHRA compliance.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1- Current MHRA licences are in place for Pharmacy.

We note the following area of good practice:

- Appropriate licences were in place at St Mary's Pharmaceutical Unit and at University Hospital Llandough.

We did not identify any findings under this objective.

Objective 2 - Issues raised through MHRA inspections are appropriately addressed within the required timescales.

We note the following areas of good practice:

- MHRA has recently completed an inspection of the SMPU in January 2019 with management's responses having just been accepted in March 2019.
- A tracker is in place for monitoring the responses to the Inspection with target dates and lead officers incorporated for the SMPU inspection.

We identified two findings under this objective:

- At the University Hospital Llandough site, the tracker does not provide sufficient detail to ensure an appropriate audit trail is maintained.
- At the SMPU site the tracker does not highlight revised implementation dates when targets are missed.

Objective 3 - **Appropriate processes are in place for monitoring, reporting and escalating any issues relating to MHRA compliance**

We note the following areas of good practice:

- Within the Directorate of Pharmacy and Medicine Management; SMPU has established a compliance and governance meeting with a scope to focus on MHRA inspection remediation and to highlight and identify any other regulatory concerns relating to the scope of activity at SMPU.
- These meetings also have terms of reference, standardised agendas, an active regulatory and compliance heat map data (performance information) and action tracker.

- The Clinical Board has established a Regulatory Compliance Group, which is a sub group of the Quality, Safety and Patient Experience committee.
- The Regulatory Compliance Group has a defined terms of reference that includes 'To receive feedback from regulatory inspection visits and to monitor and oversee actions arising from these inspections'.
- Highlight reports are sent from both SMPU and Llandough to the Clinical Board's Regulatory Compliance Group and these follow a standard structure that includes:
    1. Key performance indication;
    2. Key items for escalation; and
    3. Mitigation options and support required.
- The Clinical Board has also established a regulatory and accreditation dashboard (Heat Map) that details performance information including MHRA inspection readiness at the various sites.

We identified one finding under this objective:

- We identified that members of the compliance and governance meetings were not always in attendance.

Objective 4 - Review relevant departmental and / or Clinical Board risk registers to establish if any MHRA compliance risks are appropriately recorded and escalated where required.

We note the following areas of good practice:

- Audit reviewed the Pharmacy risk register (May 2019) and identified two risks relating to the MHRA.
- Risks can be raised from the departmental registers to the Clinical Board Quality Safety and Experience Sub Committee for potential inclusion on the Clinical Board Risk register.
- Risks from the Clinical Board can then be escalated corporately if required.

We identified one finding under this objective

- We identified that recorded risks were not always up to date and did not highlight an effective audit trail.

7. Summary of Recommendations

The audit findings and 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**	**3**	**0**	**4**

Finding 1 - Llandough MHRA inspection (Control design)	Risk
MHRA last completed an assessment of the Llandough site in December 2014 and identified seven deficiencies that required actions from the Health Board; these actions were closed during 2015. However during an internal Pharmacy review in 2018/19, circa four years since the last inspection; five issues were raised that required further work to ensure compliance with the current MHRA standards. Audit notes that the tracker in use to monitor this work does not provide the following: • Rationale for any linkage to the last MHRA inspection in 2014; • Date issues were last updated; • Reasons for missing any targets; • Revised target dates for implementation; and • Completion date of when issues have been resolved.	Reputational / patient safety risk due to non-compliance with MHRA regulations.
Recommendation 1	**Priority level**
The current tracker should be effectively updated to ensure that the outstanding deficiencies are rectified and an appropriate audit trail is maintained.	**High**
Management Response	**Responsible Officer/ Deadline**
The UHL (PSU) tracker has now been updated (3rd June 2019) In future, accepted practice will be for any deficiencies identified through self-inspection, audit or	Completed

via business intelligence e.g. regulatory inspection of other units or via a formal directive from MHRA (where new standards are implemented) will be raised as a new issue and tracked accordingly	

Finding 2 – St Mary's Pharmaceutical Unit - Tracker (Operating effectiveness)	**Risk**
An internal tracker for monitoring the implementation of MHRA deficiencies at the SMPU site was supplied to the auditor. Of the twenty three deficiencies identified thorough this review, seventeen of them have been recorded as complete. Of the six that have not been completed, the following is noted: • No revised target date is documented for any of the six; • No comments are noted on two of these, as to the reasons for not achieving the target.	Reputational / patient safety risk due to non-compliance with MHRA regulations.
Recommendation 2	**Priority level**
Management will amend the tracker to ensure an appropriate audit trail on how actions are progressing.	Medium

Management Response	Responsible Officer/ Deadline
The SMPU internal tracker has been amended to include the revised target date(s) for the 6 deficiencies noted above. They will be annotated to include narrative for the reasons for delay and updated target date	Principal Pharmacist (Quality Control and Qualified Person) by end of June 2019

Finding 3 - Monitoring (Operating effectiveness)	Risk
Within the Directorate of Pharmacy and Medicine Management, the SMPU has established a Compliance and Governance meeting with a scope to focus on MHRA inspection remediation and to highlight and identify any other regulatory concerns relating to the scope of activity at SMPU. However, from a review of the attendance register audit noted that three of the nine members have not attended any of the previous 6 meeting and a fourth member has only attended one meeting. Audit also notes that no such monitoring group was in place for Llandough.	Reputational / patient safety risk due to non-compliance with MHRA regulations.
Recommendation 3	**Priority level**
The terms of reference should be reviewed for appropriateness and staff should be reminded of the importance of attending and contributing to the compliance and governance meetings. Management should also consider setting up an equivalent meeting for the Llandough site or extending the remit of the current meeting to cover SMPU and Llandough.	**Medium**

Management Response	Responsible Officer/ Deadline
A single Compliance and Governance group for Pharmacy Technical Services i.e. UHL and SMPU has been agreed. The terms of reference were originally agreed before the establishment of a Clinical Diagnostics and Therapeutics Regulatory Compliance Group and so these terms and membership will be updated to reflect this change. The proposed membership change will reflect those who will be expected to attend regularly and those who should access when required.	Principal Pharmacist (Quality Control and Qualified Person) by end of June 2019

Finding 4 - Pharmacy Risk Register (Operating effectiveness)	Risk
Audit reviewed the Pharmacy risk register (May 2019) and identified two risks relating to the MHRA. These risks were entered in 2016 and have an assessment score of 10 and 8 out of 25 respectively. However, the following was identified; • No risk owner and risk handler have been identified; • No date of when the risks were last assessed; • No target risk score has been set; • Within one of these risks the 'what are we doing about it section' had a date of the 3rd March 2016, which is circa Three years out of date. The review also didn't note any risk relating to the outstanding deficiencies at the Llandough site that have been referenced earlier in this report.	Reputational / patient safety risk due to non-compliance with MHRA regulations.

Recommendation 4	Priority level
The risk register should be assessed for appropriateness and updated accordingly.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Pharmacy Directorate Risk Register has been reviewed and ownership of individual sections clarified. This includes the technical services components and a monthly review/update included in the senior team meeting agenda. In addition, our internal process for handling and escalating risks associated with pharmacy and medicines management activities and review through the Clinical Board has been agreed.	Principal Pharmacist (Education & Training/Quality and Safety) By end of July 2019

Appendix B - Assurance opinion and action plan risk rating

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 can take **no 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 **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.

Cardiff & Vale University Health Board

e-Advice Project

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NHS Wales Shared Services Partnership

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Draft report issued:	April 2019
Management response received:	June 2019
Final report issued:	June 2019
Auditors:	Martyn Lewis

Executive sign off:	Sharon Hopkins Director of Transformation, Improvement and Informatics.
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.

1. Introduction and Background

The review of the management of e-Advice within the Health Board has been completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Hospital Board ('the Health Board').

The relevant lead Executive for this review is the Director of Transformation, Improvement and Informatics.

e-Advice & Communications is a simple and auditable web-based messaging system designed and developed by Cardiff and Vale UHB that provides a mechanism whereby GPs and other primary care clinicians can easily request advice on non-urgent cases from secondary care consultants and receive a reply within 4 working days.

The service has been introduced with the aim of reducing the number of unnecessary referrals into secondary care by offering an alternative service by which primary care clinicians can receive timely expert advice for their non-urgent patients.

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 e-Advice, 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 e-Advice is subject to appropriate governance and testing, that data is securely transferred between systems and that it is producing the anticipated benefits.

The areas that the review sought to provide assurance on are:

- appropriate project governance is in place;
- costs and benefits defined within the business case are appropriately supported;
- an appropriately resourced plan for roll out of e-advice is in place and monitored;
- appropriate testing is performed prior to roll out, including system capacity;
- appropriate training on the use of the system is provided to users prior to roll out; and
- appropriate data transferred between systems is complete, accurate and secure with no duplicates or errors and that an appropriate audit trail is maintained.

3. Associated Risks

The potential risks that were considered in this review are as follows:

I. The project does not meet its deadlines;

II. Transfer of data is incomplete or contains errors.

III. The e-Advice project does not deliver the anticipated benefits.

IV. There are inadequate resources to meet the project objectives.

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 e-Advice is **Reasonable assurance**.

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.

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.

The original e-Advice project ended in 2016 without undergoing a formal closure process. Since then the e-Advice system has been managed as a live system rather than as a project.

The system is currently managed and supported primarily by two members of IM&T staff on a "best endeavours" basis, without any additional formal/

dedicated resource. In practical terms this has meant out of hours work has often been volunteered by staff in order to ensure the smooth running of the system.

It is understood that there is ongoing desire to expand the usage of e-Advice from existing users, and that more service areas have requested access to the system. Given this position an exercise should be undertaken to quantify the benefits currently being achieved by the system, with thought given to whether additional resource should be allocated in order to maximise these benefits and ensure that the smooth running of the system is maintained.

Another key issue identified is the need for a more formalised and documented approach to change testing. Changes are logged, and do require authorisation and testing stages, however the process would benefit from improved documentation. Testing of a sample of changes did highlight some issues with delivering bigger changes within the planned timescales, with lack of time/ resources being cited as the main reason behind this.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Project Governance			✓	
2	Costs and benefits		✓		
3	Project Plan				✓
4	Testing			✓	
5	Training				✓
6	Data Transfer/ Audit Trail				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for e-Advice.

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weakness in the operation of the designed system/control for e-Advice.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: An appropriate project governance process is in place for the system.

The e-Advice project ended in 2016, having been managed in conjunction with third party 'GE Healthcare'. Since then the system has no longer been managed as a project, but as a live application. GE Healthcare is no longer contracted by the Health Board and limited documentation relating to the original project was available during this audit.

Objective 2: Costs and benefits defined within the business case are appropriately supported.

The following area of good practice was noted:

- Outcome data is recorded for each case dealt with in the system.

The following significant finding was identified:

- No financial benefits were defined as part of the original project. An exercise to review and quantify benefits from the ongoing use of the e-Advice system is recommended to ensure benefits are maximised and that the system is adequately supported and resourced.

Objective 3: An appropriately resourced plan for roll out of e-advice is in place and monitored.

As per Objective 1, the system is not being managed as a project, but a live application, as such there is no requirement for a current roll out plan.

Objective 4: Appropriate testing is performed prior to roll out, including system capacity.

The following areas of good practice were noted:

- A dedicated test environment is in place for the testing of system changes;
- Access to the test environment is restricted to authorised users only;

- Changes must be authorised;
- A log of changes is in place and maintained.

The following significant findings were identified:

- The approach to testing and implementing changes is not currently documented. This should be created and include change categorisation, the extent of testing required, documentation of the approval process, the approach to rolling back changes, and criteria to be used when assigning a severity to changes.

Objective 5: Appropriate training on the use of the system is provided to users prior to roll out.

The following areas of good practice were noted:

- A range of e-Advice topics is made available to all staff via the training system.

There were no significant findings identified within this objective.

Objective 6: Appropriate data transferred between systems is complete, accurate and secure with no duplicates or errors and that an appropriate audit trail is maintained.

The following area of good practice was noted:

- Access controls are in place to restrict access to the system, with an account and password required;
- Password settings are sufficiently complex;
- Automated processes are in place to ensure data is transferred securely;
- A process is in place to review and rectify any data transfer errors;
- Audit logs of user activity are maintained.

The following significant finding was identified:

- e-Advice administration staff are currently dependent on local managers/ HR notifying them when a user/ staff member leaves in order that their e-Advice account is disabled, meaning it's possible for leaver accounts to remain active when this doesn't happen.

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**	**3**	**1**	**4**

Finding 1–Defined Benefits (Operating effectiveness)	Risk
An evaluation report summary and evaluation criteria produced by GE Healthcare before their contract ended was produced, however this was at an early stage and there has been no full assessment of the benefits of the project. The original stated benefits were given as: • Improved dialogue between primary and secondary care • Reduction in OP referrals by specialty • Reduction in New OP appointments by specialty • Improved patient experience • Improved education for Primary Care The e-Advice system is currently managed and supported primarily by two members of IM&T staff on a "best endeavours" basis, without any additional formal/ dedicated resource. Given the expanding use of the system, the UHB does not fully know whether the benefits deriving from the system warrant the resource, or an increased resource.	Impact to services due to insufficient resources.
Recommendation	**Priority level**
Management should undertake an exercise to review and quantify benefits from the ongoing use of the e-Advice system to ensure benefits are maximised and the system is sufficiently supported and resourced.	**Medium**

Management Response	Responsible Officer/ Deadline
With the resource available an exercise will be carried out to review and quantify the original key benefit identified in the project outline document 'a minimum of 10% avoidance of attendance in Outpatients is likely to be achieved by GPs implementing an e-advice service'. As part of the restructure process of the wider Digital team, we will look to increase our capacity for benefits realisation and evaluation. A wider benefits review will be carried as our service users recognise the benefits that e-Advice brings.	Head of Department. A benefits realisation exercise with regard to the original key benefit will be carried out within 3 months commencing on 1st June 2019.

Finding 2– Testing Processes (Operating effectiveness)	Risk
There is a lack of control of changes and testing. Due to the limited resources in place, changes to the system and testing of required changes is performed on a "best endeavours" basis. This means there is not always significant amount of documented evidence retained in relation to each change. Although a log of changes is maintained and priorities are assigned, this is done according to staff's assessment of the impact/ severity of the change, rather than following any documented criteria. Changes are typically identified through discussion with users and/or internal email request, followed by an exercise of determining requirements. Once initial development is complete, an updated version of e-Advice is released to the test environment. The requestor/s are then invited to test the change and respond	Uncontrolled changes impacting the availability of the system.

with any issues. From this point a go-live date is agreed. However these stages are not always evidenced.	
Recommendation	**Priority level**
Management should document the approach to testing and implementing changes. This should include documentation of requirements around change categorisation, the extent of testing required, the approval process, the approach to rolling back changes, and criteria to be used when assigning a severity to changes.	**Medium**
Management Response	**Responsible Officer/ Deadline**
There are processes in place to manage testing, approvals, roll back and assigning a severity to changes which allow for a quick response. It is recognised that these processes have lacked some formality due to the resource available. However work has already started on formal documentation to support ease of handover to other members of the department. This will be light-touch, with minimum documentation, aimed at supporting the change and testing process without being overly bureaucratic.	Head of Department. Work to formally document processes will take 3 months, commencing on 1st June.

Finding 3– Leavers (Operating effectiveness)	Risk
e-Advice administration staff are currently dependent on local managers/ HR notifying them when a user/ staff member leaves in order that their e-Advice account is disabled, meaning it is possible for leaver accounts to remain active when this doesn't happen. This risk is mitigated to some extent by the fact that an active directory/ network account is also required to access the system, and a process is in place to ensure active directory accounts are disabled after being inactive for 90 days.	Leaver accounts may remain active/ open to possible misuse.
Recommendation	**Priority level**
A regular, at least annual, exercise should be undertaken to confirm the validity of user accounts and ensure any leavers accounts are identified and disabled.	**Medium**
Management Response	**Responsible Officer/ Deadline**
A report to identify account inactivity of 90 days will auto-run daily following which inactive accounts will be closed. Accounts can be reactivated on request.	Head of Department. The report will be available to auto-run daily from 1st July 2019.

Finding 4– Superusers (Operating effectiveness)	Risk
User support for the system is currently primarily handled by two members of IM&T staff. There are no department based super users in place to deal with queries and act as a first point of contact. As the use of the system expands this level of resource within IM&T may not be able to cope.	Increased workload due to support queries/ impact to systems and services.
Recommendation	**Priority level**
Management should consider the use of local e-Advice super users.	**Low**
Management Response	**Responsible Officer/ Deadline**
The team are looking at ways to relieve the administration workload on them. A service announcement will be sent out to all super users reminding them of the actions that they can carry out e.g. authorising of accounts, closing accounts. New users are now able to self-register. Super users will be encouraged to take an increased role in user acceptance testing.	Head of Department. A service announcement will be sent out by the end of June 2019. Updated announcements will be published as required. Other proposed actions will be ongoing.

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.

Cardiff and Vale University Health Board

UHB Transformation Process

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	David Thomas, Director of Digital & Health Intelligence
Distribution:	Stephen Parnell, Assistant Director of Organisational Transformation Ruth Jordan, Head of Continuous Service Improvement
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.

1. Introduction and Background

The review of the Cardiff and Vale University Health Board (UHB) Transformation Process will be completed in line with the Internal Audit Plan.

The relevant lead Executive Director for the assignment is the Executive Director of Transformation, Improvement & Informatics.

The Health Board's strategy 'Shaping our Future Wellbeing 2015-2025' (SoFW) sets out the steps to achieving sustainable transformation.

In 2015/16 the Health Board began a focussed approach to transformation and worked with three Big Improvement Goals between September 2015 and November 2017.

In November 2016 a programme called 'Turning the Curve' was introduced which stopped the deteriorating financial position and delivered the Health Board's agreed financial deficit for 2016/17.

From April 2017 focus turned to the consideration of a sustainable approach to secure an improving financial picture whilst working to deliver SoFW and in July 2017 the Health Board introduced a serious consideration of application of international learning on achieving sustainable transformation.

The learning gained so far is being translated into the 'Cardiff and Vale Way' which has led to the development of the following seven strands or enablers for transformation:

- Secure a pathway approach and methodology;
- Secure a refreshed programme for accessible information for clinical staff (including the necessary platform) to drive improvement;
- Review the programme to secure a digitally enabled organisation the workforce;
- Develop Cardiff and Vale Alliance approach which integrates with partner organisations;
- Develop the Cardiff and Vale approach to management and leadership;
- Secure the model for Primary Care to drive a population outcomes approach for the system, enabling sustainability for general practice;
- Embed our vision (SoFW), values and behaviours.

Given the longer term strategic nature of the Transformation process, the scope of the current review was limited to the arrangements for developing, managing and implementing the seven enablers.

The longer term implementation of the Transformation process will be subject to review as part of future year's Internal Audit plans.

2. Scope and Objectives

The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of the UHB Transformation Process, in order to provide assurance to the Health Board Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review was to establish if the development of the seven enablers and the processes in place for their management and implementation are appropriate to allow for the effective future delivery of the Transformation Process.

The main areas that the review sought to provide assurance on were:

- The Health Board's rational for introducing a process of enablers was appropriate and a robust process was undertaken for identifying and selecting the 7 enablers;
- Effective governance arrangement are in place for each of the individual enablers;
- Appropriate progress is being made towards the implementation of each of the individual enablers;
- Robust processes are in place for monitoring and reporting progress and escalating any issues to appropriate management, Executives and to the UHB Board.

3. Associated Risks

- The Transformation process does not progress effectively due to inappropriate use and/or selection of enablers;
- Issues relating to the enablers are not effectively identified or addressed;
- The Health Board fails to deliver against its strategy in SoFW.

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 the UHB Transformation Process is **Reasonable assurance**.

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.

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.

Good progress has been made in the early introduction stages of the Transformation Project and the Enablers in place are supported by a clear rationale for their identification, use and application and these have been subject to scrutiny and approval by the Health System Management Board (HSMB) and UHB Board accordingly.

It is noted that subsequent to the issue of the audit assignment brief and commencement of our review, there was a reduction to 5 Enablers from a starting point of 7 whereby two have been merged into the Leadership and Culture Enabler. These changes have been formally approved by the UHB Board.

Overarching oversight and monitoring of progress towards delivery of the 5 Enabler's work plans are undertaken by a Transformation Enablers Steering Group which meets monthly and reports regularly to the HSMB and UHB Board. Additionally, the majority of the Enablers have individual governance groups in place and these report into the Transformation Enablers Steering Group accordingly.

However, three key findings were identified during our review and require management attention and action to ensure effective ongoing delivery of objectives. These are; absence of Clinical Board membership within the Transformation Enabler Steering Group, absence of a task and finish or appropriate oversight group in respect of the Accessible Information Enabler and the Transformation Enablers Steering Group not receiving a monthly Highlight Report in respect of the activity and progress of the Accessible Information Enabler.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Introduction Process for 7 Enablers				✓
2	Governance arrangements for Enablers			✓	
3	Progress Implementation of Enablers			✓	
4	Monitoring and Reporting of Progress				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted 1 issue that is classified as weakness in the system control/design for the UHB Transformation Process.

Operation of System/Controls

The findings from the review have highlighted 2 issues that are classified as weakness in the operation of the designed system/control for the UHB Transformation Process.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: The Health Board's rationale for introducing a process of enablers was appropriate and a robust process was undertaken for identifying and selecting the 7 Enablers.

The following areas of good practice were noted:

- The UHB's rationale for the introduction and use of the Enablers that inform and underpin the Transformation strategy is appropriate and is in alignment with the organisation's IMTP. This includes the process of streamlining from 7 to 5 enablers.
- The processes for their selection were robust and subject to scrutiny and approval by the HSMB and UHB Board.

There were no significant findings noted.

Objective 2: Effective governance arrangements are in place for each of the individual Enablers.

The following areas of good practice were noted:

- Oversight and progress relating to the delivery of the UHB Transformation Project is undertaken by a Transformation Enablers Steering Group which meets monthly and reports regularly to the HSMB.
- The majority of the Transformation Enablers have individual governance groups in place which report into and out of the Transformation Enablers Steering Group.

The following significant findings were noted:

- The Transformation Enabler Steering Group does not have any Clinical Board membership.
- The Accessible Information Enabler does not have a Task and Finish Group or any other formal Group that oversees and discusses the delivery of the Enabler's objectives.

Objective 3: Appropriate progress is being made towards the implementation of each of the individual Enablers.

The following areas of good practice were noted:

- Evidence of ongoing Progress made relating to the ongoing management and delivery of four of the five Enablers is formally and comprehensively recorded and reported to the Transformation Enablers Steering Group on a monthly basis.
- Review of the latest reports confirms that good initial progress is being made towards implementation of the four enablers.

The following significant finding was noted:

- The Transformation Enablers Steering Group does not currently receive a monthly Highlight Report with details of current progress in respect of the Accessible Information Enabler.

Objective 4: Robust processes are in place for monitoring and reporting progress and escalating any issues to appropriate management, Executives and onwards to the Board.

The following areas of good practice were noted:

- There is regular reporting of progress for each of the five Enablers to the UHB HSMB which is the primary Health Board meeting that provides oversight and scrutiny of the Transformation Programme.
- A summary of progress has also been provided directly to the UHB Board meeting.

There were no significant findings noted.

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**	**3**	**0**	**3**

Finding 1 - Transformation Enabler Steering Group - Clinical Board Engagement (Operating effectiveness)	Risk
Good practice is noted that there is Clinical Board awareness of the Transformation Project through attendance of Clinical Board Directors at the HSMB and Transformation Team members attending Clinical Board meetings. Additionally, there is also evidence of Clinical Boards starting to use the Enablers to inform their own planning processes. However, at the time of the audit there are no specific, nominated Clinical Board Leads that attend the Transformation Enabler Steering Group who may liaise with, inform and contribute directly into each Enabler as well as feedback progress to their respective Clinical Boards.	Issues relating to the Enablers are not effectively identified or addressed.
Recommendation	**Priority level**
The Transformation Enabler Steering Group should consider including nominated Clinical Board Leads to contribute directly into each Enabler where appropriate and actively inform the development of progress.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Each enabler task and finish group links with Clinical Boards and have involvement of staff . We will review this with the Boards in order to improve engagement. We will consider whether a lead or link person from each Board would improve engagement.	Steve Parnell 24th May 2019

Finding 2 - Absence of an Accessible Information Enabler Work Group (Control design)	Risk
The Accessible Information Enabler does not currently have a Task and Finish Group or a formal Group that oversees and discusses the delivery of the Enabler's objectives. Given the size and complexity of the objectives that form the Enabler work plan it would be advisable to have such a forum that includes relevant parties that contribute to the Enabler, provides governance and oversight and which reports into the Transformation Enablers Steering Group on a monthly basis.	Issues relating to the Enablers are not effectively identified or addressed.
Recommendation	**Priority level**
The Accessible Information Enabler should implement a formal Task and Finish Group that oversees and provides governance of delivery of the Enabler's objectives and interfaces with the Transformation Enablers Steering Group.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Accessible information enabler work is being reported to a number of different groups, which ensures oversight and assurance. These include HSMB, the "signals from Noise" steering group chaired by the CEO and the new Digital Design Group being established in October 2019 which will include membership from the Executive Management team and Clinical Boards. In addition, the accessible information enabler work will be reported into the new Digital & Health Intelligence committee, a new formal committee of the Board.	David Thomas 30th September 2019

Finding 3 - Accessible Information Enabler - Absence of Monthly Highlight Reporting (Operating effectiveness)	Risk
Good practice is noted that 4 of the 5 Enablers provide a monthly Highlight Report to the Transformation Enablers Steering Group that states progress against project milestones, written and RAG rated accomplishments and risks relating to their respective objectives. However, a review of the monthly Highlight Reports produced between November 2018 and March 2019 does not show any progress reporting relating to the Accessible Information Enabler. It is acknowledged that the work plan relating to the Accessible Information Enabler is presented to the Transformation Enablers Steering Group but this could not be evidenced in the Group's meeting notes.	The transformation process does not progress effectively due to inappropriate use and / or selection of Enablers.
Recommendation	**Priority level**
Progress relating to the Accessible Information Enabler should be recorded and reported via a monthly Highlight Report to the Transformation Enablers Steering Group in parity with the four other Enablers.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Following discussion between the ADI of Information and the steering group project manager, it is proposed that given the breadth and complexity of the accessible information enabler, the monthly reporting continues to be provided in the format that conveys the issues, actions and updates previously shared. This has been agreed with the AD of organisational change/transformation.	David Thomas 30th September 2019

Appendix B - Assurance opinion and action plan risk rating

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 can take **no 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 **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.

Standards of Business Conduct (DoI & GH&S) Follow-up

Final Internal Audit Report

Cardiff and Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Committee:	Audit Committee

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

ACKNOWLEDGEMENT
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

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

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

1. Introduction and Background

The follow-up review of Standards of Business Conduct will be completed in line with the Internal Audit Plan.

The relevant lead Executive for the assignment is the Director of Corporate Governance.

The original report was finalised in November 2018 and highlighted a total of six findings, which resulted in an overall assurance rating of limited assurance.

2. Scope and Objectives

The objective of the original review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for the management of standards of behaviour, in order to provide assurance to the UHB Audit Committee that risks material to the achievement of systems objectives are managed appropriately.

The purpose of the follow up review was to establish if the previously agreed management actions have been implemented, in order to ensure that the Health Board has appropriate processes in place to ensure that all its employees and Independent Members practice the highest standards of conduct and behaviour.

In following up the agreed actions the main areas that the review sought to provide assurance on were:

- The Health Board has an appropriate and up to date Standards of Behaviour Framework Policy in place and this is widely available to all relevant parties;
- Effective processes are in place to ensure that all employees and Independent Members are aware of the requirements of the Standards of Behaviour Framework and have access to appropriate information, support and advice;
- Effective Arrangements are in place to ensure that specific groups of Employees and Independent Members complete a Declaration of Interest (DoI) Form on initial employment with the UHB and at periodic intervals thereafter;
- The Health Board has an up to date Register of Interests in place and the content is reported to the Audit Committee at agreed intervals;
- Effective processes are in place for ensuring that employees and Independent Members declare any offer of a gift, hospitality or sponsorship which requires recording; and
- A Register of all declared Gifts, Hospitality and Sponsorship (GH&S) whether, accepted or declined, is maintained and the content is reported to the Audit Committee at agreed intervals.

3. Associated Risks

The potential risks considered in this review are as follows:

- Lack of awareness and / or application of the required standards of behaviour;
- Relevant interests are not declared which could lead to inappropriate decisions / actions; and
- Inappropriate acceptance of gifts, hospitality or sponsorship.

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.

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.

The Corporate Governance Team has made significant improvements to enhance the systems and controls in place for Standards of Behaviour within the organisation.

The out of date policy has been revised and shared at the appropriate groups and will be presented at Audit Committee in September 2019. They have an extensive improvement plan in place to help address the awareness of the policies and procedures, which has already had an impact on the responses received.

A new DoI Register has been created and both the DoI and GH&S forms have been updated to ensure that all the required information is captured and is in line with the policy. Links to the Intranet page have also been incorporated into the policy and to the revised forms.

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Standards of Business Conduct has significantly improved to **Substantial Assurance**.

5. Summary of Audit Findings

Follow up work was undertaken to confirm the progress that the Health Board has made against the agreed management responses from the original audit, as detailed within Appendix A.

In summary, progress against the six agreed recommendations that required implementation is as follows:

Priority rating	No of management responses to be implemented	Fully actioned	Partially actioned	Not actioned	Not Applicable
High	3	3	0	0	0
Medium	3	3	0	0	0
Low	0	0	0	0	0
Total	**6**	**6**	**0**	**0**	**0**

The detailed findings are reported in the updated management action plan at Appendix A.

Original Finding 1 - Comprehensive DOI register (Control design)	Risk
The Corporate Governance Team is responsible for maintaining the Declaration of Interests (DoI) and Gifts, Hospitality & Sponsorship (GH&S) registers. Annual requests for the completion of DoI are sent out by the Corporate Team to Independent Members and Board Members. However there is no current process in place to ensure that the other key groups of staff listed in the policy complete declarations. As per the policy point 6.2.2, Divisional directors, managers, nurses and equivalents and senior finance staff are required to complete a DoI on an annual basis. A list of Clinical Board management team members was obtained and compared to the Non-Board Register which has 28 returned DoI forms. Testing found that none of the required individuals had completed a DoI. Further testing was carried out and lists of consultants was obtained from three Clinical Boards; Specialist Services, Medicine and Surgery. From a list of 398 names only one individual was listed with a completed DoI form. Furthermore no Senior Finance staff were identified on the DOI Register.	Relevant interests are not declared which could lead to inappropriate decisions / actions.
Original Recommendation	**Priority level**
A system is introduced that will ensure that declarations are received from all required staff at the appropriate intervals as set out in the policy. The process will also ensure that missing returns are chased up and that the register is complete and accurate.	**High**

Original Management Response	Responsible Officer/ Deadline
Recommendation Agreed – a process will be developed to ensure that key staff groups listed within the policy complete declarations as set out in the policy and that those who do not are chased up.	Head of Corporate Governance 31st December 2018

Current Position

Action Complete

A new Declaration of Interests (DoI) and Gifts, Hospitality & Sponsorship (GH&S) register has been created, which now includes over 648 people who are either Executive Directors, Independent members or employees Band 8 and above.

The process for requesting annual declarations has substantially improved. An email was sent out at the end of May 2019 to all Executive Directors and Clinical Boards, Line Managers and Independent Members asking them to;

- Ensure that all staff are aware of the need to declare any interests, gifts, hospitality and sponsorship (for gifts, hospitality and sponsorship they need to be report those offered as well as those accepted).
- Ensure that staff Band 8a and above and those who are able to commit/approve expenditure complete, sign and return to us a declaration of interest form; this includes any nil returns.
- Ensure that for all gifts, hospitality and sponsorship offered/received, a declaration form is completed and sent to the Corporate Governance Team using the specific email address that has been set up capture this information. CAV.Declarations@wales.nhs.uk

At the end of July 2019, 131 responses had been received as a result of the above email. The Corporate Team have also introduced a follow up process whereby a reminder email is sent out 3 weeks after the original email. A further 3 weeks is then given and if no response is received these individuals will be escalated to the Head of Governance.

The Corporate Team has also introduced a RAG rated system to the DoI register to help identify any declaration of interests that could result in potential conflict, which allows the Corporate Team to inform the necessary managers of this information.

In addition the revised DoI form has been added to the induction page and the WOD Carousel for staff to complete during induction day and also during annual appraisals. Further discussion have been held with Workforce to consider options of completing the DoI forms as part of the employment process either through Trac or ESR.

Original Finding 2 - Awareness of the policy (Control design)	Risk
With the limited number (28) of Non-Board level staff having completed a Declaration of Interest along with a much lower than expected level (24) of declaration of Gifts and hospitality, it indicates that the level of awareness of the Standards of Behaviour Policy is insufficient. The Standards of Behaviour policy is not discussed during the induction process for new starters to the UHB. Information is available on the intranet although navigating to the relevant pages could be made easier. There are no processes or programmes in place to improve awareness and therefore the UHB will continue to report inaccurate data.	Lack of awareness and / or application of the required standards of behavior.
Original Recommendation	**Priority level**
The Corporate Team must put processes in place to help raise awareness of the policy to ensure that all employees within the UHB are complying with the required standards of behaviour. Enhancements should be made to the intranet page to improve the navigation to the policy and associated forms and guidance.	**High**
Original Management Response	**Responsible Officer/ Deadline**
Recommendation Agreed – A review of the information available on the intranet will be undertaken to ensure that the information is easy to access. A programme of awareness raising will also be developed alongside the process detailed in	Head of Corporate Governance 31st December 2018

recommendation 1 which will be continual and not a one off awareness raising programme.	

Current Position

Action Complete

Hyperlinks to the Intranet page for Standards of Behaviour have been included to the original policy.

An improvement plan has been designed by Corporate Team to help raise awareness of the policy and address our original recommendations. The plan includes actions that have already been completed, planned actions for September/October 2019 and long term plans for 20/21.

To help raise awareness of the organisations standards of behaviour, an agreement was made with the ESR team to have a monthly alert set up to remind staff of the policy, which has on average 2,500 – 3,000 staff logging on per day. In the first month of this taking place a further 300 responses were received in the department, therefore making the total returns at the time of the audit to 431.

The plan going forward to help raise awareness of the DoI and GH&S policy is to link in with the line managers development sessions and have a 15 minute slot to explain the policy and what their staff are required to do with regards to DoI and GH&S forms. The monthly ESR alert will also continue each month.

Discussions have been held with the Communications Team to go through and Comms and engagement plan on how to set out the awareness campaign across the UHB. This is to include leaflets to hand out to new staff members, visual guidance displayed across the hospital for staff members and members of the public, social media campaigns, new intranet section, posters etc.

Original Finding 3 - Gifts, Hospitality and Sponsorship Compliance (Control design)	Risk
Testing of a sample of entries recorded in the register identified : • Two entries that had been accepted were potentially inappropriate. • It was noted on one form that the gift was to be used as a raffle prize, but this was not recorded on the register and no further details provided. • 1 form was missing; • 2 forms had been provided for a member of staff but the register only recorded 1; • 4/12 forms did not state if the gift, hospitality or sponsorship had been declined or accepted; • 8/12 forms did not have approval from relevant director prior to the event; • 1 form had been signed before being submitted to the Governance Department; • 3/12 forms had not been signed by Governance Department; • None of the forms are recorded in date/chronological order on the register; • While testing was being undertaken it was found that there were forms recorded on the accepted tab that had not been transferred to the current register, and vice versa. Little reliance could be placed on how many forms had been received throughout 17/18 and to date as there was no consistency between these recordings. A separate sheet records entries that have been declined.	Inappropriate acceptance of gifts, hospitality or sponsorship.

Original Recommendation	Priority level
The Corporate Team should ensure that all forms are compliant with the SoB Policy and completed appropriately. The current format of the register needs to be reviewed, updated and amalgamated into a single register.	**High**
Original Management Response	**Responsible Officer/ Deadline**
Recommendation agreed – all submitted forms to be reviewed in line with the Policy to ensure compliance and appropriately completed. Register will be reviewed and updated and amalgamated into an appropriate format including recording in chronological order, whether the declaration has been accepted and also signed off.	Director or Corporate Governance – immediate and ongoing Head of Corporate Governance
Current Position	
Action Complete All submitted GH&S forms are reviewed by the Corporate Governance Officer to ensure compliance before they are added to the register. If not compliant they are sent back with guidance to complete correctly. Furthermore any forms that have not been approved by the Clinical Board Director are flagged to the Director of Corporate Governance and this is recorded on the register. A plan for training sessions to be delivered by the Corporate Governance team across Cardiff & Vale UHB to ensure all staff members know how to complete the forms correctly and the importance of declaring is understood. A sample of returned GH&S forms were reviewed to ensure that they had been completed in line with the policy. Nothing significant was found during this exercise.	

Original Finding 4 - Out of date policy (Operating effectiveness)	Risk
The Standards of Behaviour Framework policy was published 15th January 2015. The review of this policy should be undertaken no later than three years after the date of approval and is therefore currently out of date.	Lack of awareness and / or application of the required standards of behavior.
Original Recommendation	**Priority level**
The directorate should ensure that the policy is reviewed and updated accordingly with the appropriate approval for changes sought where necessary.	**Medium**
Original Management Response	**Responsible Officer/ Deadline**
Recommendation Agreed – policy to be reviewed and updated in line with best practice and up to date guidance.	Head of Corporate Governance - 31st December 2018
Current Position	
Action Complete The Standards of Behaviour Draft Policy went to the Local Partnership Forum prior to the scheduled Board meeting in September. There were some constructive comments made regarding the policy during that meeting, which has resulted in some slight amendments. The policy is still scheduled to go to the Board for approval at the end of September 2019. Once this has been approved it is to be updated on the intranet page and distributed to all appropriate staff members / departments across UHB. The new policy will be made available on Intranet pages with clear, easy access.	

Original Finding 5 - Declaration of Forms (Operating effectiveness)	Risk
A sample of 10 DoI forms from both the Independent Board Member Register and Non Board Register was obtained. Testing was carried out to ensure all 20 DoIs were up to date and in place. The following was identified: • 3/20 forms showed they had been signed by a member after the date of return to the corporate governance section; • 2 members were on the register twice, however only one form was submitted for each; • 1 DOI form was signed by member in September 2017, making their declarations out of date at the time of testing; • One form was not dated on return; It was also noted at the time of testing that one Board Level Director did not have a completed DoI.	Relevant interests are not declared which could lead to inappropriate decisions / actions.
Original Recommendation	**Priority level**
The Corporate Team should ensure that all forms are compliant with the SOB Policy and completed appropriately.	**Medium**
Original Management Response	**Responsible Officer/ Deadline**
Recommendation Agreed – Forms will be reviewed for compliance with the new policy once reviewed and up until then forms will be reviewed for compliance with the current policy.	Head of Corporate Governance - immediate

Current Position
Action Complete All submitted DoI forms are reviewed by the Corporate Governance Officer to ensure compliance before they are added to the register. The DoI form has been updated to include a hyperlink to the policy and now asks the reader to certify that they have read and understood the policy. Any returned forms that have not been 'ticked' to confirm this, are sent back to individual by the Corporate Governance Officer asking them to complete this section of the form. A sample of returned DoI forms were reviewed to ensure that they had been completed in line with the policy. Nothing significant was found during this exercise.

Original Finding 6 - Audit Committee (Control design)	Risk
Although the DoI and GH&S registers were reported at the September 2018 Audit Committee, the information contained within the report was incomplete, due to the limited number of returns received. In addition the format and layout of the report was inadequate.	Relevant interests are not declared which could lead to inappropriate decisions / actions. Inappropriate acceptance of gifts, hospitality or sponsorship.
Original Recommendation	**Priority level**
The Corporate Governance department must ensure that the information provided to the Audit Committee contains a full picture of the level and nature of declarations received and information on declarations not received.	**Medium**
Original Management Response	**Responsible Officer/ Deadline**
Recommendation Agreed – Future reporting to the Committee will ensure that the report is complete and in a suitable format to allow challenge and assurance of the registers.	Director of Corporate Governance – February 2019
Current Position	
Action Complete A new register has been created which allows the levels of DoI returns to be easily identifiable and those that have not. An escalation process is in place to address those that have not returned a completed form. A copy of the new DoI and GH&S	

Register will be submitted to Audit Committee in September 2019 for noting. DoI will be a standing agenda item at Audit Committee every six months with a paper for discussion, action and approval as and when required.

Appendix B - Assurance opinion and action plan risk rating

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 can take **no 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 **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.

Cardiff and Vale University Health Board

Annual Quality Statement

Final Internal Audit Report

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Auditor/s:	Elizabeth Vincent, Principal Auditor
Executive sign off:	Ruth Walker, Executive Nurse Director
Distribution:	Carol Evans, Assistant Director Patient Safety and Quality Ann Jones, Patient Safety and Quality Assurance 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.

1. Introduction and Background

The review of the 2018/19 Annual Quality Statement has been completed in line with the Internal Audit Plan. The review seeks to provide Cardiff and Vale University Health Board (the 'Health Board') with assurance regarding the process for the production of the Annual Quality Statement.

The relevant lead Executive Director for the review is the Executive Nurse Director.

The Health Board is required to publish an Annual Quality Statement (AQS) by 31st May 2019 reporting on the 2018/19 year. The AQS is a statement from the Board to the public.

2. Scope and Objectives

The overall objective of the review was to assist the Health Board with accuracy checking, including the triangulation of data and evidence, before the publication of the Annual Quality Statement.

The scope was limited to assisting the Health Board to ensure that the Annual Quality Statement is accurate, complete and consistent with information reported to the Board over the period. In addition, consideration will be given to compliance with Welsh Government guidance for 2018/19.

The main areas the review sought to provide assurance on were:

- The AQS is compliant with the relevant Welsh Government guidance.
- Planned developments and stated challenges identified in the 2017/18 AQS are appropriately reported in the 2018/19 submission.
- The timetable for the production and publication of the AQS is appropriate.
- There has been appropriate stakeholder engagement in the production and review of the AQS.
- Performance information / data demonstrating 2018/19 achievements and challenges is appropriate and consistent with our knowledge of the Health Board.
- Performance indicators detailed in the AQS are accurate and can be validated back to source information. We will test a sample of two performance indicators detailed in the AQS.

3. Associated Risks

The potential risks considered in the review are:

- Failure to follow Welsh Government guidance.

- The public is not clearly informed of any improvement and challenges experienced in the range of services provided, as well as improvement priorities for the forthcoming year.
- The information detailed in the AQS is incomplete and / or incorrect.

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 **Annual Quality Statement** is **Substantial** assurance.

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.

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.

The UHB continues to have robust processes in place to produce and publish the Annual Quality Statement (AQS) in line with the set timetable. Even though the Health Board had to work to a much tighter deadline this year, at the time of review they were on track to publish the document by the required date of 31st May 2019.

The statement is presented in a clear and user friendly format that should be easily understood by its audience. The AQS provides a clear assessment of how well the Health Board is doing, identifies areas that require improvements and reports on the progress it has made year on year.

This is communicated through the key themes that are in line with the Health and Care Standards for Wales and the Health Boards Quality Safety and Improvements (IQS) Framework.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	The AQS complies with WG guidance				✓
2	2018/19 developments and challenges are appropriately recorded				✓
3	The AQS timetable is appropriate				✓
4	There has been appropriate stakeholder engagement				✓
5	There is appropriate data to support 2018/19 achievements and challenges is appropriate and consistent with our knowledge of the trust				✓
6	PIs detailed in the AQS are accurate			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have not highlighted any issues that are classified as weakness in the system control/design for the Annual Quality Statement.

Operation of System/Controls

The findings from the review have highlighted one issue that is classified as weakness in the operation of the designed system/control for the Annual Quality Statement.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan at Appendix A.

Objective 1: The AQS is compliant with the relevant Welsh Government guidance.

The following areas of good practice was noted:

- The draft AQS report incorporates the key requirements of the Welsh Health Circular that was issued by the Welsh Government in January 2019;
- The AQS provides a clear assessment of how well the Health Board is doing, identifies areas that require improvements and reports on the progress it has made year on year. This is communicated through the key themes that are in line with the Health and Care Standards for Wales and the Health Board's Quality Safety and Improvements (IQS) Framework.
- The AQS contains a mixture of case studies and patient stories that is based on this year's theme 'Older Person' and continues to use infographics in a meaningful way to present the information clearly to the public;
- The AQS continues to provide signposts to key documents and links to detailed information, particularly around how feedback can be received within the Health Board;
- The AQS is written in plain English that would be understandable to those with no knowledge of the subject matter, and refrains from using terminology that is NHS specific.

There were no significant findings identified under this objective.

Objective 2: Planned developments and stated challenges identified in the 2017/18 AQS are appropriately reported in the 2018/19 submission.

The following areas of good practice was noted:

- The planned developments and stated challenges that were identified in the 2017/18 AQS are appropriately reported against in the 2018/19 submission.
- The majority of the developments and challenges progressed within the year had been updated through the narrative of the relevant quality theme.

There were no significant findings identified under this objective.

Objective 3 - The timetable for the production and publication of the AQS is appropriate.

The following areas of good practice was noted:

- The UHB had developed an appropriate timetable for compilation, review, design, approval and publication of the 2018/19 AQS, which was shared at the December meeting of the Quality Safety and Experience Committee; and
- We could evidence that the deadlines set in the timetable for the production of the AQS had been met, therefore confirming that the timeframe was realistic to ensure that the report will be finalised in line with the Welsh Government deadline of 31st May 2019.

There were no significant findings identified under this objective.

Objective 4: There has been appropriate stakeholder engagement in the production and review of the AQS:

The following areas of good practice were noted:

- Appropriate engagement took place with a range of internal and external stakeholders in the development and review of the AQS; and
- The AQS had been discussed at length at the Stakeholder Reference Group that was attended by key staff.

No significant findings were identified under this objective.

Objective 5: Performance information / data demonstrating 2018/19 achievements and challenges is appropriate and consistent with our knowledge of the Health Board:

The following area of good practice was noted:

- Through our general awareness of the organisation and the range of audit reviews that have been carried out in 2018/19 we are able to confirm that the achievements and challenges that have been documented in the draft 18/19 AQS are appropriate.

No significant findings were identified under this objective.

Objective 6: Performance indicators detailed in the AQS are accurate and can be validated back to source information:

The following area of good practice was noted:

- The performance indicators detailed in the AQS have been used appropriately to support improved performance detailed within the narrative for each quality theme.
- Review of the performance indicators relating to Timely Care confirmed that the figures were accurate and could be traced back to source data.

No significant findings were identified under this objective.

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**	**0**	**1**	**1**

Finding 1 - Accuracy of data (Operating Effectiveness)	Risk
A sample of seven performance figures from the Staying Healthy theme was verified back to the source information to ensure the data entered into the draft AQS was accurate. During this process it was identified that one of the seven figures shown related to last year's data and should not have been included in the report. This oversight has been acknowledged by the Patient Safety & Quality Manager and the draft AQS will be updated to reflect this. Evidence was provided to support the remaining six performance figures.	The information detailed in the AQS is incomplete or incorrect.
Recommendation	**Priority level**
The department should consider incorporating an accuracy check of all data into the AQS timetable, which should be done as late as possible in the AQS process.	**Low**
Management Response	**Responsible Officer/ Deadline**
The Patient Safety and Quality team will introduce a process whereby there is time set aside (and included within the timetable) to undertake all the necessary data quality checks, before the final version is agreed. This will be included in the paper to the December 2019 QSE Committee.	Assistant Director Patient Safety and Quality/ December 2019

Appendix B - Assurance opinion and action plan risk rating

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 can take **no 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 **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.

Carbon Reduction Commitment

Final Internal Audit Report

2019/20

Cardiff and Vale University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Abigail Harris, Director of Planning
Distribution:	Geoff Walsh, Director of Capital, Estates & Facilities Jon McGarrigle, Trust Energy Advisor Fitzroy Hutchinson, Energy Manager
Committee:	Audit Committee

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

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.

Disclaimer notice - Please note:

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

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

1. Introduction and Background

The CRC Energy Efficiency Scheme (CRC) is a UK Government initiative to reduce carbon dioxide (CO2) emissions from large and medium-sized organisations meeting certain qualification criteria.

Participation for such organisations, including C&V UHB, is mandatory. The first phase of the scheme ran from April 2010 to the end of March 2014. The second phase (in to which health boards joined) runs from 1 April 2014 to 31 March 2019.

The UK government announced in 2016 that the CRC energy efficiency scheme will be abolished following the 2018-19 compliance year. This will therefore be the final audit of the UHB's participation in the scheme.

Health Boards are required to submit their annual report by 31st July 2018.

The CRC guidance states a requirement for participants to be subject to annual internal audit review to ensure compliance with guidance.

2. Scope and Objectives

The assignment originates from the 2019/20 internal audit plan. The subsequent report will be reported to the Audit Committee.

The overall objective of the review was to assess compliance with CRC requirements and guidance.

The scope of the audit review was limited to the following aspects:

- A review of the 2018/19 annual report (due for submission by 31st July 2019), to assess:
- Accuracy of reported figures/totals;
- Correct treatment of data including actuals/estimates, inclusions/exclusions etc.; and
- Audit trail to supporting evidence;
- A review of the final position in terms of management of allowances; and
- Sufficiency of the Evidence Pack, including document retention arrangements following closure of the scheme (required until March 2025).

This review drew on the findings of relevant audit assignments undertaken within the reporting year to prevent any duplication.

3. Associated Risks

The potential risks considered in the review are as follows:

- Previous agreed recommendations have not been implemented;

- CRC guidance is not being followed;
- Reported data is inaccurate, which may incur financial penalties;
- Failure to sufficiently budget for, or achieve value for money from, the purchase of allowances;
- Evidence pack is not appropriately maintained.

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 risks associated with established controls within the Carbon Reduction Commitment audit is a **substantial assurance**.

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.

Our review has confirmed that the Health Board had appropriate processes in place for calculating the data for inclusion within its CRC report for 2018/19, the final year of the CRC scheme.

The Health Board identified issues with the data calculated via the Bureau database which lead to a change in the process for calculating the CRC data. A prudent approach was however adopted utilising a combination of British Gas statements and last year's data to ensure that appropriate usage figures were recorded.

The Health Board has retained an appropriate evidence pack to support the CRC report and this provides an adequate audit trail.

The CRC report and associated data was formally submitted by the Health Board before the required deadline of 31st July 2019.

Following surrender of the required allowances for 2018/19, the Health Board will be left with a potential surplus of allowances. A plan for selling the surplus allowances will need to be agreed and actioned as soon as possible to ensure that the Health Board maximises the potential income.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Report Data Testing				✓
2	Purchase of Allowances			✓	
3	Evidence Pack Maintenance				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted 0 issues that are classified as weaknesses in the system control/design for Carbon Reduction Commitment.

Operation of System/Controls

The findings from the review has highlighted 1 issue that is classified as a weakness in the operation of the designed system/control for Carbon Reduction Commitment.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Report Data Testing.

The following areas of good practice were noted:

- The HB has an external consultant who is responsible for the preparation of the CRC report after the relevant information have been provided by the HB and keeps the HB on track regarding any legislative updates;
- There was a clear audit trail from the CRC spreadsheet prepared by the consultant to demonstrate where the data in the report came from. Working papers showed supporting calculations of how data was arrived at;
- Due to computational issues identified with the Health Board's Bureau database, the data for the current year's CRC report was based on a review of British Gas statements and last year's figures. A prudent approach was adopted to ensure that appropriate figures were recorded;
- Sample testing carried out on the reported CRC data confirmed that the majority of figures had been correctly determined; and
- Where estimated figures were utilised these were deemed appropriate and were subject to the required uplift prior to reporting.

There were no significant findings identified under this objective.

A detailed review of the CRC computation excel document did however identify the following errors:

- Within the Gas sites Gas MPR, 9094729000, there was an error of 100 kWh. The supplier's statement stated 294,341.06 but 294,271.06 had actually been recorded; and
- The Electric solar which relates to the University Hospital Llandough and Barry Hospital sites was recorded as 71,265 KWh. This however only related to 1 site and the actual total figure should have been 165,663 KWh relating to the following 4 areas:

- HYC Llandough (70kW) generated 52,116 kWh (18/19)
- HYC Llandough (50kW) generated 38597 kWh (installed 15/05/18)
- Rookwood (50kW) generated 51451 kWh (installed 15/05/18)
- Barry Hospital generated 23499 kWh (18/19)

It is noted that both of these errors were fully corrected before submission of the final CRC report on 30/07/19.

Objective 2: A review of the final position in terms of management of allowances.

The following areas of good practice were noted:

- The HB submitted their CRC report on 17/7/19 before the deadline of 30/07/19; and
- The HB has sufficient allowances brought forward from previous years to cover the required surrender for 2018/19.

The following significant finding was identified under this objective:

- Following the surrender of allowances for 2018/19 the Health Board will be left with a potential surplus of 1,779 allowances. As this is the final year of the scheme, the Health Board will need to ensure that it agrees and implements a strategy for selling the surplus so as to maximise the level of income received.

Objective 3: Sufficiency of the Evidence Pack, including document retention arrangements following closure of the scheme.

The following areas of good practice were noted:

- A comprehensive evidence pack is retained which includes relevant documents that can be clearly referred to in order to provide a robust audit trail;
- The evidence pack is also reviewed by the external consultant of which a report is produced; and
- The evidence pack is securely held on the Health Board's network.

There were no significant findings identified under this objective.

7. Summary of Recommendations

The audit findings and 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 – Surplus of allowances (Operating Effectiveness)	Risk
The UHB brought forward a surplus of 11,915 allowances and did not therefore need to purchase any additional allowances in the forecast sale of 2018/19. The UHB will be required to surrender 10,136 allowances for 2018/19 and will therefore be left with a potential surplus of 1,779 allowances at the end of the Scheme. As at the time of the audit the strategy for utilising the surplus allowances has yet to be formally agreed. The plan is to work alongside the external consultant once the current year's information has been passed through to the HB for vetting. This would also involve discussions with the Director of Estates around the proposed strategy that would be undertaken. However, there is a risk that the HB may not be able to sell their excess allowances. All participants involved in CRC reporting with a view to selling or purchasing allowances have a formal trading window up until October 2019. Based on information received from the external consultant as at the time of the audit (17/07/19), The UHB could receive between £17,790 and £30,243 for its surplus allowances. This is based on a price of between £10 and £17 per unit but these figures are likely to decrease as time progresses.	The information detailed in the AQS is incomplete or incorrect.
Recommendation	**Priority level**
The UHB should ensure that the strategy is agreed as soon as possible so that the surplus allowances can be sold for the best achievable price.	**Medium**

Management Response	Responsible Officer/ Deadline
The UHB will be agreeing the strategy regarding the course of action to be adopted for surplus allowances during August 2019.	**Head of Energy and Performance /** **September 2019**

Appendix B - Assurance opinion and action plan risk rating

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 can take **no 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 **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.

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Cardiff and Vale University Health Board

Mental Health Clinical Board - Sickness Management Follow-Up

Final Internal Audit Report

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Steve Curry, Chief Operating Officer
Distribution:	Ian Wile, Director of Operations Joanne Wilson, Directorate Manager, MHSOP Mark Jones, Directorate Manager, Adult Mental Health
Committee:	Audit Committee

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

ACKNOWLEDGEMENT
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

1. Introduction and Background

The follow-up review of Mental Health Clinical Board Sickness Management was completed in line with the 2019/20 Internal Audit Plan.

The relevant lead Executive for the assignment is the Chief Operating Officer.

The original Mental Health Clinical Board Sickness Management report was finalised in October 2018 and highlighted a total of 4 issues which resulted in an overall assurance rating of limited assurance.

2. Scope and Objectives

The objective of the original review was to evaluate and determine the adequacy of the systems and controls in place within the Mental Health Clinical Board for the management of sickness absence, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately.

The purpose of the follow up review was to establish if the previously agreed management actions have been implemented, in order to ensure that the Health Board has appropriate processes in place within the Clinical Board to ensure that wards are managing sickness absence appropriately.

As per the original audit, the follow-up review focussed on the Mental Health Services for Older People (MHSOP) and Adult Mental Health Directorates.

In following up the agreed actions the main areas that the review sought to provide assurance on were:

- Sickness absence is appropriately recorded, monitored and managed in accordance with local procedures and the Management Attendance at Work Policy; and
- Previous Internal Audit recommendations have been appropriately actioned.

3. Associated Risks

The potential risks considered in this review were as follows:

- Increased sickness absence levels;
- Failure to meet Health Board and Welsh Government Sickness absence targets; and
- Reduced service provision / additional costs due to staff absence.

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.

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.

It is evident that the Clinical Board has made progress towards implementing the agreed management actions from the original review. This has led to an increased knowledge of the NHS Wales Managing Attendance at Work Policy and the associated processes for managing sickness absence.

The sampled wards tested during the original review and the current follow-up have shown considerable improvement in sickness management. The results of the current testing identified that all sampled sickness absence was appropriately managed within Cedar ward. Within the other three wards, whilst some issues of non-compliance were identified, the levels were lower than within the original audit.

As detailed within section 5 below, the follow-up has concluded that two of the management responses have been fully actioned (1 high & 1 Low) and 2 have been partially actioned (1 High & 1 Low).

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Mental Health Clinical Board – Sickness Management has improved to **Reasonable Assurance**. Management will however need to ensure that the outstanding actions are fully implemented and all future sickness absence is consistently managed in accordance with the All Wales Managing Attendance at Work policy.

5. Summary of Audit Findings

Follow up work was undertaken to confirm the progress that the Health Board has made against the agreed management responses from the original audit, as detailed within Appendix A.

In summary, progress against the four agreed recommendations that required implementation is as follows:

Priority rating	No of management responses to be implemented	Fully actioned	Partially actioned	Not actioned	Not Applicable
High	2	1	1	0	0
Medium	0	0	0	0	0
Low	2	1	1	0	0
Total	**4**	**2**	**2**	**0**	**0**

In summary, the progress made against the four management responses that required implementation is as follows:

- An email was sent from the Directorates to all ward managers which included a copy of the NHS Wales Managing Attendance at Work Policy. In addition, within the email was a reminder of the importance of sending timely letters, conducting interviews and checking self-certification notes. Sample testing was carried out on sickness management and although it has improved considerably there were still some issues identified with the completion of documentation;
- The Directorates provided the wards with "trigger tables" but these related to the All Wales Sickness Policy. Staff need to be provided with the updated prompts that are detailed within the NHS Wales Managing Attendance at Work Policy;
- The email sent to Ward Managers included a reminder to ensure that where conversations have been held with HR / OH re: additional triggers, these are to be more clearly noted in sickness files; and
- Band 6 and 7 managers have attended or are booked to attend the NHS Wales Managing Attendance at Work Policy training. However, from testing it was highlighted that there are still inconsistencies with recording of start and end sickness dates on sickness documentation, ESR and Rosterpro.

Original Finding 1 – Management of sickness episodes (Operating effectiveness)	Risk
The Sickness Absence Policy confirms that "successful sickness management is reliant on having and maintaining consistent and accurate records" which includes completing self-certificates and Return to Work Interviews. Audit selected a sample of 10 employees from each of the five wards (50 in total) who had sickness absence to ensure that self-certificates and Return to Work documentation were available, completed correctly and within a timely manner. Sickness management had been reviewed previously in Oak, Cedar, Ash and East 14. Audit was requested to also review sickness management within Alder ward. **Oak Ward** Review of the ten sampled staff identified the following issues: • 2 instances whereby self-certificates were missing from sickness files. • 1 self cert was missing a reason for the sickness. • 1 Return to Work was not completed within 7 days of the employee returning to work. • 1 RTW form was missing the employee's signature. **Cedar Ward** Review of the ten sampled staff identified the following issues: • 1 instance whereby the self cert was unavailable for a sickness episode. • 3 instances whereby dates were missing from the self cert form. • 2 instances whereby the reason for absence was not recorded on the self cert form. • 7 instances whereby an out of date version of the Return to Work form had been used and therefore the date the employee returned to work was not recorded on the form.	Increased sickness absence levels.

- 3 instances whereby the RTW was not carried out within seven days of the return to work date.
- 3 instances whereby the RTW had not been signed by either the employee or the manager.

Ash Ward

Review of the ten sampled staff identified the following issues:

- 1 instance whereby no self-certification form was completed (the fit note did not start at the beginning of the sickness episode).
- 5 instances whereby the self certs did not have a reason for the absence completed on them.
- 3 instances whereby the self certs did not have fully completed dates of sickness.
- 3 instances whereby a RTW was not carried out within 7 days of the staff member returning to work
- 5 instances whereby sickness episodes had days which were not authorised by a self cert or med cert.

East 14

Review of the ten sampled staff identified the following issues:

- 1 RTW had not been carried out within 7 days of the employee returning to work.

Alder Ward

The ward has had five new managers within seven months during the current year. Due to the frequent change of Managers and the pressures of the ward, sickness has not been managed appropriately. At the time of the review, a new Ward Manager had commenced on the ward and is aware that sickness absence needs to be managed more effectively.

Review of the ten sampled staff identified the following issues:

- 7 instances whereby there was no documentation to support the episodes of

sickness. Of the three available: • 1 instance whereby a self cert was not available for the episode of sickness. • 2 instances whereby RTW forms were not available for the episodes of sickness. • 2 instances whereby sickness days had not been authorised.	
Original Recommendation	**Priority level**
Management should ensure that all sickness episodes are managed and documentation is completed in accordance with the All Wales Sickness Policy. Management should ensure that a self-certificate is completed correctly and a return to work interview is held with the employee including the completion of the return to work form. Clinical Board management should consider introducing periodic training on the sickness management process in order to increase awareness and compliance levels.	**High**
Original Management Response	**Responsible Officer/ Deadline**
• Directorates to send all managers a link to the sickness policy /NHS Wales Managing Attendance at Work Policy, reminding them of the importance of sending timely letters, conducting interviews and checking self-certification notes. • All Band 6 and 7 managers to attend refresher sickness training. • Further sickness surgeries have been scheduled and sickness rates have fallen.	Directorate Managers for Adult and MHSOP / May 2019

Current Position

Action Complete

The managers were sent a copy of the NHS Wales Managing Attendance at Work Policy. In addition, the email confirmed that all letters should be sent on a timely basis, interviews are booked within specified timescales and self-certificate forms are checked to ensure completed correctly. The email also confirmed that all managers and deputies need to attend sickness refresher training. This point was discussed with the Ward Managers:

- Oak Ward - At the time of the review the Ward Manager booked herself onto the sickness training course which was going to be held in July;
- Cedar ward - The Ward Manager is booked for the sickness training course in July;
- Ash ward - The Ward Manager confirmed he has attended the new sickness training course and so have 3 of his deputies and 1 is booked for June/ July; and
- Alder ward - The Ward Manager and the 2 Band 6s are all booked on the new sickness training course.

Sickness surgeries were detailed within the email and this point was discussed with the Ward Managers and they have been involved with them.

Follow-up sample testing was also carried out and the results identified an improvement in the sickness management within the wards as follows:

Alder Ward

Review of the nine sampled staff identified the following issues:

- 1 instance whereby sickness absence was correctly recorded on Return to Work (RTW) and self-certificate but was recorded as special leave on Rosterpro.

Ash Ward

Review of the eight sampled staff identified the following issues:

- 1 instance whereby sickness episode had days which were not authorised by a medical certificate.

Oak Ward

Review of the ten sampled staff identified the following issues:

- 3 instances whereby no self-certificate forms were completed.
- 2 instances whereby sickness episodes had days that were not fully covered by a self cert or a medical certificate.
- 1 instance whereby no RTW was completed.
- 3 instances whereby the RTW was not fully completed and / or signed.

It is however noted that there has been a change in management within the Oak ward and the identified issues relating to sickness were prior to the new Ward Manager being in place.

There were no issues identified within Cedar Ward.

Original Finding 2 – Monitoring of sickness episodes (Operating effectiveness)	Risk
The All Wales Sickness Policy confirms that "Managers are required to actively manage where an employee has demonstrated a pattern or frequency of absence" which includes employees attending informal discussions and formal sickness interviews as requested by the employees Manager. Audit reviewed sickness triggers to establish if they had been managed correctly and in	Increased sickness absence levels.

compliance with the All Wales Sickness Policy. The following issues were identified across the 5 sampled wards: **Oak Ward** Two instances whereby sickness triggers were not managed appropriately. **Cedar Ward** One instance whereby a required informal discussion had not been undertaken. **Ash Ward** Four instances whereby triggers had been hit but the required interviews had not been undertaken in accordance with the All Wales Sickness Policy. **Alder Ward** Due to the lack of sickness absence management documentation on the ward, there was no evidence that the triggers were being monitored for any of the ten sampled staff.	
Original Recommendation	**Priority level**
Management should ensure that the sickness triggers are being managed correctly with informal discussions and formal sickness interviews being carried out in accordance with the All Wales Sickness Policy.	**High**
Original Management Response	**Responsible Officer/ Deadline**
• Directorates to send "trigger table" out to all managers, reminding them to check with line managers if they have any doubt or queries with individual cases.	Directorate Managers for Adult and MHSOP / April 2019

• Senior Nurse Managers to conduct random sickness file checks as part of 1:1 with managers.	

Current Position

Action Part Complete

"Trigger table" had been sent out to all managers. At the time of the review, Audit checked that the Ward Managers had the "trigger table" and they all had a copy but they were out of date and related to the All Wales Sickness Policy.

Random sickness file checks were to be undertaken and this point was discussed with Ward Managers who confirmed that they had been involved with the review of the sickness file checks.

Management will need to ensure that a copy of the current "Trigger table" from the NHS Wales Managing Attendance at Work Policy.

Follow-up Sample testing was undertaken on review prompts to ensure that they had been complied with in line with the NHS Wales Managing Attendance at Work Policy:

Alder Ward

- 1 instance whereby the employee had an informal discussion but had not hit the review prompt so discussion was undertaken too early.

Ash Ward

- 1 instance whereby employee had hit the next review prompt and a sickness meeting had failed to be carried out.

Updated Management Response	Updated Responsible Officer / Deadline
Directorate Managers to send new Trigger Table to all managers.	Directorate Managers / July 2019

Original Finding 3 - Monitoring of Long Term Sickness (Operating effectiveness)	Risk
The All Wales Sickness Policy confirms that long term sickness should be managed positively by managers so as to provide help and support to the employees. Audit selected a sample of staff that had long term sickness to ensure that it had been managed appropriately. Detailed below are our findings: **Ash Ward** One long term sickness meeting failed to be undertaken for one employee.	Increased sickness absence levels
Original Recommendation	**Priority level**
Long term sickness meetings should be held as required to ensure that the employee is receiving support and help.	**Low**
Original Management Response	**Responsible Officer/ Deadline**
• Directorates to send all managers a general reminder of the need for formal sickness letters to be sent and for LTS forms to be signed and copied. • Managers to be asked to ensure that where conversations have been held with HR / OH re: additional triggers, these are to be more clearly noted in sickness files	Directorate Managers for Adult and MHSOP / April 2019

Current Position
Action Complete Directorates to be reminded of the need for formal letters was incorporated within the email. Managers to ensure that conversations held with HR/OH re additional prompts are documented was included within the email. Audit checked this as part of the testing and they were available and long term interviews were held as required.

Original Finding 4 – Sickness dates (Operating effectiveness)	Risk
It was evidenced from our testing that there were a number of inconsistencies across all five wards with the recording of start and end sickness dates. There were different start and end sickness dates recorded on sickness documentation and ESR. The majority of differences were only 1 or 2 days which suggests that there is an issue with correctly and consistently recording the dates that sickness ends and the actual dates of return to work.	Increased sickness absence levels.
Original Recommendation	**Priority level**
Management should remind ward staff that the recording of sickness dates should reconcile between sickness documentation and ESR, and all sickness dates should be accurately and consistently recorded.	**Low**

Original Management Response	Responsible Officer/ Deadline
• All band 6 / 7 managers to attend refresher sickness training.	Directorate Managers for Adult and MHSOP / May 2019

Current Position
Action Part Complete As per finding 1, all Ward Managers and Band 6s have attended or are booked onto the NHS Managing Attendance at work policy training. Audit undertook some sample testing on the dates and it was evidenced that there were a number of inconsistencies across all four wards with the recording of start and end sickness dates. There were different start and end sickness dates recorded on sickness documentation, rosterpro and ESR. This issue was identified in the previous review and again the majority of difference were only 1 or 2 days which suggests that there is an issue with correctly and consistently recording the sickness dates. Management will need to ensure that all ward staff are aware of the correct procedure for accurately recording sickness absence days.

Updated Management Response	Updated Responsible Officer / Deadline
Directorates will ensure all Ward Managers and Deputy Ward Managers attend Managing Attendance at Work training Directorate Managers to request Managers pay particular attention in recording start and end sickness dates on ESR, Rosterpro and on forms, ensuring dates are correct and match	Directorate Managers / October 2019

Appendix B - Assurance opinion and action plan risk rating

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.

Follow up - All recommendations implemented and operating as expected.

 **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.

Follow up - All high level recommendations implemented and progress on the medium and low level recommendations.

 **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.

Follow up - No high level recommendations implemented but progress on a majority of the medium and low recommendations.

 **No assurance** - The Board can take **no 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 **high impact on residual risk** exposure until resolved.

Follow up - No action taken to implement recommendations.

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.

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Environmental Sustainability Report

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Executive sign off:	Abigail Harris, Director of Planning
Distribution:	Geoff Walsh, Director of Capital, Estates & Facilities Jon McGarrigle, Trust Energy Advisor Fitzroy Hutchinson, Energy Manager
Committee:	Audit Committee

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

ACKNOWLEDGEMENT
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the 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

The review of the Environmental Sustainability Report was completed in line with the Internal Audit Plan. The review sought to provide the Cardiff and Vale University Health Board (the 'Health Board') with assurance regarding the process for the production and approval of the Environmental Sustainability Report (the 'report').

The Government Financial Reporting Manual (the 'FReM') requires that entities falling within the scope of reporting under the Greening Government Commitments, and which are not exempted by the *de minimis* limit, or other exemptions under Greening Government Commitments (or other successor policy), shall produce a sustainability report to be included within the Management Commentary in accordance with HM Treasury issued Sustainability Reporting in the Public Sector guidance.

The relevant lead Executive for the assignment is the Executive Director of Planning.

2. Scope and Objectives

The overall objective of the review was to assess the adequacy of management arrangements for the production of the Sustainability Report within the Annual Report:

- Whether the form and content of the report complies with the requirements of guidance published by the Welsh Government.

- Whether the information published within the report provides an accurate and representative picture of the quality of services it provides and the improvements it has committed to undertake.

The audit focused upon the 2018/19 report, which will be published within the Annual Report. The scope of the audit review was limited to the following aspects:

- The Health Board has appropriate arrangements for the preparation, approval and publication of the report including ensuring compliance with relevant guidance.

- Testing a sample of selected indicators to ensure the underpinning data is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

This review drew on the findings of any relevant audit assignments undertaken within the reporting year to prevent any duplication.

3. Associated Risks

The potential risks considered in the review were as follows:

- Reputational risk from non-compliance with Welsh Government guidance and breach of key public disclosure reporting requirement and lack of transparency.
- Reputational risk that published information does not present a fair and balanced picture to stakeholders of the performance in the year.
- Data quality risk that published information is either incomplete or inaccurate due to information governance controls overall or system control over reported information for individual data elements.

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 risks associated with establishment controls within the Sustainability Reporting 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.

Our audit has confirmed that the format and content of the 2018/19 Sustainability Development Report complies with guidance issued by the Welsh Government and fairly represents the organisations sustainability position and performance. There was documented guidance in place setting

out roles and responsibilities for producing the report which was presented in a clear and user friendly format, and there were adequate arrangements in place for producing the report.

However the process for producing the report has evolved and changed over the last few years. Consequently the process documentation could be improved by updating the roles and responsibilities of staff involved in preparing the report and supplementing the guidance with the methodology used to complete the three mandatory tables. The current process, which now takes place within a reduced timescale, has also resulted in the approval and report sign-off taking place after the report is published, although to date this has not been evidenced by audit. The process could also be improved by drawing up a timetable each year to help ensure the report is checked and published within the required deadline.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	The form and content of the report complies with the requirements of guidance published by the Welsh Government.			✓	
2	The information published within the report provides an accurate and representative picture of the quality of services it provides and the improvements it has committed to undertake.				✓
3	The Health Board has appropriate arrangements for the preparation, approval and publication of the report including ensuring compliance with relevant guidance.			✓	
4	The data underpinning the report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted 2 issues that are classified as weakness in the system control/design for Sustainability Reporting.

Operation of System/Controls

The findings from the review have highlighted 2 issue that was classified as a weakness in the operation of the designed system/control for Sustainability Reporting.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: The form and content of the report complies with the requirements of guidance published by the Welsh Government:

The following areas of good practice were noted:

- Responsibilities for production of the Sustainability Report had been clearly assigned and documented;
- There was evidence that Welsh Government guidance was utilised in the development of the Sustainability Report;
- The Sustainability Report included the main sections and three mandatory tables as required by the guidance;
- The Sustainability Report detailed the ongoing initiatives and programmes designed to improve sustainability within the UHB.

The following findings were identified for this objective:

- The approval and sign-off of the final sustainability report takes place retrospectively after the report has been published but to date no evidence of this has been provided to audit.
- The procedural guidance note requires updating to reflect the current roles and responsibilities of staff involved in the preparation of the report and the process for preparing the three mandatory tables;
- There was no timetable in place for the preparation of the 2018/19 Sustainability report.

Objective 2: The information published within the report provides an accurate and representative picture of the quality of services it provides:

The following areas of good practice were identified:

- The UHB was accredited with the Environmental Management Standard ISO14001 covering all sites within the UHB's portfolio;

- The report references key performance indicators and benchmarks where they exist to support the narrative.

No findings were identified for this objective.

Objective 3: The Health Board has appropriate arrangements for the preparation, approval and publication of the report including ensuring compliance with relevant guidance.

The following areas of good practice were identified:

- The draft Sustainability Report was subject to review by Internal Audit prior to approval and publication;

No findings were identified for this objective.

Objective 4: The data underpinning the report is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review.

The following areas of good practice were identified:

- There was sufficient supporting information provided that could be reconciled back to the data included in the report;
- A Cardio tool developed by the Stockholm Institute for use by the NHS Wales was used to covert energy consumption data into Greenhouse gas emissions;
- The finite resource consumption table within the Sustainability report for 2018/19 states the water apportionment of the total annual cost.

No findings were identified for this objective.

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**	**3**	**0**	**3**

Finding 1: Accuracy Check & Sign Off (Operating effectiveness)	Risk
The guidance procedure for producing the Sustainability Report requires the draft report to be independently checked for accuracy by a member of estates staff prior to submission for finalisation to the Environmental Management Steering Group / Health & Safety Group and sign off by the Director of Capital, Estates and Facilities. The final report should then be submitted to internal audit for review and the Communications Team for publication. However the process has evolved over time and accuracy checking of the draft sustainability report is now undertaken by internal audit prior to submission to the Communications Team. We were informed that the report is then retrospectively submitted to the Environmental Management Steering Group / Health & Safety Group for approval and the Director of Capital, Estates and Facilities for sign off, although no evidence of approval and sign-off is provided to audit.	Reputational risk from non-compliance with Welsh Government guidance and breach of key public disclosure reporting requirement and lack of transparency.
Recommendation 1	**Priority level**
Evidence of the retrospective approval of the sustainability report by the Environmental Steering Group / Health & Safety Group and sign off by the Director of Capital Estates and Facilities should be provided to audit each year. The documented procedural guidance should be updated to reflect the actual review and approval process currently in place.	**Medium**

Management Response	Responsible Officer/ Deadline
Future Sustainability reports will be approved and signed off at the Capital Estates and Facilities Health & Safety Group. Depending on timescales retrospective approval may need to be provided, however the approval and sign off of the report shall be documented in the relevant minutes of the group.	Head of Energy and Performance / Immediately

Finding 2: Guidance Document (Control design)	Risk
The documented procedure for the preparation of the Sustainability Report outlines the individuals responsible for providing information used for the compilation of the report. It also documents the various stages that should be undertaken to produce the report. However some of the roles and responsibilities outlined in the guidance have changed, and there is no guidance as to how each of the three mandatory tables required for the report (Greenhouse Gas Emissions, Waste and Use of Resources) should be prepared.	Reputational risk from non-compliance with Welsh Government guidance and breach of key public disclosure reporting requirement and lack of transparency.
Recommendation 2	**Priority level**
The staff roles and responsibilities highlighted in the procedural guidance should be reviewed and updated as necessary. The guidance should be supplemented with detailed information on how to prepare each of the three mandatory tables.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Future Sustainability report guidance will be reviewed and updated for staff roles and responsibilities as necessary. Where necessary guidance will be supplemented with detailed information on how to prepare each of the three mandatory tables.	Energy Manager / 31st October 2019

Finding 3: Timetable (Control design)	Risk
Whilst the sustainability reporting process guidance highlighted the steps required for the production of the sustainability report, there is no timetable in place which puts each step within the process into an agreed timeline. This would help the lead work towards the timely completion of the Sustainability report by the deadline, and would serve as a guide to all staff responsible for providing the relevant data required for the production of the report.	Reputational risk from non-compliance with Welsh Government guidance and breach of key public disclosure reporting requirement and lack of transparency.
Recommendation 3	**Priority level**
Management should draw up a timetable each year to help ensure appropriate time is allocated for the sustainability report preparation, review process, audit, approval and submission to the Communications Team. The requirement to produce a timetable each year should be incorporated into the procedural guidance.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Once the timescale for the Sustainability report submission is known an indicative timetable will be developed. Timings however may change depending on when information is available for inclusion in the report and the availability of Officers to verify and audit information and data.	Energy Manager / Immediately

Appendix B - Assurance opinion and action plan risk rating

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.

 **Moderate assurance** - The Board can take **moderate 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.

 **Unsatisfactory** - The Board has **unsatisfactory** arrangements in place to secure governance, risk management and internal control, within those areas under review, which 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.

Specialist Clinical Board – Rosterpro

Final Internal Audit Report

Cardiff and Vale University Health Board

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

Review reference:	C&V-1920-34
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Auditor/s:	Ian Virgil – Head of Internal Audit. Murray Gard – Principal Auditor.
Executive sign off:	Steve Curry – Chief Operating Officer.
Distribution:	Carys Fox – Director of Nursing. Jessica Castle – Director of Operations.
Committee:	Audit Committee.

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

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.

Disclaimer notice - Please note:

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

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

1. Introduction and Background

The review of rostering within the Specialist Services Clinical Board was completed in line with the 2019/20 Internal Audit Plan for Cardiff and Vale University Health Board.

The Health Board relies on its workforce in order to provide high quality services to its patients. Effective rostering arrangements for the management of staff are essential to ensure that the required staff members are available when needed.

All National Health Service organisations rely on a level of temporary nursing staff, in order to maintain service continuity. The inherent nature of providing health services, with the variations in demand, capacity and workforce availability dictate that such expenditure is unavoidable.

However, an organisation can influence the demand for temporary nursing staff via a flexible, efficient and robust rostering system.

The relevant lead Executive Director for this review is the Chief Operating Officer.

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Specialist Services Clinical Board for the management of Rostering, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review was to establish if ward rosters are effectively planned and managed and the use of bank and agency nursing staff is appropriately assessed and utilised.

The audit focussed on the Critical Care Directorate within the Clinical Board and covered both University Hospital of Wales & University Hospital Llandough sites.

The areas that the review sought to provide assurance on are:

- Rotas are drawn up in line with Health Board policy and ensure that staff members work their contracted hours.
- Rotas are drawn up in advance to reflect the correct establishment and skill mix of staff.
- Appropriate processes and procedures are in place for the booking of bank and agency nurses.

3. Associated Risks

- Staff members do not work their contracted hours;

- Patient care is compromised due to inappropriate skill mix of staff onwards; and
- Financial loss due to unnecessary usage of bank and agency nursing.

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 established controls within the Specialist Services Clinical Board – Rosterpro review 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.

We identified that there are multiple interdependent systems operating within Critical Care for the monitoring of rosters and individuals working hours, a reconciliation exercise has shown that the systems are generally accurate over our sample period (January – March 2019);

The review highlighted one high priority finding relating to staff members accumulating large amounts of negative hours (greater than 12 hours) over our sample period; whilst employing bank and agency staff to work shifts.

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.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Rotas are drawn up in line with Health Board policy and ensure that staff members work their contracted hours.		✓		
2	Rotas are drawn up to reflect the correct skill mix of staff.				✓
3	Appropriate processes and procedures are in place for the booking of bank and agency nurses.			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weaknesses in the system control for the Specialist Services Clinical Board's use of Rosterpro.

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weaknesses in the operation of the designed system for the Specialist Services Clinical Board's use of Rosterpro.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Rotas are drawn up in line with Health Board policy and ensure that staff members work their contracted hours.

We note the following areas of good practice:

- Rosters are generally verified on a daily basis and at the end of the week that roster was worked;
- Leave, regardless of reason is recorded on Rosterpro, for example, long term sick, annual leave;
- For shifts longer than 6 hours, the hours worked per shift accommodates an unpaid break time;
- The actual number of hours worked is generally recorded;
- The maximum number of consecutive 12 hours shifts worked is three in a row from our sample.

We identify three significant findings under this objective:

- The production of the rotas in terms of advance warning for staff was generally not in line with the Health Board's '*Rostering Procedure for Nurses and Midwives';*
- Instances were identified where by the cumulative hours worked of individuals had high negative balances (greater than 12 hours), over our sample period.
- Instances were identified where the reconciliation of hours worked was not accurate and up to date.

Objective 2: Rotas are drawn up to reflect the correct skill mix of staff.

We note the following areas of good practice:

- Audit reviewed the skill mix at both Llandough and UHW on a live basis during July 2019. Overall the level of staff and skill mix was satisfactory.

We did not identify any findings under this objective.

Objective 3: Appropriate processes and procedures are in place for the booking of bank and agency nurses.

We note the following areas of good practice:

- Critical Care have good internal relationships with other departments that have suitable trained staff that can cover shifts in critical care;
- There is a bank book on the ward, where staff say if they are willing to undertake additional shifts;
- The 'bank and agency duty roster timesheet verification control form' was initialled as worked by the nurse in charge on every occasion of our sample;
- Bank and agency shifts reconciled from Rosterpro to the off duty verification control form.

We identified one significant findings under this objective:

- There was no process map in place that identifies the procedure to follow.

7. Summary of Recommendations

The audit findings and 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**	**3**	**1**	**5**

Finding 1 - Contracted Hours (Operating effectiveness)	Risk
The audit reviewed the contracted hours of 15 individuals working shifts at the University Hospital of Wales over the period January to March 2019; to ensure contracted hours had been appropriately worked and recorded; the following was highlighted: • Four individuals were found to have high negative balances (greater than 12 hours), over the sample period (January to March 2019); It is noted that Critical Care utilised bank and agency staff to cover shifts over the period that these highlighted staff were carrying high balances of negative hours. • One individual was carrying a very high positive balance throughout the period sampled; • Two sets of hours worked balance monitoring sheets had not been located. One of these was due to the individual having left their post.	Staff members do not work their contracted hours.
Recommendation 1	**Priority level**
Management should ensure employees contracted hours are managed appropriately.	**High**

Management Response	Responsible Officer/ Deadline
• As a Directorate Management Team we welcome the audit and accept its recommendations. As we recognise we can't change some of the findings detailed above, our focus has been upon implementing new systems and process to ensure that such incidences do not occur in the future. • It is important to note that whilst the audit was undertaken in June 2019, the sample of rosters audited covered January to March 2019. At the end of January 2019 a new nurse leadership team, including a Lead and two Senior Nurses commenced their roles within Critical Care. Under the leadership of this team several initiatives have been put in place to manage rostering across the UHW and UHL sites. The Senior Nurses now hold monthly 1:1 meetings with each Band 7 responsible for a team or rostering. The purpose of these meetings is to ensure that high positive/negative balances are no longer accrued, and historic high positive/negative balances are reduced back to a reasonable level. The meetings have been well received and appear to be making the requisite improvements albeit formal review of the rostering process is scheduled for the end of September when we will have six months of data.	Lead Nurse. Complete – with review scheduled for September 2019.

Finding 2 - Procedure Requirements (Operating effectiveness)	Risk
Section 2 .1 of the Rostering Procedure for Nurses and Midwives states ' Each week of the roster will be produced, signed off and published a minimum of 6 weeks in advance'. Audit reviewed the rosters for UHW and Llandough over the period January – March 2019, with the following being noted; • The six week timescale was not achieved in Llandough over the sample period; • At UHW over the period 3rd March – 30th March 2019 the rosters were signed off on Rosterpro retrospectively. Audit notes that this doesn't mean rosters weren't produced in time rather that they were just not signed off within Rosterpro on a timely basis.	Rotas are drawn up in line with Health Board policy staff members work their contracted hours.
Recommendation 2	**Priority level**
Appropriate staff will be reminded of the procedural requirement for drawing up rotas 6 weeks in advance and timely signing off within Rosterpro.	**Medium**
Management Response	**Responsible Officer/ Deadline**
• A new process for developing the Critical Care rota was implemented in May 2019. • Rotas are now generated monthly by two Band 7's on a rotational basis. The Lead & Senior Nurse review each prior to publication. This means that rosters are now routinely issued in accordance with the procedural requirement of 6	Lead Nurse. Complete - with review scheduled for December 2019.

weeks advance notice. Audit of the efficacy of the new process will be undertaken by the Senior Nurse in December 2019. • UHW and UHL rotas are generated and published at the same time, as they need to be written in conjunction with each other to ensure safe staffing across both sites.	

Finding 3 - Process Map (Control design)	**Risk**
Audit notes that there is no documented process map in place for requesting the use of Bank and Agency staff. Thorough our conversations with members of staff, it was identified that there is currently no system in place to check if staff with high negative hours balances are available to work shifts prior to booking bank or agency staff.	Financial loss due to unnecessary usage of bank and agency nursing.
Recommendation 3	**Priority level**
A process map should be devised and distributed to appropriate staff. This should include a robust system for utilising staff with negative balances prior to booking bank or agency staff.	**Medium**
Management Response	**Responsible Officer/ Deadline**
• Process map will be devised and distributed to all Critical Care Flow Co-ordinators by Lead / Senior Nurse.	Senior Nurse - September 2019.

Finding 4 - Reconciliation (Operating effectiveness)	Risk
There are interdependent systems operating within Critical Care for producing and monitoring of rosters including individuals hours worked within the rosters. A reconciliation exercise has shown that the systems are generally accurate with a couple of exceptions: • The electronic spreadsheet used to track individuals working time balances was not being kept up to date; • One instance was identified where there was an arithmetic error in the calculation hours owed; • One of the episodes of sickness noted on Rosterpro was not accurate, as the individual was on shift; • Two of the day rotas were not signed and verified.	Staff members do not work their contracted hours.
Recommendation 4	**Priority level**
Management should remind staff that accurate and up to date records are to be kept at all times.	Medium
Management Response	**Responsible Officer/ Deadline**
• New ways of working have been instigated across Critical Care since May 2019, with Band 7's having clearly defined duties and accountability for the production and maintenance of accurate records. • Oversight of the records and rostering is now a key component of the Senior Nurse and Band 7 1:1 meetings that occur on a monthly basis, with review of the efficacy and impact of the new system scheduled for December 2019.	Senior Nurse. Complete - with review scheduled for December 2019.

Finding 5 - Rosterpro Requirements (Operating effectiveness)	Risk
Critical Care falls under the exclusion criteria of the Nurse Staff Levels Act 2016 (Section 25B) and as such there are no minimum numbers for qualified and unqualified staff. Staff numbers are generally based on a consistent level throughout the week, however, bed occupancy rates and the condition of individual patients have an effect on the level and skill mix of staff. The optimum requirements in terms of numbers and grades of staff set in Rosterpro (system used for producing rosters) have recently been reviewed within UHW (June 2019) and split into four areas that are reflective of how the ward operates. However the optimum requirements for Llandough have not yet been reviewed, as the figures have not yet been confirmed.	Rotas are drawn up in line with Health Board policy staff members work their contracted hours.
Recommendation 5	**Priority level**
Optimum requirements for Llandough will be reviewed and if necessary updated appropriately.	Low
Management Response	**Responsible Officer/ Deadline**
• Staffing levels at Llandough have been reviewed since the time of the audit. As a result a 1wte Band 7 has been added to the establishment for UHL.	• 27/08/19. • Lead & Senior Nurse / 30/09/19. • Critical Care DMT.

Appendix B - Assurance opinion and action plan risk rating

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 can take **no 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 **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.

Legislative / Regulatory Compliance Follow-up

Final Internal Audit Report

2019/20

Cardiff and Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Executive sign off:	Nikki Foreman, Director of Corporate Governance
Distribution:	Glynis Mulford, Corporate Governance Officer
Committee:	Audit Committee

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

ACKNOWLEDGEMENT
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1. Introduction and Background

The follow-up review of Legislative / Regulatory Compliance was completed in line with the Internal Audit Plan.

The relevant lead Executive for the assignment is the Director of Corporate Governance.

The original report was finalised in January 2019 and highlighted a total of seven findings, which resulted in an overall assurance rating of limited assurance.

2. Scope and Objectives

The objective of the original review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for the management of legislative and regulatory compliance, in order to provide assurance to the UHB Audit Committee that risks material to the achievement of systems objectives are managed appropriately.

The purpose of the follow up review is to establish if the previously agreed management actions have been implemented, in order to ensure that effective processes are in place so that the Health Board complies with all licencing, statutory and regulatory requirements and any associated risks or issues are effectively identified and addressed.

In following up the agreed actions the main areas that the review sought to provide assurance on were:

- Effective processes are in place within the Health Board for establishing compliance requirements relating to licenced, statutory and regulated activities;
- Appropriate actions are effectively carried out by the relevant services /departments to ensure that the required compliance is achieved;
- Compliance requirements and the level of achievement are appropriately monitored and recorded at a corporate level within the Health Board;
- The outcomes from the monitoring of compliance requirements and other internal/external reviews are periodically reported to an appropriate UHB committee; and
- Risks relating to licenced and regulated activities are appropriately assessed and recorded on the appropriate Clinical Board / Health Board Risk Registers.

3. Associated Risks

The potential risks considered in this review are as follows:

- Failure to meet licensed, statutory or regulatory requirements which may lead to prosecution or loss of service; and
- Reputational and financial loss due to non-compliance with the requirements of regulated activities.

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.

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

Since our previous review the Corporate Governance Team has made good initial progress towards improving the process for the management of legislative and regulatory compliance. An effective policy has been developed that includes appropriate appendices to support and assist the process. An overhaul of the existing Tracker Report has taken place, which involved a considerable amount of work and a complete new format was agreed upon and introduced.

The Corporate Governance Team have received from the Clinical Boards a list of all the Regulatory Bodies that they are responsible for, the standards that they are inspected against and who the Executives leads are. The collation of most of this information and the updating of information within the Tracker Report took place whilst the follow-up audit was being carried out, so we were unable to test against it.

As such, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Standards of Business Conduct has improved to **Reasonable Assurance**.

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.

5. Summary of Audit Findings

In summary, the Health Board's progress with its agreed management responses against the seven recommendations that required implementation is as follows:

Priority rating	No of management responses to be implemented	Fully actioned	Partially actioned	Not actioned
High	4	2	2	0
Medium	3	0	1	2
Low	0	0	0	0
Total	**7**	**2**	**2**	**2**

The action plan within Appendix A provides full details of the findings, priority ratings and management responses from the original review, along with details of the current position, as verified by our follow-up work.

Two of the four high priority recommendations have been fully actioned following the creation of the new 'Management of External Agency Visits, Inspections and Accreditations Procedure' and the updating of the list of all regulatory bodies.

Evidence was provided to confirm that initial progress has been made towards implementing the remaining two high priority and one of the medium priority recommendations; Although the Health Board has received further data from the Clinical Boards to enhance the list of Legislative and Regulatory bodies, and a more comprehensive list is in place to work from we were unable to test against this information due to the timing of its implementation. A new Legislative and Regulatory Tracker Report has been developed with the addition of dashboard dials which will be shared at the September Audit Committee.

No real progress has been made towards implementing the remaining two Medium priority recommendations that relate to evidencing the completion of actions from South Wales Fire Service (SWFS) Notices and the attendance levels at the Departmental Fire Safety Managers (DFSM) meetings.

Management will need to ensure that the outstanding actions are implemented along with continuing to develop and update the new Legislative and Regulatory Tracker Report.

Original Finding 1 - Ineffective Corporate process for identifying compliance requirements (Control design)	Risk
The current processes that are in place corporately for identifying the activities associated with statutory, regulatory and licencing bodies need strengthening. The Corporate Administration Officer, who is responsible for maintaining the tracking report, uses the Chief Executive post log as the source document for obtaining the information. However examples have been identified when documentation relating to statutory, regulatory and licencing bodies has not been received via the Chief Executive's office. Therefore reliance can't be placed on this method to collate all the necessary information. The Officer also sends an email twice a year to a list of contacts requesting further information prior to each Audit Committee. However the list of contacts is not subject to any review or updating. We analysed the list and found that 2 of the 21 names recorded are no longer found on outlook. No email addresses, post details or departments are recorded for the named contacts. Most significantly there is also no record of which statutory, regulatory or licenced activity each person is responsible for. The standard email that is sent by the Corporate Administration Officer asks for some of the information that is required to complete the register but not all, therefore incomplete information is received. A copy of the actual report from the respective regulator is not requested as supporting evidence.	Failure to meet licensed, statutory or regulatory requirements which may lead to prosecution or loss of service. Reputational and financial loss due to non-compliance with the requirements of regulated activities.

Original Recommendation	Priority level
The Corporate Governance Team should re-evaluate the processes in place for identifying the activities associated with statutory, regulatory and licencing bodies so that there are robust systems in place to capture this information more effectively and completely.	**High**
Original Management Response	**Responsible Officer/ Deadline**
Agreed this is an essential responsibility of the Corporate Governance Team which to date has not been undertaken effectively. This piece of work needs to be undertaken as a matter of urgency due to the risks it imposes with non-compliance with statutory and regulatory activities by not having adequate processes in place.	Head of Corporate Governance End of February 2019

Current Position

Actioned Completed

The Corporate Governance Team has developed a new 'Management of External Agency Visits, Inspections and Accreditations Procedure, which was approved at Management Executive (ME) on 09/09/19 and will be presented to Health Systems Management Board (HSMB) in October. The procedure is to ensure that the Health Board has a coordinated and effective process in place for the management of all external agency visits, some of which are planned whilst others can be undertaken with very little notice. The reviews maybe routine are risk based visits, or for accreditation purposes.

Appendices have been developed in line with procedure to assist staff, particularly those who are involved in external reviews and accreditations. These include an overview of the visits and inspection, plan templates and pathways.

Original Finding 2 - Incomplete Tracking Report (Operating effectiveness)	Risk
As a benchmark, the Health Board's Tracking Report (for the period ending 31st August 2018) was compared against Velindre NHS Trust's Legislative Compliance Register to establish if the content was comprehensive and included similar, expected activities. The Velindre Compliance Register listed 30 activities of which only 11 could be found on the Health Board's Tracking Report. From the missing 19 we felt that at least 7 were relevant to the Health Board and should therefore be included on its Tracking Report. Due to the high number of inconsistencies between both registers we feel that the Health Board's Tracking Report is incomplete and may not be capturing all the relevant regulators.	Failure to meet licensed, statutory or regulatory requirements which may lead to prosecution or loss of service. Reputational and financial loss due to non-compliance with the requirements of regulated activities.
Original Recommendation	**Priority level**
A full list of Regulators that are relevant to the UHB needs to be established to ensure that the register is capturing all the required information.	**High**
Original Management Response	**Responsible Officer/ Deadline**
Agreed this should be in place and the fact that it is not places the organisation at risk.	Head of Corporate Governance End of February 2019

Current Position
Action Completed The Corporate Governance Team shared a revised list of Regulatory Bodies with all Clinical Boards asking them to confirm if there were any Regulators from this list that were missed. This information has now been received and collated and the Corporate Governance Team are confident that this is now an exhaustive list of Regulatory Bodies that the organisation is inspected against.

Original Finding 3 - Sampled activities not recorded accurately on Tracking Report (Control design)	Risk
The information shown on the Regulatory and Review Bodies Tracking Report for the period ending 31st August 2018 for the sampled areas was inaccurate and not up to date. The last entry shown on the register for a SWFS notice was January 2018, however we found that a further 11 notices have been issued up to August 2018; 6 at UHW, 3 at CRI and 2 at Llandough. Also a number of the entries shown on the register for SWFS had actually been completed but this had not been accurately reflected on the register. The Tracking Report only included details of three reports for the Health and Safety Executive (HSE) that dated back as far as 2015/ 2016. Two of these have been completed and should no longer feature on the Tracking Report; the third entry is still ongoing and is being discussed at the H&S Committee. The true number of reports issued up to August 2018 for the HSE and Environmental Health is ten; none of these are shown on the report.	Failure to meet licensed, statutory or regulatory requirements which may lead to prosecution or loss of service. Reputational and financial loss due to non-compliance with the requirements of regulated activities.

In addition the HTA report that was issued in September 2017, which identified a number of critical non conformities is still shown on the Tracking Report. As part of the 2017/18 Audit Plan, an internal audit review of the progress against the HTA inspection was carried out, which confirmed that the majority of these issues had been addressed as at March 2018. This information was not reflected on the Tracking Report which further highlights that the information shown is out of date.	
Original Recommendation	**Priority level**
The Corporate Governance Team should ensure that all the relevant information that is required for the completion of the Tracking Report is obtained and up to date.	**High**
Original Management Response	**Responsible Officer/ Deadline**
Agreed the information should be up to date and accurate	Head of Corporate Governance End of February 2019
Current Position	
Partially Actioned The Corporate Governance Team emailed out to all the Clinical Boards asking them to confirm that the relevant information against any of the Regulatory Bodies that they are responsible for is shared with the department. This will assist the Corporate Governance Team in ensuring that the necessary information required for the completion of the Tracking Report is relevant and up to date.	

As this piece of work is still being developed and the information received from the Clinical Boards was only recently received, no testing against this could be carried out. Therefore we were unable to provide assurance that the management action had been fully implemented.

Original Finding 4 - Audit Committee Paper (Control design)	**Risk**
The Tracking Report was presented to the Health Board's Audit Committee in September 2018 and is usually reported to them every six months. On this occasion the register was submitted without a covering paper which should introduce and explain its purpose to the Audit Committee. In addition the information provided was insufficient due to the numerous incomplete sections shown on the register. The formatting and layout of the report also made it impossible to read. Due to these weakness the Audit Committee was unable to effectively review the Tracking Report and provide assurance to the Board that the register is satisfactory.	Lack of assurance provided to the Audit Committee.
Original Recommendation	**Priority level**
The Corporate Governance department must ensure that the information provided to the Audit Committee is supported by a covering paper, is legible and contains a comprehensive list of the compliance requirements relating to licensed, statutory and regulated activities.	**High**

Original Management Response	Responsible Officer/ Deadline
It has already been agreed at the last Audit Committee that this report would be reviewed to ensure that it provided the Committee with a comprehensive list of compliance requirements relating to the statutory and regulated activities.	Head of Corporate Governance February 2019 Audit Committee

Current Position
Partially Actioned A Regulatory Compliance Report will be presented at the September Audit Committee, which will list all the Regulatory Bodies that the organisation is inspected against and the standards in which they relate to. As highlighted in the above finding the Corporate Governance Team is in the development stages of incorporating the Dashboard dials, and an example of which will also be shared at September Audit Committee. The Dashboard dials will be updated on a quarterly basis throughout the organisation and reported to Audit Committee after it has been presented at the HSMB.

Original Finding 5 - SWFS notices (Control design)	Risk
A sample of eight notices for the South Wales Fire Service (SWFS) was chosen from the Tracking Report. All 8 were recorded as complete and evidence to support their completion was requested from the Senior Fire Safety Officer. The following issues were identified; • 1/8 no evidence was provided to support its completion. The Senior Fire Safety Officer felt that the original findings from SWFS were unjust and both management actions had been dismissed by him. • 1/8 unable to provide evidence to support that the work had been completed. The work was carried out by a private company which would have been requested by the Clinical Board or Estates. Completion of works carried out by Estates that relates to enforcement notices are not fed back to the Senior Fire Safety Officer. • 2/8 both notices from SWFS had three actions identified. Evidence could only be found to support the completion of three out the six actions.	Required actions may not be completed.
Original Recommendation	**Priority level**
The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	**Medium**
Original Management Response	**Responsible Officer/ Deadline**
Agreed	Head of Health and Safety February 2019 Audit Committee

Current Position
Not actioned The new Fire Safety Officer explained that the current fire risk assessment tool does not allow for tracking completed actions and that they currently rely on ad hoc re-inspections, annual follow ups or requests from SWFRS to re audit areas previously found to have compliance deficiencies. They are however proposing to use a different fire risk assessment tool i.e. the IPR 3.5 MICAD System to carry out this function to enable them to track all outstanding deficiencies in real time, therefore providing a precise account of where they really are against their findings. This system however is still in its development stage and they do not anticipate that it will be fully functional until mid-2020. We were also unable to carry out any additional testing against SWFRS Notices to establish if any improvements have been made since our previous finding as the Tracker Report is not completed and the information was not available.

Original Finding 6 - Process in place to establish compliance is achieved (Operating effectiveness)	Risk
A meeting with the Senior Fire Safety Officer and further testing identified that the current processes in place to ensure compliance is achieved for the SWFS notices could be improved. All actions identified in the UHB fire risk assessment are split into three categories; management, corporate and estates. The management actions are managed by the Departmental Fire Safety Managers (DFSM) from each Clinical Board. Corporate actions are the responsibility of the Fire Safety Department and Estates actions go via the Estates department. The management actions are monitored at the DFSM bimonthly meeting. Copies of the DFSM meetings were obtained to ensure that the required people are attending each	Required actions may not be completed.

meeting and their frequency. Analysis of the attendance figures identified that the attendance levels are low and it is the same members of staff who are always present. Key areas who have the most management actions are not attending therefore we are unable to provide assurance that the management actions are being appropriately scrutinised.	
Original Recommendation	**Priority level**
The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers.	**Medium**
Original Management Response	**Responsible Officer/ Deadline**
Agreed	Head of Health and Safety February 2019
Current Position	
<u>Not actioned</u> Copies of the three most recent DFSM meetings were obtained, which covered the period October 2018 – May 2019 to establish if the attendance levels for the Clinical Board Fire Safety Managers had improved. PCIC had a representative attending each meeting, whereas Mental Health, Surgery and Medicine had no one attending any of the meetings. For the remaining clinical boards a representative attended one out of the three meetings. Only five people attended the May meeting.	

Original Finding 7 - Process in place corporately for identifying re-inspections (Control design)	Risk
The process in place at a corporate level for identifying when compliance against the listed activities is due to expire or re-inspection is due is inadequate. The Tracking Report includes a column headed 'Date next scheduled visit/renewal of Licence/ Accreditation' however this is incomplete in most instances. The Report does not include the standard frequency of when each visit should take place which would be useful and should be added. Although the standard email that is sent out by the Corporate Administration Officer asks when the next visit/ review is due to take place, this is not always answered. This however is not pursed by the Corporate Team with a follow up email or telephone conversation.	Failure to meet licensed, statutory or regulatory requirements which may lead to prosecution or loss of service. Reputational and financial loss due to non-compliance with the requirements of regulated activities.
Original Recommendation	**Priority level**
The Corporate Team should re-evaluate the Report to ensure that all the necessary information required to maintain a comprehensive list is in place. The Corporate Team should also review the standard email that is sent out to ensure that all the required information is requested. They should also pursue those who have not provided the relevant information.	**Medium**
Original Management Response	**Responsible Officer/ Deadline**
Recommendation agreed	Head of Corporate Governance February 2019

Current Position

Partially Actioned

As outlined in the new policy there is a requirement to have one central point for the receipt, logging, tracking and monitoring of progress against the Regulatory reviews. The Corporate Governance Team reviewed and decided to create a more detailed Tracking Log so that it was in line with the new policy and would also address our original finding. Unfortunately the first draft was based around the new Audit Tracker Report that the department has just introduced, and it soon became clear that this format would not work for the Legislative and Regulatory Tracker Report. The Corporate Governance team liaised with Director of Operations to relook at the report with the intention of replicating a similar system to one being used in CD&T. In addition they wanted to develop a dashboard, which will allow the Clinical Boards to know where they are against the statutory, regulatory or licenced activity that will be reported to the Audit Committee. This has recently been developed so no testing against it could be carried out.

To ensure that the right information was being captured to develop the Tracker log the Corporate Governance Team sent out an email to the Clinical Boards asking various questions regarding their Regulatory visits, and we have been informed that standard emails will go out in future that will not be too dissimilar to that of the original email. A deadline date will be provided in the standard email and should no response be received after that date, those identified will be escalated to their respective Clinical Board Directors. The Lead Executives and the Director of Corporate Governance will also be included into the email trail.

Unfortunately without the standard email currently in place and the Tracker Report still in its infancy we were unable to verify if the relevant information is being gathered and if the Tracker Report has been updated appropriately. Future testing will need to be carried out in this area to ensure that the recommendation has been completed fully.

Appendix B - Assurance opinion and action plan risk rating

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 can take **no 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 **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.