Audit and Assurance Meeting 3 March 2020

03 March 2020, 09:00 to 12:30

Agenda

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Welcome and Introductions
John Union

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John Union

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Declarations of Interest
John Union

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John Union

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Action Log - 3 December 2019
John Union

5 - Action Log Dec 2019 v3.pdf (3 pages)

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Chair's Action taken since last meeting

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ITEMS FOR REVIEW AND ASSURANCE

7.1
Internal Audit Progress and Tracking Report
Ian Virgil

7.1 - CV AC A&A Progress Report cover March 2020.pdf (3 pages)

7.1.1 - CV AC A&A Progress Report March 20.pdf (25 pages)

7.1.1
Consultant Job Planning Follow-up
Stuart Walker

7.1.2 - CUHB1920.41 Consultant Job Planning Follow-Up Final Report.pdf (21 pages)

7.1.2
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David Thomas

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7.2
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WAO

7.2 - WAO 2020 Audit Plan for CVUHB.pdf (18 pages)

7.3
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Scott Lavendar

7.3 - Cardiff & Vale year-end report 19-20.pdf (1 pages)

7.4
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Nicola Foreman

7.5 - Draft report for Audit - March 2020.pdf (4 pages)

7.5.1 - DoI Register for Audit - March 2020.pdf (9 pages)

7.5.2 - Corporate Governance Standards of Behaviour Process Map.pdf (3 pages)

7.5
Regulatory Compliance Tracking Report

Nicola Foreman

7.5 - Regulatory Compliance Covering Report.pdf (4 pages)

7.5.1 - Regulatory Heat Map - March Audit.pdf (7 pages)

7.6
Internal Audit Tracking Report

Nicola Foreman

7.6 - Internal Audit Tracker Covering Report.pdf (3 pages)

7.6.1 - Internal Audit Summary Tables - Appendix 1.pdf (3 pages)

7.6.2 - Inter Audit Recommendation Tracker - March 2020v2.pdf (20 pages)

7.7
Wales Audit Tracking Report

Nicola Foreman

7.7 - External Audit Recommendation Tracking covering report.pdf (2 pages)

7.7.1 - External Audit Summary Table - Appendix 1.pdf (1 pages)

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Nicola Foreman

8.1 - Audit Cover Report - Annual Report Timetable and Summary - 03.03.20.pdf (12 pages)

8.2
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Nicola Foreman

8.2 - Terms of Reference - covering report.pdf (2 pages)

8.2.1 - Audit Committee TOR.pdf (9 pages)

8.3
Committee Work Plan 2020/21

Nicola Foreman

8.3 - Covering report - work plan 2020.21.pdf (2 pages)

8.3.1 - Audit Committee Work Plan 2020.21.pdf (1 pages)

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Nicola Foreman

- 8.4 - Audit and Assurance Annual Cover ReportNF.pdf (2 pages)
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- 9.1.5 - CUHB1920.30 CW CB Consultant Leave Final Report.pdf (17 pages)

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- 9.1.6 - CUHB1929.39 Medical Staff Study Leave Final Report.pdf (20 pages)

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- 9.1.7 - CVU Control of Contractors 1920_Final Report.pdf (32 pages)

9.1.8
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- 9.1.8 - CUHB1920.24 digital readiness final report.pdf (24 pages)

9.2
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ITEMS TO BRING TO THE ATTENTION OF THE BOARD / COMMITTEE

John Union

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REVIEW OF THE MEETING

John Union

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Date and time of Committee meeting:

12.1
Tuesday, 21 April 2020, at 9.00am, Coed y Bwl, Woodland House

UNCONFIRMED MINUTES OF THE AUDIT COMMITTEE
HELD ON MONDAY, 3 DECEMBER 2019
COED Y BWL ROOM, GROUND FLOOR, WOODLAND HOUSE
MAES Y COED ROAD, HEATH, CARDIFF CF14 4HH

Present:

John Union	JU	Chair – Audit
Eileen Brandreth	EB	Independent Member - ICT
Dawn Ward	DW	Independent Member – Trade Union

In attendance:

Anne Beegan	AB	Wales Audit Office
Robert Chadwick	RC	Executive Director of Finance
Nicola Foreman	NF	Director of Corporate Governance
Craig Greenstock	CG	Counterfraud Manager
Mark Jones	MJ	Wales Audit Office
Alexandra Scott	AC	Patient Safety Quality Assurance Manager
Ian Virgil	IV	Interim Head of Internal Audit

Secretariat: Glynis Mulford

Apologies:

Stuart Walker	SW	Executive Medical Director

		ACTION
AC: 19/12/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	
AC: 19/12/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
AC: 19/12/003	**DECLARATIONS OF INTEREST** The Chair invited Members to declare any interests in the proceedings. None were declared.	
AC: 19/12/004	**MINUTES OF THE AUDIT COMMITTEE HELD ON 30 SEPTEMBER 2019** The Committee reviewed the minutes of the meeting held on 30 September 2019. **The Committee resolved that:** The Committee received and approved the minutes of the meeting held on 30 September 2019.	
AC: 19/12/005	**ACTION LOG FOLLOWING THE LAST MEETING** The Committee reviewed the Action Log of the meeting held on 30	

September 2019, and noted that the following amendments should be made:

AC: 19/09/005 – Wales Audit Report on Medical Equipment: In regards to how other Health Boards deal with equipment less than £5k inventory. **COMPLETED**

AC: 19/009/007 – Brexit Update: To check as this item had been raised at Board.

AC: 19/09/012 – Clinical audit: change wording on action from internal audit to clinical audit.

The Committee resolved – that:

a) the action log be amended and noted.

AC: 19/12/006 **CHAIRS ACTION TAKEN SINCE LAST MEETING**

No actions have been taken.

AC: 19/12/007 **INTERNAL AUDIT PROGRESS AND TRACKING REPORT**

Mr Ian Virgil, Acting Head of Internal Audit presented an overview of the progress report on the internal audit plan. The following comments were made:

- Members were provided with the details of delayed audits. The delay to the Tentacle IT system, which had received a limited rating, had been reviewed at a recent cancer meeting. Responses to those recommendations would be produced shortly.
- The Consultant Job Planning report was in draft due to delay in receiving responses from Management. The draft report had been received by the Management Executive meeting and the outstanding information would be pursued.
- Five other reports were delayed due to resourcing issues in the Internal Audit team. Members were advised that vacant posts had been appointed to and the outstanding reports would be completed by the end of the year.
- The remaining 11 reports gained positive outcomes with substantial or reasonable ratings.
- The Kier Construction report was a specific piece of work looking at supply chain contractors and as it centred on processes outside the Health Boards remit. Feedback could not be provided and would not feed into the annual opinion.
- The Continuing Healthcare (CHC) reports were assigned separately as the processes for child and adult CHC differed.

The Chair asked for comments and questions:

Independent Member – ICT asked how the Committee followed through on actions on the tracker. In response it was confirmed that

actions would be placed on the Internal Audit tracker and monitored until they were completed. As Clinical Boards became aware of the process the tracker would become more robust. Further assurance would be provided as the tracker would be presented at the Management Executives meeting and the leads would distribute the tracker to their team to respond. In addition, Clinical Board Directors would review the tracker at the HSMB meeting.

The vast majority of audits received a positive outcome, but two reports received limited assurance which may impact on the year end opinion.

Adjustments to the plan were explained in regard to Brexit Planning which was delayed to fit in with the availability of Management. The Board would be changing the strategy around Commercial Outlets and therefore this item had been removed from the plan. Members were happy with the described adjustments.

Timeliness of responses showed that the Health Board had achieved 79% against the KPI. This was below the target of 90% but had increased from last year when the compliance rate was 56%, this represented a big improvement.

In conclusion, the Chair confirmed that it was encouraging to see the amount of substantial and reasonable reports coming through.

The Committee Resolved that:

a) The Committee considered the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports;
b) Considered and approved updates to the Internal Audit Plan; and
c) Agreed to the adjustments to the Internal Audit Plan.

AC: 19/12/008

INTEGRATED CARE FUND REPORT – CARDIFF AND VALE REGIONAL PARTNERSHIP FUND

Anne Beegan, Wales Audit Office (WAO) informed Members that the report focused on the Integrated Care Fund and Regional Partnership Boards (RPB) across Wales and whether funds were being used effectively to deliver services. A few areas had been identified for improvement and this was consistent across Wales. Also highlighted was membership of the various levels within the RPB to ensure independence, as there was a potential conflict of interest around decisions being made concerning the Integrated Care Fund (ICF).

The Chair asked for comments and questions:

- Independent Member – Trade Union asked how would the WAO know that the recommendations would be adopted and implemented? It was confirmed that WAO called these "areas for improvement" because they were areas that were fed back to the

RBPs. Where there was an area for improvement, this sat within the national report and would be monitored through Welsh Government. The WAO would not follow-up on specific actions as this would be undertaken nationally. The work was followed through the lens of the ICF but the message to WG from WAO was that the same process was being used with the Transformation Fund which was much bigger. Therefore questions were in the pack for Board members to raise and consider regarding the RPBs role. On a positive note, good practice was seen from C&VUHB.

- Reference was made to an exit strategy and the requirement for an exit fund in regards to when monies stop or need to be used for something else.
- Another area to consider was the ability to strongly evaluate projects. Feedback received during projects was that it was difficult to demonstrate that the projects being funded had an impact and therefore were justified in being mainstreamed. This was especially difficult when a project was up against service areas where funding had been cut. There was a need to be clear on what RPBs wanted to achieve with the funds made available and how projects would be mainstreamed.
- Some of the propositions made were to move healthcare into the community and how to move funding from healthcare into this area and who should be governing these decisions. Some of the money involved was small scale compared to core funding which should fit in with the strategy It was realised that the conversations were difficult and that the committee needed to keep eye on the original objectives.
- One of the bigger concerns was the scrutiny and governance of RPBs. It was confirmed that it was within our gift to play a role in this, LA strategy, links with PSBs and wellbeing challenges. It was noted that this was a complex matter and should be included within the IMTP.

The Committee resolved that:

a) The Integrated Care fund Report be noted

AC: 19/12/009 **AUDIT COMMITTEE UPDATE**

Mark Jones, Wales Audit Office provided an overview of the Audit Plan and went through several key points:

- The Substance Misuse Action Fund Grant claim had a positive outcome and WAO audited the 2018-19 Funds held on the Trust Account. This would be considered by the Trustees on 19 December 2019. Planning for 2019/20 audit had commenced.
- A review would be undertaken on Operating Theatres. Some areas highlighted for consideration were staff engagement and moral.
- There had been delays experienced with Orthopaedic Service follow-up fieldwork.
- The all Wales Counterfraud phase 2 was a national piece of

- work and a deep dive would be undertaken across all public sector bodies. The deadline for the report would be tight and WAO are looking for a two page high level report.
- The mandated work would cover quality governance arrangements linked to the Cwm Taf report and would build on the work and methodology.

The Committee resolved that:

a) the Wales Audit Office Committee Update be noted.

AC: 19/12/010 **STRUCTURED ASSESSMENT**

Anne Beegan, Wales Audit Office presented the report that followed up on financial work where a number of recommendations had been made. It also followed on from recommendations made in previous work. The report was positive and covered what needed to be addressed.

In regards to governance arrangements, there was scope to improve performance reporting at Board and committee level and the flows of information between the senior management teams and the Board. There was a need for traction around Strategic Planning and its delivery but it was acknowledged that the Health Board was in a positive financial position. It was noted that there were still challenges in managing workforce productivity and efficiency, including job planning compliance and a few policies that needed updating.

- Independent Member – Trade Union confirmed that she appreciated the comment made in the report regarding the workload of Independent Members.
- In regards to the National Fraud Initiative, it was explained that it ran every two years and was delivered by Shared Services. The initiative matched various things such as where people claimed benefits and procurement issues where there may be multiple credit invoices and how they marry together.
-

The Committee resolved that:

a) The Structured Assessment be noted

AC: 19/02/011 **IMPLEMENTING THE WELLBEING OF THE FUTURE GENERATIONS ACT**

Anne Beegan, Wales Audit Office informed members that the Auditor General for Wales was required to assess the extent to which Health Boards were implementing the Act. The work was refreshed and focused on an update of corporate arrangements and centred on a particular step and how this was being demonstrated. The Health Board put forward a step around Health and Wellbeing hubs and tested the five key ways of working. The workshops

provided a more collaborative way forward and provided learning for future steps in relation to the Act. Using the examples, Cardiff and Vale would feature in the national report.

The Committee resolved that:

a) The Wales Audit Office Structured Assessment be noted

AC: 19/12/012 **EFFECTIVENESS OF CLINICAL AUDIT REPORT**

Alexandra Scott, Patient Safety Quality Assurance Manager informed Members that the Health Board facilitated a high level of national mandated audits and confirmed that there was an extensive local audit programme. There was a targeted programme of activity and the Health Board was prudent in completing the audits. There were 38 national audits mandated by Welsh Government which were planned in advance. The outcomes were reported to a local forum of the Clinical Board and the Quality, Safety and Experience sub Committee. High level reports on local and national audit plans will also be put before the QSE Committee meeting in December.

Audits were undertaken largely by clinicians who undertook quality improvement as part of their training. The three audit tiers were explained with tier 3 being undertaken for personal development. It was confirmed that the health board did not provide any resource for this.

The chair asked for questions and comments:

There was no clinical audit tracker in place as there was a more dynamic programme in operation which looked at priorities and was responsive to demand. It was explained that each year Clinical Boards forwarded there priorities and informed their teams of the number of audits to be undertaken during the year. These audits will be monitored through the QSE Committee. The National audits were different as they were planned in advance and the outcome was unknown until the results were published. Corporate oversight was provided and if an audit failed locally, it would be reported to WG and an improvement and action plan put in place to address the results.

In regard to the Audit and Assurance Committee providing oversight and assurance within its scope, it was stated that the committee would ensure there was an audit plan in place, but this would be monitored and delivered through QSE Committee.

The Committee resolved that:

a) Arrangements in placed would be considered to deliver and effective programme of clinical audit — SW

AC: 19/12/013	**DECLARATIONS OF INTEREST AND GIFTS AND HOSPITALITY TRACKING REPORT** The Director of Corporate Governance provided an overview of the above report. The number of declarations had increased to 1,278, which accounted for 10% of the workforce. For the majority of forms received there were no concerns with what had been declared. The current process being rolled out is designed to ensure that the procedure and policy is embedded into the Health Board and for the tracker to be converted electronically so that it can be completed and uploaded automatically to the declaration register. A communications campaign has been undertaken to raise awareness across the Health Board. The onus was on the individual to declare any interests and there is still a requirement to declare a nil return. There was discussion around the form in regard to international standards relating to the wording on immediate family. To provide clarity the DOCG said she that she would check the wording on the form and policy and report back to the Committee. **The Committee resolved that:** a) the Declarations of Interest, Gifts, Hospitality & Sponsorship Register be noted.	**NF**
AC: 19/12/014	**REGULATORY BODIES TRACKING REPORT** The Director of Corporate Governance provided an updated report from last month which highlighted and summarised inspection outcomes. The latest Internal Audit report received a rating of reasonable assurance. Input from Clinical Boards and Corporate Departments is becoming more robust and reports and inspections are being fed into the Audit and Assurance Committee so that it has an oversight of what was happening across the Health Board. Some of the items on the tracker had been allocated to other committees of the Board to monitor. Members were informed that regulators had been asked to write to the CEO. This was in order to tighten up governance arrangements and for the Corporate Governance Department to be aware of when inspections took place. **The Committee resolved that:** a) the inspections which have taken place since the last meeting of the Audit Committee in September 2019 and their respective outcomes be noted. b) the continuing development of the Legislative and Regulatory Compliance Tracker be noted.	
AC: 19/12/015	**INTERNAL AUDIT TRACKING REPORT**	

The Director of Corporate Governance presented the Internal Audit tracking report and Members reviewed the completed actions. The tracker provided baseline information and would be updated at future meetings. The document backtracked two years and the response received was encouraging, although it was acknowledged that it would take time to catch up and embed into the system. The acting Head of Internal Audit said he would provide sample validation from Clinical Boards to test for accuracy in a future Internal Audit review. **IV**

The Chair confirmed that he would review the trackers with the Director of Corporate Governance. **JU / NF**

The Committee resolved that:

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

AC: 19/12/016 **WALES AUDIT OFFICE TRACKING REPORT**

The Director of Corporate Governance presented the External Audit tracking report and informed Members that since the last meeting 60% of actions had been completed and the Health Board could demonstrate that there had been movement on actions not yet completed. Any outstanding reports would be added to the tracker.

The Committee resolved that:

(a) The progress which has been made in relation to the completion of WAO recommendations be noted

AC: 19/12/017 **REVIEW LOSSES AND SPECIAL PAYMENTS**

The Executive Director of Finance presented the report and informed Members that the Losses and Special Payments Panel met twice a year to review all losses and special payments and is tasked with considering the circumstances around all such cases and to make appropriate recommendations to the Committee.

The Committee resolved that:

a) The detailed minutes of the Panel meeting attached at Appendix 1 be noted.

AC: 19/12/018 **COUNTERFRAUD AND CORRUPTION POLICY**

Craig Greenstock, Counterfraud Manager, informed Members that since the last policy was written, changes had occurred under the GDPR which resulted in minor changes to wording. The updated policy now complied with all GDPR requirements.

	The Committee resolved that: a) The Counter Fraud and Corruption Policy be received, considered and approved
AC: 19/12/019	**ITEMS FOR NOTING AND INFORMATION** The Committee received the following Internal Audit reports for information: 1. Mental Health CB 3rd Sector Contracts 2. Claims Reimbursement Final Report 3. Private Overseas Patients Final Report 4. Surgery CB Medical Finance Governance Follow-up Final 5. Deprivation of Liberty Safeguards Final Report 6. Charitable Fund Final Report 7. PCIC Business Continuity Final Report 8. Maelfa: Wellbeing Hub 9. PCIC Clinical Board CHC Adults Follow-up 10. Children & Women Clinical Board: CHC Child Follow-up **The Committee resolved that:** **a)** Items for information were noted
AC: 19/02/020	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD / COMMITTEE** There were no items to bring to the attention of the Board / Committee.
AC: 19/02/021	**DATE OF THE NEXT MEETING OF THE COMMITTEE** Tuesday, 3 March 2020, 9.00am – 12.00pm Cefn Mably Room, Ground Floor, Woodland House, Heath, Cardiff CF14 4HH

Action Log
Following Audit & Assurance Committee Meeting
3 December 2019

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
AC 19/04/012	Tracking Report from Recommendations from Regulatory Bodies	A project plan on the dashboard would be taken to Management Executives and HSMB for consultation and approval	N Foreman	30.09.19	**COMPLETED.** Plan agreed to roll out high level dashboard to Corporate Governance
AC 19/09/012	Clinical Audit	A detailed report on internal audit would be brought to the next meeting.	S Walker	3.12.19	**COMPLETED.** Item on agenda for December meeting *(Agenda Item 7.6)*
AC 19/09/009	WAO Progress Report	To bring the Integrated Care Fund and Structured Assessments Reports to the next Committee meeting	WAO	3.12.19	**COMPLETED.** Items on agenda for December meeting. *(Agenda Item 7.3)*
AC 19/09/007	Brexit Update	Request for update to be brought to a future meeting	A Harris		**COMPLETED** This was discussed at the Board meeting in July.
AC 19/09/005	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	3.12.19	**COMPLETED** Chair to discuss off line with the Executive Director of Therapies and Health Science and if action completed to bring back to December meeting.
AC 19/05/007	Internal Audit Progress Report: Cyber Security – Limited Assurance	Follow-up review was on the 2019/20 plan	I Virgil	25.02.20	**CLOSED** This item has been superseded by the ICO undertaking an audit of Cyber Security during February / March.
AC 19/12/015	Internal Audit Tracking Report	The Chair to review tracker with the Director of Corporate Governance	J Union and N Foreman	7.07.20	**COMPLETED**

Actions in Progress					
AC 19/12/012	Effectiveness of Clinical Audit Report	To consider arrangements to deliver effective programme of Clinical Audit	S Walker		This is currently being considered as part of the Self-Assessment of Current Quality Governance arrangements - May 2020
AC 19/12/013	Declarations of Interest and Gifts and Hospitality Tracking Report	To provide clarity on the wording on the form and policy regarding international standards relating to wording on immediate family.	N Foreman	31.03.20	Immediate family includes parents, grandparents, spouse, children, grandchildren, brothers, sisters, mother in law, father in law, daughters in law and sons in law. This would also include adopted, half and step members. The form and policy will be amended to ensure that these definitions are clear and the new form and policy will be introduced from the new financial year.
AC 19/12/015	Internal Audit Tracking Report	The acting Head of Internal Audit to provide sample of validation from Clinical Boards to test for accuracy in a future Internal Audit and Review	I Virgil	7.07.20	To be brought to the July 2020 meeting
AC 19/09/017	Declarations of Interest Report	To provide details of those who had not submitted declarations and the breakdown of non-compliance	N Foreman	21.04.20	This is currently 60% of 8a and above but has reduced down from 75% reported at the last meeting. These are followed up twice by the Corporate Governance Officer then escalated to the Head of Corporate Governance who also does a chase. For the April Audit Committee we will report non compliance by % of each Clinical Board this will also be reported to HSMB to ensure the Clinical Board Directors are aware of non compliance in their areas.
AC 19/05/007	Internal Audit Progress Report	The review of Performance Reporting Data Quality – RTT would be moved to the 2019/20 plan	I Virgil	25.02.20	This has been forwarded from February to the April 2020 meeting

Actions referred to other Committees/Board					

REPORT TITLE:	Internal Audit Progress Report							
MEETING:	Audit & Assurance Committee				MEETING DATE:	03.03.20		
STATUS:	For Discussion		For Assurance	x	For Approval	x	For Information	
LEAD EXECUTIVE:	Director of Governance							
REPORT AUTHOR (TITLE):	Head of Internal Audit							

PURPOSE OF REPORT:

SITUATION:

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

- Detail 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 two reports that have been given a Limited 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 / removed 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 & Assurance 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 & Assurance Committee March 2020

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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2. Assignments With Delayed Delivery
3. Outcomes From Completed Audit Reviews
4. Delivery of the 2019/20 Internal Audit Plan
5. Development of the 2020/21 Internal Audit Plan
6. Final Report Summaries

Appendix A - Assignment Status Schedule
Appendix B - Assurance Summary by Domain
Appendix C - Audit reporting finalisation timescales
Appendix D- Audit & Assurance Key Performance Indicators

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

Disclaimer notice - Please note:

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

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

1. INTRODUCTION

1.1. This progress report provides the Audit & Assurance Committee with the current position regarding the work 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 & Assurance 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 by the March Audit & Assurance Committee but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
Infection Prevention & Control	Draft	Reasonable	Management responses not received in time for Committee
Surgery CB – Specialing of Ward Patients	Work in Progress		Delay in completing fieldwork due to accessing ward areas
Medicine Clinical Board – QSE Governance	Work in Progress		Delay in commencing fieldwork due to availability of Internal Audit resources
Strategic Planning / IMTP	Work in Progress		Fieldwork delayed at request of Management
CD&T Lab Turnaround Times (TAT)	Work in Progress		Delay in agreeing brief. Then delay in completing fieldwork due to accessing ward area

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

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Budgetary Control	Substantial	
Brexit Planning	Reasonable	
Safeguarding Adults and Children		
Freedom of Information Reviews		
C&W CB – Consultant Leave		
Medical Staff Study Leave		
Control of Contractors		
Consultant Job Planning Follow-up	Limited	
Tentacle IT System		
Digital Readiness	Not Rated	

4. DELIVERY OF THE 2019/20 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.

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

4.2. The majority of the audits that have reached reporting stage for the current year have concluded positively with ratings of reasonable or substantial assurance. There are however two audits that have been finalised with ratings of limited assurance.

The outcome of the Consultants Contract Follow-up illustrates that the previously agreed management actions have not been progressed. The fact that this follow-up remains Limited will have a more significant impact on the potential year-end opinion.

As detailed in section 4.3 below, the planned follow-ups of General Data Protection Regulations (GDPR) and Cyber Security have been removed from the Plan. This reflects the fact that the Information

Commissioners Office (ICO) are carrying out an audit of these areas during February and March. Reliance will therefore be placed on the outcome of the ICO audit to provide assurance on the progress that has been made towards implementing the previously agreed management actions in these areas.

The Health Board will need to be mindful of the impact of the two limited assurance reports, especially the Consultants Job Planning Follow-up. However, the Reasonable and Substantial outcomes for the remaining reports that have been finalised to date suggests that Health Board remains on course for a positive overall opinion. However, with the number of audits in the plan still to be delivered, this could potentially change between before 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 remaining planned work.

4.3. Adjustments to the 19/20 plan.

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

- GDPR and Cyber Security Follow-ups – Removed from plan - Reliance to be placed on the ICO audit being undertaken in February and March 2020;
- Engagement around Service Change – Deferred to 20/21 – Agreed with Director of Planning;
- Integrated Health Pathways – Deferred to 20/21 – Agreed with Director of Transformation; and
- IT Service Management (ITIL) – Deferred to 20/21 – Was scheduled for completion either in Q4 of 19/20 or Q1 of 20/21 – Agreed with Director of Transformation.

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.

When audit reports are issued as draft, management are required to provide responses, along with sign off for the report from the lead Executive, within 15 working days.

Since the last Audit & Assurance Committee five reports were not responded to within the required timescale due to delays in either receiving management responses or Executive sign-off.

The Health Board's rate of compliance with the KPI for provision of management responses was around 80%. However, the significant delays in responding to recent reports means that this has fallen to around 69%.

5. DEVELOPMENT OF THE 2020/21 INTERNAL AUDIT PLAN

5.1. The process for developing the 2020/21 Internal Audit plan has commenced. Meetings have been held with the majority of Executive Directors, including the Chief Executive, the Clinical Board Directors of Operations and the Chairman.

An initial draft plan will be submitted to a meeting of the Executive Management Team during March for comment. An updated draft will then be presented to the April Audit & Assurance Committee for formal approval.

6. FINAL REPORT SUMMARIES

6.1. Budgetary Control

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's three year Integrated Medium Term Plan (IMTP) for 2019-2022 has been approved by the Welsh Government (WG) for the first time in three years. The IMTP forms the basis of the Health Boards Financial Plan and annual budgets are appropriately set in accordance with the IMTP and Welsh Government resource allocation.

The Health board has a clear and robust framework in place for monitoring and reporting performance against the budget with regular reporting on financial performance against the budget at all levels from Divisional Managers, Clinical Boards Directorates, Clinical Boards and Finance Committee up to the Board.

Senior Financial Business Partners are assigned to each Clinical Board to provide support to the Clinical Board and the delegated budget holders. Budgets are appropriately delegated down to directorate managers within each Clinical Board. However, delegated budget holders are not required to sign-up to their budget, which we would consider best practice.

The level of reporting at all levels is sufficient to enable effective monitoring and review of the UHB, Clinical Boards and Directorates financial performance against their budgets.

6.2. Brexit Planning

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 overall the arrangements in place for control within the Brexit planning arrangements were of a reasonable standard as at 31st October 2019. If the same controls are applied at the final Brexit point then the associated risks should be managed appropriately, if the issues identified within this report are addressed.

Good practice was noted across the majority of areas reviewed e.g. there was positive engagement and communication with both internal and external stakeholders.

The review highlighted one high priority finding relating to the business continuity arrangements with the Mental Health Clinical Board. Enhancements are also required across a number of other areas that were reviewed as part of the audit.

6.3. Safeguarding Adults and Children

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 review found that the systems and processes in place for the management and oversight of safeguarding within the Health Board are of a reasonable standard.

There are dedicated Safeguarding pages on the Intranet that provide information on all relevant guidance and processes to follow for safeguarding issues as well as details of key contacts.

There is a clear structure in place and the reporting arrangements are well defined. The Safeguarding Steering Group meets on a bi-monthly basis to oversee Safeguarding issues and regular updates are then provided to the Health Board's Quality, Safety & Experience Committee.

The Audit found that arrangements in place to allow for multi-agency working were appropriate also noting that the Health Board is a member of the Cardiff & Vale Regional Safeguarding Board.

There were a few minor issues raised regarding the updating of terms of reference and also the absence of evidence to support several of the processes in place.

However the audit did identify two high priority issues during the audit. These related to the poor compliance rate for the statutory & mandatory training modules for safeguarding and also poor attendance of some of the Clinical Boards at the Safeguarding Steering meetings.

6.4. Freedom of Information Reviews

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 note that at present the UHB is partway through a significant, wholesale Digital Strategy transformation programme covering all aspects of UHB digital integration. This includes information governance, of which FoI is one small part.

We found that the UHB was not complaint with FoI requirements throughout 2018; however we note that this was recognised and steps were taken to address the deficiencies. Staffing changes were made and the current team and structure has been in place since November 2018. We also note that this is part of the ongoing digital transformation and may not yet be fully complete or permanent.

FoI compliance has improved significantly over the previous year with an overall compliance rate for January to September 2019 of 85.22% and the assurance rating reflects the current situation.

Although there has been a significant improvement over 2018 there are still opportunities for further process improvements, and to further embed FoI compliance requirements throughout the entire area of board operations.

The key issues identified in the report are the lack of permanent staffing in place to cover FoI, which leads to an underlying risk of the Health Board being unable to maintain compliance with the FoI Act in the event of key staff leaving and the lack of any formal quality assurance process or approval of responses prior to release.

6.5. Children & Women CB – Consultants Annual Leave

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.

Consultants' annual leave is administered through Intrepid which has many in-built controls and so is a good basic, fail-safe platform for such purposes. Additionally, many consultants will be familiar with the system from their junior doctor training. Aspects of the overall control framework can be strengthened by developing the policy and ensuring that it is underpinned at Directorate level by localised procedures, thereby promoting more consistent administrative functions.

The review identified seven medium priority recommendations for management consideration.

A separate review of Medical Staff Study Leave, also administered through Intrepid, was completed in conjunction with this work. Those recommendations that relate primarily to Intrepid but are reported in that report are the need to:

- assess and review the use of Intrepid as a tool for recording activities other than those of junior doctors and formulate a plan going forward; and
- develop the Intrepid User Group to coincide with the introduction of the updated Policy and procedures.

These findings have been taken into account in arriving at the assurance ratings for this review.

6.6. Medical Staff Study Leave

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

Overall the Health Board Medical Staff Study Leave Procedure provides a sound administrative control framework and testing confirmed that the Procedure is being properly applied at Directorate level.

However, elements of the control framework can be strengthened. Developing the HB Procedure. to incorporate direction on areas such as budgeting, and ensuring that it is underpinned at Directorate level by localised procedures will promote more consistent administrative functions.

Study leave is administered through Intrepid which has many in-built controls and so is a good basic, fail-safe platform for administration purposes. Intrepid was initially designed to be a junior doctor administration tool but over time its use has been extended. It would therefore be opportune to assess and review its fitness of purpose for its current uses as well as develop the role of the Intrepid User Group.

The review identified six medium priority recommendations for management consideration.

6.7. Control of Contractors

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.

Being cognisant of the work that has been invested by the UHB over recent years, general compliance was noted with the established control frameworks including:

- Governance;
- Vetting of contractors, for compliance to HSE requirements, prior to commencement of work; and
- Monitoring and reporting of contractors (and related incidents where applicable).

However, application of the expected standards was reduced in the following areas:

- Risk Assessment and Method Statements (RAMS) need to be received prior to commencement of work and retained;
- A data cleansing exercise of the Backtraq system needs to be undertaken to ensure only current, verified contractors are recorded;
- The induction process needs to be updated to reflect consistency with UHB policies;
- The sign in/out reporting functionalities of Backtraq require improvement;
- The formality of the sign in/out process of contractors on community sites requires addressing;
- A review on the use (and retention) of Job Evaluation Forms (JRFs) is required to ensure consistency of application;
- The formality of monitoring of contractors on site, and reporting post completion, needs to be enhanced;
- The Permit to Work procedure needs to be finalised and ratified; and
- The requirement for reporting of UHB compliance to the Control of Contractors policy, on an annual basis, needs to be addressed.

It is acknowledged that some of the above will be addressed through contractor review meetings, which will be scheduled through the newly established contractor frameworks; in addition to the implementation of a JRF database for use by Supervising Officers.

6.8. Digital Readiness

This was an advisory audit and therefore the assignment was **not** allocated an assurance rating, the following conclusion was however noted.

Cardiff & Vale UHB is not well advanced in the use of digital technologies, and this is due to a variety of reasons, including the low expenditure on IT, the historically fractured nature of the management of IM&T across the organisation and the and lack of formalised ADI role. This position is

changing with the structures within the UHB being revised. The ADI role has been formalised, as has the CCIO and the reporting and management Committee has been elevated to a formal Board Sub-committee. The Health Board is developing a digital strategy and continuing to revise structures to allow a vision for how technology will enable service delivery to take shape. These changes, along with other intended changes will better position the health board to take advantage of digital technology.

The development process for the Digital Strategy acknowledges that is needs to be led by users and Clinical Boards are being asked to consider their functional requirements. The development process also includes a focus on user needs and the Health Board has a framework for engaging with users with a Clinical Informatics Group in existence.

Although there is no articulated vision for the use of digital technologies, staff across the Health Board are generally positive about the potential benefits of technology and there is an appetite for increased use of this.

There are also structures in place to facilitate the generation of ideas for new ways of working and taking these forward.

There are a number of barriers which will impact the delivery of a digital strategy, and we note that the draft Strategy acknowledges and proposes mechanisms to minimise these. The chief of these is the lack of funding as this is sought on a case by case basis. The required level of resource in ICT has not been fully defined, however it is likely is not fully sufficient to allow for full collaborative working with users. In particular, there is a lack of analysts to work with Clinical Boards. This issue is exacerbated by the legacy systems position and the nature of the NHS in Wales with systems and services being provided by a mixture of local ICT and national systems provided by NWIS.

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
Charitable Funds	15		Finance	Q2	Final – Issued October 19	Reasonable	Dec
Private and Overseas Patients	17		Medical	Q1	Final – Issued October 19	Reasonable	Dec
Maelfa: Wellbeing Hub	SSU		Planning	Q3	Final – Issued October 19	Reasonable	Dec
Surgery CB – Medical Staff Governance Follow-up	37		COO	Q1	Final – Issued October 19	Reasonable	Dec

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
MH CB – Third Sector Contracts	29		COO	Q1	Final – Issued October 19	Substantial	Dec
Kier Construction Compliance with the Fair Payment Charter	SSU		Planning	Q3	Final – Issued November 19	n/a	Dec
PCIC CB – Business Continuity	35		COO	Q2	Final – Issued November 19	Reasonable	Dec
Deprivation of Liberties Safeguards (DoLS)	19		Medical	Q1	Final – Issued November 19	Reasonable	Dec
PCIC CB – CHC Adult Follow-up	07		COO	Q2	Final – Issued November 19	Reasonable	Dec
C&W CB – CHC Child Follow-up	07		COO	Q2	Final – Issued November 19	Reasonable	Dec
Claims Reimbursement	02		Nursing	Q3	Final – Issued November 19	Substantial	Dec
Consultant Job Planning Follow-up	41		**Medical**	**Q2**	**Final – Issued December 19**	**Limited**	**March**
Freedom of Information Reviews	**23**		**Transformation, Improvement & Informatics**	**Q3**	**Final - Issued January 20**	**Reasonable**	**March**
Tentacle IT System	**25**		**Transformation, Improvement & Informatics**	**Q1**	**Final – Issued January 20**	**Limited**	**March**
Use of Digital Technology	**24**		**Transformation, Improvement & Informatics**	**Q2**	**Final – Issued February 20**	**n/a**	**March**
Budgetary Control	14		**Finance**	Q3	**Final – Issued February 20**	**Substantial**	**March**
Safeguarding Adults & Children	**22**		**Nursing**	**Q1**	**Final – Issued February 20**	**Reasonable**	**March**

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
C&W CB – Consultant Leave	**30**		**COO**	**Q3**	**Final – Issued December 19**	**Reasonable**	**March**
Medical Staff Study Leave	**39**		**Workforce**	**Q3**	**Final – Issued December 19**	**Reasonable**	**March**
Brexit Planning	**09**		**Planning**	**Q2**	**Final – Issued February 20**	**Reasonable**	**March**
Control of Contractors	**SSU**		**Planning**	**Q2**	**Final – Issued February 20**	**Reasonable**	**March**
Infection Prevention and Control	21		Nursing	Q2	Draft – Issued February 20	Reasonable	April
Rookwood Relocation Capital Project	SSU		Planning	Q4	Draft – Issued February 20	Reasonable	April
Risk Management / BAF Development / Risk Registers	03		Governance	Q4	Work in Progress		April
Management of Health Board Policies	04		Governance	Q4	Work in progress		April
Strategic Planning / IMTP	08		Planning	Q3	Work in Progress		April
UHB Core Financial Systems	13		Finance	Q3	Work in Progress		April
Surgery CB – Enhanced Monitoring of Ward Patients	31		COO	Q2	Work in Progress		April
Medicine CB – QSE Governance	32		COO	Q2	Work in Progress		April
CD&T CB – Laboratory Turnaround Times (TAT)	33		COO	Q3	Work in Progress		April

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Pre-Employment Checks	40		Workforce	Q4	Work in Progress		April
Service Improvement Team	42		Planning	Q3	Work in Progress		April
Neonatal and Obstetrics Capital Project	SSU		Planning	Q4	Work in Progress		April
Health & Care Standards	01		Nursing	Q4			April
Medicine CB – Internal Medicine Follow-up	38		COO	Q3			April
Strategic Performance Reporting	11		Transformation, Improvement & Informatics	Q3			May
Data Quality Performance Reporting	12		Transformation, Improvement & Informatics	Q4			May
Facilities / Estates Service Board Governance	46		Planning	Q4			May
IM&T Backlog	*SSU*		*Transformation, Improvement & Informatics*	*Q4*			*May*
Removed / Deferred Audits							
Management of Long Term Agreements (LTAs)	16		Finance	Q2	Removed from plan. Agreed by September AC		
Commercial Outlets	43		Planning	Q3	Director of Estates requested removed from plan. Agreed by December AC		
Engagement around Service Change	10		Planning	Q4	Deferred to 20/21. Agreed with Exec Dir of Planning. To be agreed by March AC		

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Integrated Health Pathways	20		Transformation, Improvement & Informatics	Q3	Deferred to 20/21. Agreed with Exec Dir of Transformation. To be agreed by March AC		
IT Service Management (ITIL)	28		Transformation, Improvement & Informatics	Q4	Deferred to 20/21 – Scheduled in plan for either Q4 19/20 or Q1 20/21		
GDPR Follow-up	27		Transformation, Improvement & Informatics	Q4	To be removed - ICO carrying out GDPR audit during Feb which will cover all actions from our audit. – TBA by March AC		
Cyber Security Follow-up	47		Transformation, Improvement & Informatics	Q3	To be removed - ICO carrying out Cyber audit during Feb which will cover all actions from our audit. – TBA by March AC		

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**	**Removed / Deferred Audits**
			Not rated	**No**	**Limited**	**Reasonable**	**Substantial**		
Corporate Governance, Risk and Regulatory Compliance	6					● Legislative Comp Follow-up	● Standards of Behaviour Follow-up ● Claims	● H&CS ● Risk Management ● Management of HB Policies	
Financial Governance and Management	5					● Private & Overseas Patients (Draft) ● Charitable Funds	● Budgetary Control	● Core Financials	● Management of LTAs
Clinical Governance, Quality and Safety	5					● DoLS ● Safeguarding Adults & Children ● *Infection Prevention & Control (Draft)*	● Annual Quality Statement		● Integrated Health Pathways
Strategic Planning, Performance Management and Reporting	7					● PCIC CB – Adult CHC Follow-up ● C&W CB – Child CHC Follow-up ● Brexit Planning		● Strat Plan / IMTP ● Strategic Performance Reporting ● Data Quality Performance Reporting	● Engagement Around Service Planning

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**	**Removed / Deferred Audits**
			Not rated	**No**	**Limited**	**Reasonable**	**Substantial**		
Information Governance and Security	7		● Use of Digital Technology		● Tentacle IT System	● Freedom of Information Reviews		● 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 ● Specialist CB - Rosterpro ● PCIC CB – Business Continuity ● Surgery CB – Medical Staff Governance Follow-up ● C&W CB – Consultant Leave	● MH CB –Third Sector Contracts	● Surgery CB – Specialing of Ward Patients ● Medicine CB – QS&E Governance ● CD&T CB – Laboratory Turnaround Times (TAT) ● Medicine CB – Internal Medicine Follow-up	
Workforce Management	3				● Consultant Job Planning Follow-up	● Medical Staff Study Leave		● Pre-Employment Checks	

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**	**Removed / Deferred Audits**
			Not rated	**No**	**Limited**	**Reasonable**	**Substantial**		
Capital and Estates Management	10		● Kier Construction Compliance with the Fair Payment Charter			● Sustainability Reporting ● Maelfa Wellbeing Hub ● Control of Contractors ● *Rookwood Relocation (Draft)*	● Carbon Reduction Commitment	● Service Improvement Team ● Facilities / Estates Service Board Governance ● Neonatal & Obstetrics Project	● Commercial Outlets

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	12/09/19	G
Legislative / Regulatory Compliance Follow-up	Reasonable	Final	20/09/19	11/10/19	23/09/19	23/09/19	G
Charitable Funds	Reasonable	Final	30/09/19	22/10/19	17/10/19	17/10/19	G
Private & Overseas Patients	Reasonable	Final	24/09/19	16/10/19	14/10/19	21/10/19	G
Maelfa: Wellbeing Hub	Reasonable	Final	03/10/19	25/10/19	21/10/19	22/10/19	G
Surgery CB – Medical Staff Governance Follow-up	Reasonable	Final	01/10/19	23/10/19	22/10/19	31/10/19	G
MH CB – Third Sector Contracts	Reasonable	Final	02/10/19	24/10/19	22/10/19	31/10/19	G
Kier Construction Compliance with the Fair Payment Charter	n/a	Final	15/11/19	15/11/19	15/11/19	15/11/19	G
PCIC CB – Business Continuity	Reasonable	Final	31/10/19	22/11/19	20/11/19	21/11/19	G
Deprivation of Liberties Safeguards (DoLS)	Reasonable	Final	04/10/19	28/10/19	21/11/19	21/11/19	R
PCIC CB – CHC Adult Follow-up	Reasonable	Final	20/11/19	12/12/19	21/11/19	21/11/19	G
C&W CB – CHC Child Follow-up	Reasonable	Final	21/11/19	13/12/19	22/11/19	25/11/19	G
Claims Reimbursement	Reasonable	Final	22/11/19	14/12/19	24/11/19	25/11/19	G
Consultants Job Planning Follow-up	Limited	Final	17/12/19	10/01/20	02/01/20	07/01/20	G
Freedom of Information Reviews	Reasonable	Final	20/12/19	16/01/20	23/01/20	24/01/20	R

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	
Tentacle IT System	Limited	Final	04/10/19	25/10/19	16/01/20	17/01/20	R	
Use of Digital Technology	n/a	Final	19/12/19	17/01/20	17/02/20	18/02/20	R	
Budgetary Control	Substantial	Final	12/02/20	05/03/20	13/02/20	17/02/20	G	
Safeguarding Adults & Children	Reasonable	Final	02/12/19	23/12/19	06/02/20	18/02/20	R	
C&W CB – Consultant Leave	Reasonable	Final	03/01/20	24/01/20	21/02/20	21/02/20	G	
Medical Staff Study Leave	Reasonable	Final	09/01/20	30/01/20	21/02/20	21/02/20	R	
Brexit Planning	Reasonable	Draft	14/02/20	09/03/30	21/02/20	24/02/20	G	
Control of Contractors	Reasonable	Draft	06/02/20	28/02/20	20/02/20	24/02/20	G	
Infection Prevention & Control	Reasonable	Draft	31/01/20	21/02/20				

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	81% 30 from 37	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 30 from 30	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	R	69% 20 from 29	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 29 from 29	80%	v>20%	10%<v<20%	v<10%

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Cardiff and Vale University Health Board

Consultant Job Planning Follow-Up

Final Internal Audit Report

2019/20

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 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 follow-up review of the Consultants Job Planning report was completed in line with the Internal Audit Plan.

The relevant lead Executive for the assignment was the Medical Director.

The original report was finalised in May 2018 and highlighted 6 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 for the management of Consultant Job Planning in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of system's objectives are managed appropriately.

The purpose of the follow up review was to establish if the previously agreed management actions had been implemented, in order to ensure that Consultant Job Planning is managed and monitored appropriately so that sufficient activity is undertaken to meet the needs of the Health Board.

The scope of this follow up review **did not** aim to provide assurance against the full scope and objectives of the original audit. The 'follow up review opinion' provides an assurance level against the implementation of the agreed action plan only.

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

- All consultants have up to date, accurate and agreed job plans in place;
- Job plans reflect the Health Board's activity requirements and available finances;
- Job plans include personal outcomes that are linked to the Health Board's organisational objectives and the level of achievement is subject to appropriate assessment;
- Job plans are subject to effective review on an annual basis or more regularly where changes in circumstances require;
- An effective team based approach to job planning is utilised to support individual job plans where appropriate and beneficial; and
- The job planning process complies with relevant guidance with all parties engaged and the level of compliance is effectively monitored and reported.

3. Associated Risks

The potential risks considered in this review were as follows:

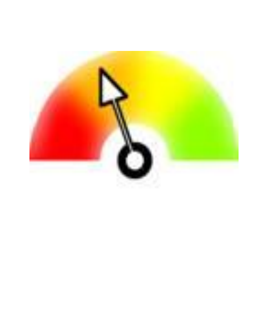
- Sessions worked may not be sufficient to allow for adequate provision of the service; and

- Consultants job plans may not reflect actual conditions or be developed by mutual consent.

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 review did not aim to provide assurance against the full scope and objectives of the original audit. The 'follow-up' 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.

Limited Assurance		**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.

From discussions with key staff and testing of a sample of Consultant Job Plans taken from two Clinical Boards within the Health Board, we have concluded that whilst the results of the previous audit were presented to the HSMB and additional training sessions were provided to Consultants, none of the High Priority recommendations have been fully implemented.

The overall number of the Health Board's consultants with an up to date, signed off job plan or annual review within the last 12 months remains low and at the end of September 2019 was only 37.5%. The quality of job plans also remains poor, with none of the sample reviewed having recorded any personal, service or Health Board outcomes which is a requirement of the Welsh Government Contract. In addition, little progress had been made towards implementing an electronic job planning system.

Our testing has concluded that of the six recommendations originally raised, the agreed management actions had only been fully implemented for one Medium and one Low Priority recommendation; management action had been partially implemented for one High Priority recommendation; and no progress had been made towards implementing the agreed management actions for three recommendations (2 High Priority, 1 Medium Priority).

The limited progress made against the original recommendations and agreed actions, specifically in relation to the low level of consultants with a current, signed off job plan or review, the poor quality of job plans and the

failure to adequately assess the benefits of implementing an electronic job planning system means that the level of assurance that can be given to manage the risks associated with Consultant Job Planning remains as **Limited Assurance**. As such we will undertake a further follow up review in 2020/21.

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.

Priority rating	No of management responses to be implemented	Fully actioned	Partially actioned	Not actioned
High	3	0	1	2
Medium	2	1	0	1
Low	1	1	0	0
Total	**6**	**2**	**1**	**3**

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

- The results of the original audit had been presented to the HSMB in June 2018 but monthly reporting of job planning compliance rates via the Clinical Board Performance Reviews had ceased. The Health Board compliance rate for completed, signed off job plans at the end of September 2019 was just 37.5%;
- There was still a wide variety of job plan formats in use, none of which complied with the requirements of the Welsh Government Contract. Testing also identified instances where the number of sessions recorded in job plans did not match those recorded on ESR;
- None of the job plans tested included the outcomes measures template contained within the C & V job planning guidance;
- The guidance for developing team and annualised hours job plans had been reviewed and updated;
- Additional training highlighting the outcomes from the previous audit had been provided to consultants; and
- Not all job plans tested had been fully signed off and although a pilot was undertaken of an electronic job planning system, this was ineffective and will need to be carried out on a much larger scale to enable a proper evaluation of the potential benefits to be undertaken.

Finding 1 - Annual Job Plans (Operating effectiveness)	**Risk**
In accordance with Job Planning guidance issued by the Cardiff & Vale UHB, job planning must be completed annually for all consultants. The Welsh Government Consultants Contract also states that annual job plan reviews should ideally take place within one month of the consultants' incremental date. A sample of 28 consultants from across the Medicine and Children & Women's Clinical Boards was selected for testing to ascertain whether each consultant had a documented, individual job plan in place that had been completed or reviewed within the last 12 months. Despite multiple requests Job Planning documentation was not provided for 6/28 consultants selected for testing; one from the Medicine Clinical Board and five from the Children & Women's Clinical Board. Only 10/22 job plans received had been completed within the last 12 months, although documentation relating to 6 job plans was undated.	Sessions worked may not be sufficient to allow for adequate provision of the service.
Recommendation 1	**Priority level**
Clinical Boards must ensure that all consultants complete a job plan or have their existing job plan reviewed on an annual basis.	**High**
Management Response	**Responsible Officer/ Deadline**
1. Processes are in place to support the completion and reporting of job planning activity. There is monthly reporting of the annual job planning process via the Clinical Board Performance reviews. There has been recent improvement in a small number of Clinical Boards. Immediate steps will be taken by the Medical Director and the Director of Workforce to target those Clinical Boards with poor	1. Clinical Board Directors – Monitor compliance on a monthly basis through the Clinical Board Performance Reviews with joint review of improvement trajectory

performance and those not significantly improving (5 out of 8) to request an improvement plan which will ask for reported improvement in annual job planning review rates over a period of three months. Clinical Board Directors should ensure that the Clinical Directors take responsibility for these being undertaken and have internal Clinical Board systems to monitor improvement. 2. The Medical Director and Workforce Director will present to the HSMB in June 2018 the outcome of the Internal Audit Report - outlining the actions to be taken and re-emphasise the information available to the Clinical Boards and Clinical Directorates.	monitored via the Medical Director /Director of Workforce. Immediate request for improvement plan, documenting improvement trajectory over three months. 2. 15th June 2018 Medical Director /Director of Workforce.

Current Position

Partially Implemented

1. Monthly job plan compliance rates are no longer reported at Clinical Board Performance Reviews (as noted in part 1 of the management response above). The compliance rate for the HB as a whole is now reported to the Strategy and Delivery Committee. This is questionable given the very low compliance rate as at the end of September 2019 which reported that only 37.5% of Consultants and SAS Doctors had a valid job plan. We were not provided with any evidence that 3 month improvement plans were implemented for five targeted Clinical Boards as per the management response above (part 1), and current compliance rates have not improved since the original audit was undertaken during 2017/18.
2. The outcome of the original audit was presented to the HSMB.

Updated Management Response	Updated Responsible Officer / Deadline
Annualised job planning requires a systematic process in place at CBD level to ensure it happens, alongside a centralised recording and assurance process to measure compliance with this requirement. A new process will need to be defined and agreed that supports this, with a centralised electronic monitoring system adopted - see below.	Executive Medical Director / Initial proposal to be taken to MLT in Feb 2020. Implementation of centralised monitoring system by Aug 2020. CBD process in place by end of 19/20 financial year.

Finding 2 - Job Planning Documentation (Operating effectiveness)	Risk
Job Planning documentation was only provided for 22/28 consultants tested. Review of the documentation provided identified a number of issues with the quality and completeness of the documentation: • The job plan template provided within the UHB Job Planning guidance had only been used for six of the job plans received. In accordance with UHB Job Planning guidance, use of the standard job plan template should be encouraged but is not compulsory as long as all the relevant information is provided. However the majority of non-standard job plans reviewed did not contain all the necessary information. • The number and split of sessions between DCC and SPA recorded on ESR did not agree to job planning documentation for 13 of the 22 consultants that provided documentation; • Six of the 22 job plans provided were 'summary sheets' and did not provide any detail to support the number of sessions recorded in ESR; • The information provided in the job planning documentation reviewed was inconsistent with much of the information lacking detail of the tasks that would be carried out in each session; and • Some of the job planning documentation provided was incomplete.	Consultants job plans may not reflect actual conditions or be developed by mutual consent.
Recommendation 2	**Priority level**
The UHB job planning guidance should require consultants to use the standard Job Plan template contained within the guidance unless they can provide a valid reason for not doing so. Job Planning documentation should be completed in full	**High**

and should include full details of the activities to be undertaken in each session. Line managers should ensure that the number and split of sessions recorded in ESR agrees to and is supported by a fully completed job plan.	
Management Response	**Responsible Officer/ Deadline**
1. Clinical Board Directors and Clinical Directors should ensure that summary job plans data are submitted to the Medical Workforce Team on a regular basis so that updates can be made in the ESR system. This will be recognised by implementation of actions in Management Recommendation 1 in terms of outcomes. 2. Medical Workforce to update ESR system with summary job plan data – this has been already reviewed by the Medical Director and Director of Workforce recently and there is no back-log of data to currently input into the system (maximum wait two weeks). Clinical Directors/DM will be able to submit to ESR and their data will be entered in a timely way. The previous guidance issued will be immediately reissued to Clinical Board Senior Teams for cascade to their Clinical Directorates.	1. Clinical Board Directors/Clinical Directors – one to three months. 2. Medical Director – Immediate.

Current Position

Not Implemented.

Testing of a sample of job plans confirmed that job plans were in a variety of formats, none of which matched the job plan template contained within the guidance.

The overall number and split of sessions between DCC and SPA differed between the job plans and those recorded on ESR for nine of a sample of 20 job plans tested. A further 10 job plans was requested for testing, but to date these have not been received.

Updated Management Response	Updated Responsible Officer / Deadline
All UHB Job Plans should be completed according to a standardised format. It will no longer be acceptable for job plans to be recorded in local formats. This is essential for introduction of a centralised IT monitoring system. This format will not be the current template, but one utilised to facilitate digital recording of the job plan.	Executive Medical Director / Aug 2020.

Finding 3 - Outcomes Measures (Operating effectiveness)	Risk
A key requirement of the Job Planning process is that all consultants must have outcome measures agreed for the year ahead that reflect UHB operational targets and the use of SPA sessions. The UHB guidance states that outcome measures should be written in a format that is sufficiently detailed and can be measured, i.e. as SMART outcome measures. The UHB guidance also includes a template for recording and monitoring outcome measures. However no evidence was provided for any of the consultants tested that they had set and recorded outcome measures for the year ahead. There is therefore no assurance that outcome measures are being agreed and monitored.	Consultants job plans may not reflect actual conditions or be developed by mutual consent.
Recommendation 3	**Priority level**
Clinical Board management must ensure that all consultants complete the outcome measures template contained within the UHB Job Planning guidance as part of the job planning process.	**High**
Management Response	**Responsible Officer/ Deadline**
1. Review of job planning guidance with regard to job plan template and re-issue to Clinical Board Senior Teams for cascade to their Clinical Directorates. 2. The Medical Director and Workforce Director will present to the HSMB in June 2018 the outcome of the Internal Audit Report - outlining the actions to be taken and re-emphasise the information available to the Clinical Boards and Clinical Directorates.	1. Medical Director and AMD for Workforce and Revalidation - one month. 2. 15th June 2018 Medical Director/Director of Workforce.

Current Position
Not Implemented. The Medical Director and Assistant Medical Director (Medical Workforce and Revalidation) had presented the findings of the original audit to the HSMB. However testing of a sample of 20 job plans selected from two Clinical Boards within the Health Board showed no improvement from the original audit with none of the job plans reviewed having any personal outcomes recorded. A further 10 job plans was requested for testing from a third Clinical Board, but to date these have not been received.

Updated Management Response	Updated Responsible Officer / Deadline
The addition of SMART outcomes to job plans is a subsequent step to introducing a centralised recording process and will take longer to implement, and indeed a change in organisational job planning culture. As such I would propose this is an action for after the full introduction of the centralised digital solution and new process.	Executive Medical Director / 2021/22 job planning round

Finding 4 - Team and Annualised Job Plans (Operating effectiveness)	Risk
Job planning documentation was only provided for 22/30 consultants tested. Of these, four consultants were on a Team Job Plan and two consultants were on an Annualised Hours Job Plan. In accordance with the UHB 'Guidance on Developing a Team Job Plan or Annualised Hours Plan', these should be supported by an individual personalised schedule based on their average NHS working week and any external commitments. However individual, personalised schedules were not provided for any of the consultants that were on Team or Annualised Hours job Plans.	Consultants job plans may not reflect actual conditions or be developed by mutual consent.
Recommendation	**Priority level**
In accordance with the guidance, Clinical Board management should ensure that individual, personalised schedules are completed for all consultants that are on Team or Annualised Hours Job Plans.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Review of job planning guidance with regard to job plan template and re-issue to Clinical Board Senior Teams for cascade to their Clinical Directorates. This will emphasise the need for all members of a team to complete individually the team job plan.	Clinical Board Directors action - Issues by Medical Director and AMD for Workforce and Revalidation - one month.

Current Position
Implemented. The guidance on developing a team or annualised job plan published on the Medical Director's intranet page is undated. However we were informed that this is periodically updated to reflect any changes to the training provided by the Assistant Medical Director (Medical Workforce and Revalidation).

Finding 5 - Job Plan Training (Control Design)	**Risk**
It is noted that detailed, documented Job Planning guidance has been produced and made readily available by the UHB. Job planning training is also being delivered by the Assistant Medical Director (Workforce and Revalidation) to all new Clinical Directors and to Clinical Boards on request. However the results of the sample testing undertaken as part of the audit demonstrate that the level of compliance with the job planning process is poor.	Consultants job plans may not reflect actual conditions or be developed by mutual consent.
Recommendation	**Priority level**
The UHB should consider developing additional methods of communication and / or training for both line managers and consultants to improve the completion rate and quality of consultant job plans.	**Low**
Management Response	**Responsible Officer/ Deadline**
A planned schedule for training should be refreshed and communicated, including sources of information available to Clinical Directors.	Assistant Medical Director Workforce Revalidation working with Medical Workforce Department/LED/Communications Team / Three months
Current Position	
Implemented. Evidence was provided to confirm that a series of training sessions detailing the findings from the original audit was delivered by the Assistant Medical Director (Medical Workforce and Revalidation).	

Finding 6 - Agreement of Job Plans (Operating effectiveness)	Risk
Job Plans should be mutually agreed and signed by both the Consultant and the appropriate clinical manager to evidence this agreement. However only one of the Job Plans reviewed had been signed and dated by the Consultant and only three Job Plans had been signed by the Consultants clinical manager. It was noted that the majority of job plans reviewed were stored in electronic format which does not lend itself to manual signatures. However there is a facility within all Microsoft Word and Excel documents which allows them to be signed off digitally.	Consultants job plans may not reflect actual conditions or be developed by mutual consent.
Recommendation	**Priority level**
All completed job plans must be signed by the Consultant and the clinical manager responsible for agreeing them. The standard Job Plan documentation included in the UHB Job Planning guidance should be updated to incorporate the use of digital signatures.	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. The job plan review does not require an actual signature but there does need to be a record of the job plan being agreed by all parties and signed. 2. An electronic job planning system will be trialled in Cardio Thoracic should provide a seamless and electronic system solution in the future, pending evaluation of the pilot and consideration of costs. This will include the ability for electronic sign off.	1. Clinical Board Director/CD - 3 months. 2. Assistant Medical Director - Workforce - 3 months review pilot progress.

Current Position
Not Implemented. As noted in recommendation 1 above, only 37.5% of Consultants across the Health Board had a valid, fully signed off job plan as at the end of September 2019. From a sample of 20 Job Plans tested it was identified that five had not been fully signed off by both the Consultant and an authorised representative of the Health Board. A further 10 job plans was requested for testing, but to date these have not been received. Whilst a 'pilot' had been carried out of an electronic job planning system in Cardio Thoracic, this consisted of just one consultant. It was therefore not possible to evaluate the potential benefits of the system.

Updated Management Response	Updated Responsible Officer / Deadline
Fully agree that we need a digital solution - which we are starting the process of developing the right Business Case for. This will need associated new admin support. The trial was unsuccessful but the principle is already in place in a number of other organisations and another pilot attempt is not necessary.	Executive Medical Director / BC finalised by the end of financial year 19/20.

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.

Cardiff & Vale University Health Board

Tentacle IT System

Final Internal Audit Report

2019/20

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Appendix A Management Action Plan
Appendix B Management opinion and action plan risk rating

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Executive sign off:	Jonathon Gray, Exec Director of Transformation David Thomas, Director of Digital & Health Intelligence
4/9/19Distribution:	Caroline Bird, Deputy Chief Operating Officer Alyn Coles, Service Improvement Manager
Committee:	Audit Committee

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1. Introduction and Background

The review of the Tentacle IT system used within the Health Board has been completed in line with the 2019/20 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.

The Tentacle IT system is an in house developed system which is used for tracking and reporting on cancer patients within the UHB.

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 the Tentacle IT system, 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 data held within the Tentacle system is accurate, secure from unauthorised access and loss and that the system is used fully.

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

- An appropriate governance process is in place for the system;
- Appropriate control is maintained over the database.
- All input is authorised, complete, accurate, timely and input once only;
- Proper control is exercised over access to application systems;
- Controls ensure the accuracy, completeness, confidentiality and timeliness of output, reports and interfaces;
- A complete audit trail is maintained which allows an item to be traced from input through to its final resting place;
- Appropriate business continuity arrangements are in place which include backing up copies of data and programs, storing and retaining them securely, and recovering applications in the event of failure;
- The system is fully used and fits within the strategic aims of the organisation.

3. Associated Risks

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

i. Inappropriate access to system / data.
ii. Inaccurate data held in system.
iii. Loss of processing / data.
iv. The UHB is not maximising the benefits from the system.

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 Tentacle is **Limited 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
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.

Tentacle is a system that has been developed over time to meet the needs of the organisation. It is based on Access databases and these are held securely on the UHB network. However the level of resource available to maintain and develop the system is minimal and as a consequence some key governance items have not been followed. There is no system documentation and no formal record of changes being tested and accepted by users. Due to the age of the system the version of Access used is old

and unsupported, and the compatibility with office 365 is unclear. These issues are further exacerbated by the requirements of the single cancer pathway which mean that the system no longer fully meets the needs of the organisation.

The UHB have acknowledged this and functionality is being developed within PMS to allow it to take over the Tentacle functions. This is being done under a project structure.

Where data is manually entered there are data entry controls in place and most data is imported into tentacle using scripts and there are quality checks built into this process. However the process is manual and undocumented and leads to a risk or incomplete date if it is not carried out.

5. Assurance Summary

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

Assurance Summary					
1	Governance			✓	
2	Database Controls		✓		
3	Outputs				✓
4	Application Access			✓	
5	Input Controls			✓	
6	Audit Controls				✓
7	Resilience and Continuity				✓
8	Strategic Fit		✓		

** 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 was classified as weakness in the system control/design for Tentacle.

Operation of System/Controls

The findings from the review have highlighted eight issues that are classified as weakness in the operation of the designed system/control for Tentacle.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

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

The following area of good practice was noted:

- the system has been developed in house to meet the needs of the organisation;
- changes to the system are tested by users; and
- the replacement of Tentacle functionality is via a formal project process.

The following significant finding was identified:

- There is no formalised structure to changes and developments made to Tentacle and no formal record or sign off of testing or readiness. This is mainly due to the minimal resource available to Tentacle.

Objective 2: Appropriate control is maintained over the database.

The following significant findings were identified:

- The system is built on Access databases, with the versions used being 2013 and 2007. Both of these have critical vulnerabilities, in addition access 2007 has come to the end of support and so is unsupported, with no further patches being developed.

- The system is stored on the UHB network, and is in a folder under the Information Area folder. This area is where information is stored and used for sharing across the UHB. Although Tentacle is in a separate folder it is still accessible by everyone. This means that the system / database and data can be copied / accessed.

Objective 3: All input is authorised, complete, accurate, timely and input once only.

The following areas of good practice were noted:

- the majority of data imported, and the scripts for this include data quality processes;
- where imported items do not load and are recognised as such, there is a subsequent report / table created of these items for review;
- data entry controls are enforced for manual data entry;
- training is provided to staff on how to use the system; and
- there is a monthly report from the data warehouse on consultants to allow Tentacle to be updated.

The following significant findings were identified:

- Data for Tentacle is downloaded from other systems and imported into Tentacle. The upload process is manual and scripts have to be run in the correct order. This process is not set out anywhere in a formal procedure and there are only 2 people who know how to do it, and who have access to the relevant databases. This leads to a risk of the system being out of date in the event of both staff members being absent.

- Where items in the download are valid, but the consultant is not known to the system then the item will not be loaded. There is no report of these and the missing data is only identified during use of data / discussion with users.

Objective 4: Proper control is exercised over access to application systems.

The following areas of good practice were noted:

- Tentacle has differing access levels with differing privileges and these are restricted according to need;
- access to administrator privileges is restricted to key staff; and
- the database with import scripts is password protected.

The following significant findings were identified:

- A review of user access to the system noted that there was a generic user in place and that 4 people from a random sample of 20 had left C&V with 3 still having a NADEX account.

Objective 5: Controls ensure the accuracy, completeness, confidentiality and timeliness of output, reports and interfaces.

The following area of good practice was noted:

- there are a variety of reports available for users with key information.

There were no significant findings identified within this objective.

Objective 6: A complete audit trail is maintained which allows an item to be traced from input through to its final resting place.

The following area of good practice was noted:

- audit logging is turned on for high risk, patient affecting actions.

There were no significant findings identified within this objective.

Objective 7: Appropriate business continuity arrangements are in place which include backing up copies of data and programs, storing and retaining them securely, and recovering applications in the event of failure.

The following area of good practice was noted:

- the system is held on the UHB SAN and so there is a high level of resilience.

There were no significant findings identified within this objective.

Objective 8: The system is fully used and fits within the strategic aims of the organisation.

The following significant finding was identified:

- The system works best using Access 2007 and is adequate using Access 2013, which most users have. However the current version of Access is Access 2016 and the likely direction of travel for the UHB is to Office 365. The system does not work with 64 bit versions of office. As such Tentacle may not be compatible with future iterations of office software within the UHB.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**6**	**2**	**9**

Finding 1– Database (Operating effectiveness)	Risk
The system is built on Access databases, with the versions used being 2013 and 2007. Both of these have critical vulnerabilities, in addition access 2007 has come to the end of support and so is unsupported, with no further patches being developed. This increases the risk of unauthorised access and loss of data.	Inappropriate access to system / data.
Recommendation	**Priority level**
The database should be updated to the latest, supported version.	**High**
Management Response	**Responsible Officer/ Deadline**
Due to the work ongoing to replace Tentacle, Management do not agree with the recommendation to update the database to the latest version given the fact that a formal project is underway to replace Tentacle within the next 18 months. Whilst not accepting the recommendation to upgrade to the latest version, it is accepted that the database should be on a version that is supported. The data base has recently been updated, therefore, to version 2013 – where the end date of mainstream support is 10/04/2023.	Service Improvement Manager, Cancer Services Completed (Update to version 2013)

Finding 2– Change Management (Operating effectiveness)	Risk
There is no formalised structure to changes and developments made to Tentacle and no formal record or sign off of testing or readiness. This is mainly due to the minimal resource available to Tentacle. Without this in place there is a loss of audit trail and a risk that the change will not deliver the appropriate functionality.	The UHB is not maximising the benefits from the system.
Recommendation	**Priority level**
The level of recording of developments and changes to Tentacle should be improved. At a minimum the record should record what change was made, the date of testing, staff involved with UAT and a formal agreement of user acceptance.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. A record is now maintained of changes made. The User Acceptance Testing process will be agreed and added into this record.	Service Improvement Manager, Cancer Services – partially completed with final deadline of 21st February 2020

Finding 3– User Access (Operating effectiveness)	**Risk**
A review of user access to the system noted the following issues: • a generic user in place (worker); and • from a random check of 20 people 4 have left C&V with 3 still having a NADEX account. This leads to a risk of inappropriate access to information	Inappropriate access to system / data.
Recommendation	**Priority level**
The use of generic accounts should be restricted. Staff who have left the UHB should be removed from the system.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Generic Accounts – Generic Accounts for Tentacle are already restricted. They are tied to an individual PC in a controlled room – for MDT purposes. Management agree that staff who have left the UHB should be removed from having access to the Tentacle system.	Service Improvement Manager, Cancer Services – by 21st February 2020

Finding 4– System Location (Operating effectiveness)	Risk
The system is stored on the UHB network, and is in a folder under the Information Area folder. This area is where information is stored and used for sharing across the UHB. Although Tentacle is in a separate folder it is still accessible by everyone. This means that the system / database and data can be copied / accessed.	Inappropriate access to system / data.
Recommendation	**Priority level**
Tentacle and its associated databases should held in a secure location on UHB network.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Management partially accept this recommendation due to the technicalities of access to Tentacle. Tentacle users need access to the folder where the database is stored to be able to access Tentacle. It is, therefore, not possible to restrict access completely. **It should also be noted that the database is password protected – therefore affording security around inappropriate access to the system.** Given the technicalities, Management will explore whether access to the folder can be limited to Tentacle Users only.	Service Improvement Manager, Cancer Services – by 21st February 2020

Finding 5– Future Compatibility (Control Design)	**Risk**
The system works best using Access 2007 and is adequate using Access 2013, which most users have. However the current version of Access is Access 2016 and the direction of travel for the UHB is to Office 365. The system does not work with 64 bit versions of office. As such Tentacle may not be compatible with future iterations of office software within the UHB.	Loss of processing / data.
Recommendation	**Priority level**
The future use of office software should be established to ensure Tentacle remains viable until a replacement is developed.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The use of Tentacle will be considered as part of the roll out of updated office software.	Assistant Director of ICT September 2020

Finding 6– Imports (Operating effectiveness)	Risk
Data for Tentacle is downloaded from other systems and imported into Tentacle. The upload process is manual and scripts have to be run in the correct order. This process is not set out anywhere in a formal procedure and there are only 2 people who know how to do it, and who have access to the relevant databases. This leads to a risk of the system being out of date in the event of both staff members being absent.	Inaccurate data held in system.
Recommendation	**Priority level**
The process for loading information into Tentacle on a daily basis should be set out in a procedure, together with the required passwords for access. This should be available to key staff in the event of the Tentacle leads being absent.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. A Standard Operating procedure will be developed.	Service Improvement Manager, Cancer Services – by 29th February 2020

Finding 7– Import Failures (Operating effectiveness)	**Risk**
Where items in the download are valid, but the consultant is not known to the system then the item will not be loaded. There is no report of these and the missing data is only identified during use of data / discussion with users. This means that there is risk of incomplete data being used / reported on.	Inaccurate data held in system.
Recommendation	**Priority level**
The load process should be amended to identify items that have not loaded. E.g. by including a batch check against items to load and loaded items in order to identify instances where items have not successfully loaded.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. The process will be amended and Standard Operating procedure will also include the process for error checks.	Service Improvement Manager, Cancer Services – by 29th February 2020

Finding 8– System Documentation (Operating effectiveness)	**Risk**
The system has been developed on an ad hoc basis over time to suit the needs to the organisation, however there is no system documentation. In the event of the system developer leaving the organisation would have to try to establish the systems structure from the beginning. Audit notes that the developer has entered notes into tables and scripts which would assist in this process.	The UHB is not maximising the benefits from the system.
Recommendation	**Priority level**
If the system is to be continued to be used, then system documentation should be developed.	**Low**
Management Response	**Responsible Officer/ Deadline**
The system is being replaced within a planned 18 month timescale. Management do not feel resource should be expended on writing documentation. It should be noted that code within the system has been annotated as a back-up.	Annotation of code - completed

Finding 9– User Guides (Operating effectiveness)	Risk
There are no user guides for the system. Audit notes that training is given to all users and the system manager is integrated into the directorate, so staff come and ask if there is a problem. However the lack of guides may mean that staff do not use the system properly.	The UHB is not maximising the benefits from the system.
Recommendation	**Priority level**
Brief user guides should be developed for the system.	**Low**
Management Response	**Responsible Officer/ Deadline**
The system is being replaced within a planned 18 month timescale. Management do not feel resource should be expended on writing a detailed user guide. A brief user guide will be developed for the interim period.	Service Improvement Manager, Cancer Services – by 17th April 2020

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.

Archwilydd Cyffredinol Cymru
Auditor General for Wales

2020 Audit Plan – **Cardiff and Vale University Health Board**

Audit year: 2020-21

Date issued: February 2020

Document reference: 1736A2020-21

This document has been prepared as part of work performed in accordance with statutory functions. Further information on this is provided in in Appendix 1.

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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, the Wales Audit Office and, where applicable, the appointed auditor 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.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

This document was produced by Anne Beegan, Dave Thomas, Mark Jones and Mike Usher on behalf of the Auditor General for Wales.

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Summary

1 As your external auditor, my objective is to carry out an audit which discharges my statutory duties as Auditor General and fulfils my obligations under the Code of Audit Practice, namely to:

- examine and certify whether your financial statements are 'true and fair' and lay them before the National Assembly together with any report that I make on them;
- satisfy myself that the expenditure and income reported in your accounts have been incurred or received lawfully and in accordance with the authorities which govern them; and
- assess whether you have made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

2 The purpose of this plan is to set out my proposed work, when it will be undertaken, how much it will cost and who will undertake it.

3 There have been no limitations imposed on me in planning the scope of this audit.

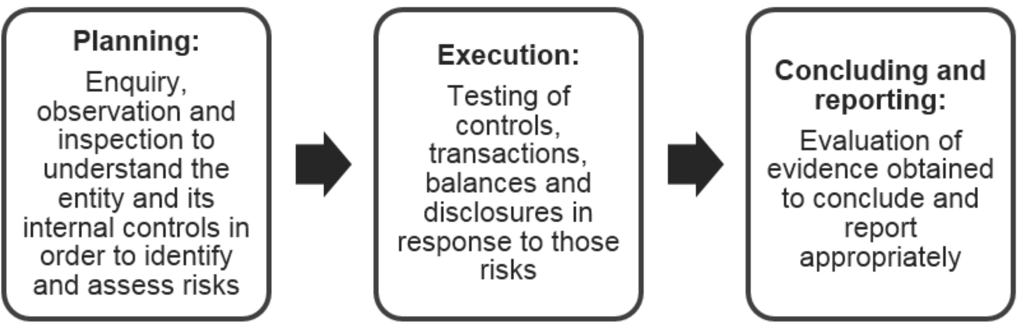
4 My responsibilities, along with those of management and those charged with governance, are set out in Appendix 1.

Financial audit

5 It is my responsibility to issue a certificate and report on the financial statements which includes an opinion on their 'truth and fairness' and the regularity of the expenditure and income within them. Appendix 1 sets out my responsibilities in full.

6 The audit work we undertake to fulfil our responsibilities responds to our assessment of risks. This understanding allows us to develop an audit approach which focuses on addressing specific risks whilst providing assurance for the financial statements as a whole. Our audit approach consists of three phases as set out in Exhibit 1.

Exhibit 1: my financial audit approach



7 The risks of material misstatement which I consider to be significant, and which therefore require special audit consideration, are set out in Exhibit 2 along with the work I intend to undertake to address them.

Exhibit 2: Financial audit risks

Financial audit risks	Proposed audit response
Significant risks	
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business; and • add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.
Under the NHS Finance (Wales) Act 2014, health boards ceased to have annual resource limits with effect from 1 April 2014. They instead moved to a rolling three-year resource limit, for revenue and capital net expenditure, with the first three-year period running to 31 March 2017. The Health Board has exceeded its rolling three-year revenue limit in 2016-17, 2017-18 and 2018-19 and I therefore qualified my regularity opinion on the Health Board's financial statements for those years. For 2019-20 the Health Board expects to break even, but this would nonetheless result in a cumulative deficit of £36.7 million for the three years to 31 March 2020.	My audit team will continue to monitor the Health Board's financial position for 2019-20 and the cumulative three-year position to 31 March 2020. This review will also consider the impact of any relevant uncorrected misstatements over those three years. If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2019-20 financial statements. As in previous years, I would also expect to place a substantive report on the statements to explain the basis of the qualification and the circumstances under which it had arisen.

Financial audit risks	Proposed audit response
I audit some of the disclosures in the Remuneration Report, such as the remuneration of senior officers and independent members, to a far lower level of materiality due to their sensitivity. These disclosures are therefore inherently more prone to material misstatement. In recent past audits I have identified material misstatements in the remuneration report submitted for my audit, which the Health Board then corrected. These past misstatements mean that I judge the 2019-20 disclosures to be at risk of further misstatement.	My audit team will review all entries in the Remuneration Report to verify that the Health Board has reflected all known changes to senior positions, and that the disclosures are complete and accurate.
I also audit the Health Board's related party disclosures to a far lower materiality. In recent years I have reported weaknesses in the Health Board's related party arrangements, which led to material misstatement in the draft accounts. As a result of my audit findings, the Health Board undertook remedial work and corrected its related-party disclosures, prior to my certification. These past misstatements mean that I judge the disclosures to be at risk of further misstatement for 2019-20.	My audit team will review and test the completeness and accuracy of the related-party disclosures.
Other areas of audit attention	
On 18 December 2019 the First Minister issued a formal Ministerial Direction to the Permanent Secretary requiring her to implement a 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff.	We are considering the accounting treatment and audit implications of the direction (the first in Wales since 1999) in conjunction with the NAO who are currently addressing the same issue in NHS England.
For 2019-20 there is an increase of 6.3% (to 20.3%) in an employer's pension contributions, which represent a significant additional cost to the Health Board. We understand that the Welsh Government will bear the 2019-20 cost of this increase.	My audit team will test these additional costs to confirm whether the Health Board has disclosed and accounted for them correctly.
The Introduction in 2020-21 of 'International Financial Reporting 'Standard 16 Leases' may pose implementation risks if the Health Board has not made good progress to date with its preparatory work.	My team will undertake some early work to review preparedness for the introduction of IFRS 16 Leases. See Appendix 3 Exhibit 8 for more detail.

8 I do not seek to obtain absolute assurance on the truth, fairness and regularity of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The quantitative level at which I judge such misstatements to be material for the Health Board is calculated as 1% of gross expenditure. On this basis my current planning materiality is £14 million. I review my levels of materiality throughout the audit, for example when the Health Board presents me with its draft financial statements.

9 Whether I judged an item to be material can also be affected by certain qualitative issues such as legal and regulatory requirements, or areas of the financial statements that I consider to be of particular interest to the reader that I therefore judge to be sensitive. I set significantly lower levels of materiality for such areas, which include the remuneration[1] of senior officers and independent members, certain related party disclosures, and audit fees.

10 The levels at which I judge such misstatements to be material will be reported to the Audit Committee and the Board on 28 May 2020, prior to completion of the audit.

11 For reporting purposes, I will treat any misstatements below a 'trivial' level (set at 5% of materiality) as not requiring consideration by those charged with governance and therefore I will not report them.

12 My fees and planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided in accordance with the agreed timescales, to the quality expected and have been subject to a robust quality assurance review;
- information provided to support the financial statements is in accordance with the agreed audit deliverables document[2];
- appropriate accommodation and facilities are provided to enable my audit team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accountable Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete and management has responded to issues that may have affected the financial statements.

13 I also undertake the audit of:

[1] These disclosures typically include salary, pension benefits and any exit-package costs.

[2] The agreed audit deliverables document sets out the expected working paper requirements to support the financial statements and include timescales and responsibilities

- the annual financial statements of the Health Board's charitable funds; and
- any annual grant claims for specified areas of Health Board expenditure.

These audits will be undertaken in accordance with the timescales agreed with the Health Board.

Performance audit

14 It is my responsibility to satisfy myself that the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance work each year.

15 I set out in this section, the programme of performance audit work to be undertaken at the Health Board. The content of the programme is informed by an ongoing analysis of the risks and challenges facing NHS Wales as well as consideration of issues and risks that are specific to the Health Board. I have also taken account of the work programme of Healthcare Inspectorate Wales (HIW)[3] [4].

16 The topics I plan to examine as part of my 2020 performance audit work are summarised in Exhibit 3.

Exhibit 3: contents of my 2020 performance audit work programme

Theme	Approach/key areas of focus
NHS Structured Assessment	Structured assessment will continue to form the basis of the work I 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, I 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. I also plan to use my structured assessment work to maintain a high-level view on how well each NHS body is embedding their statutory requirements under the Well-being of Future Generations (Wales) Act 2015 into corporate arrangements.

[3] An operational protocol between HIW and the Auditor General sets out how the two organisations will work together, March 2015

[4] Wales Audit Office, Working Together to Provide Assurance describes the collective arrangements the AGW and HIW make use of to review governance arrangements in the NHS, November 2016

Theme	Approach/key areas of focus
All Wales Thematic Reviews	**Unscheduled care arrangements** During 2020 I plan to scope and roll out a thematic review which will examine different aspects of the unscheduled care system. This work will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. This data analysis will help me to determine which aspects of the unscheduled care system I will then focus on during the remainder of 2020. Where relevant, my work will also seek to examine the progress made in responding to my previous recommendations relating to unscheduled care, including GP out-of-hours and Emergency Ambulance Services Commissioning (EASC). **Welsh Health Specialised Services Committee (WHSSC)** I also plan to use an element of the 2020 audit fee to undertake a review of WHSSC. This work will use aspects of my structured assessment methodology to examine the governance arrangements of WHSSC.
Locally focused work	I will also undertake thematic performance audit work that reflects issues specific to the Health Board. The precise focus of this work will be agreed with executive officers and the Audit and Risk Assurance Committee and will be reflected in the regular updates that are produced for the audit/other committee.
Implementing previous audit recommendations	The examination of governance arrangements I undertake as part of my structured assessment work includes a review of the arrangements that the Health Board has in place to track progress against my previous audit recommendations. This allows my team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables me to more explicitly measure the impact my work is having.

17 In addition to my Structured Assessment work, where my broader programme as set out in Exhibit 3 allows me to do so, I may take opportunities to make comments on the Health Board's application of the sustainable development principle[5] as set out in the Well-being of Future Generations (Wales) Act 2015. Where this is identified, my audit team will raise this with the relevant Health Board lead.

18 The performance audit projects included in last year's audit plan, which are either still underway or which have been substituted for alternative projects in agreement with the Health Board, are set out in Appendix 2.

[5] The Act defines the sustainable development (SD) principle as acting in a manner: '…which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs'.

Fee, audit team and timetable

Fee

19 Your estimated fee for 2020 is set out in Exhibit 4. My fee rates for 2020 have increased overall by 3%, however, my audit teams are continuing to drive efficiency in their audits to ensure fee increases are not passed onto you. The estimated fee of £390,652 represents a 4.9% decrease compared to the fee set out in the 2019 annual audit plan.

Exhibit 4: audit fee

Audit area	Proposed fee for 2020 (£)[6]	Actual fee for 2019 (£)
Financial accounts work	**235,000**	**255,000**
Performance audit work:		
• Structured Assessment	60,437	72,196
• All-Wales thematic reviews[7]	70,640	63,275
• Local projects	24,575	20,181
Performance audit work total	**155,652**	**155,652**
Total fee	**390,652**	**410,652**

20 Planning will be ongoing, and changes to my programme of audit work and therefore my fee, may be required if any key new risks emerge. I shall make no changes without first discussing them with the Director of Finance.

21 Further information on my fee scales and fee setting can be found on our website.

Audit team

22 The main members of my local audit team, together with their contact details, are summarised in Exhibit 5.

[6] The fees shown in this document are exclusive of VAT, which is no longer charged to you.

[7] As detailed in the respective audit plans.

Exhibit 5: my local audit team

Name	Role	Contact number	E-mail address
Mike Usher	Engagement Director	02920 320568	mike.usher@audit.wales
Dave Thomas	Director with responsibility for performance audit work	02920 320604	dave.thomas@audit.wales
Mark Jones	Audit Manager (financial audit)	02920 320631	mark.jones@audit.wales
Anne Beegan	Audit Manager (performance audit)	07879 848666	anne.beegan@audit.wales
Rhodri Davies	Audit Lead (financial audit)	02920 320637	rhodri.davies@audit.wales

23 I can confirm that my team members are all independent of the Health Board and your officers. In addition, I am not aware of any potential conflicts of interest that I need to bring to your attention. However, I need to draw your attention to the fact that Dave Thomas's partner works in the Health Board as a Radiology Department Assistant. Dave has made the necessary declarations in respect of auditor independence to our Law and Ethics Team, and he will not have any involvement with audit work concerning radiology services at the Health Board.

Timetable

24 I will provide reports, or other outputs as agreed, to the Health Board covering the areas of work identified in this document. My key milestones are set out in Exhibit 6.

Exhibit 6: timetable

Planned output	Work undertaken	Report finalised
2020 Audit Plan	December 2019 to January 2020	February 2020
Financial accounts work: • Audit of Financial Statements Report • Opinion on Financial Statements • Financial Accounts Memorandum	February to June 2020	May 2020 June 2020 July 2020

<table>
<tr><th>Planned output</th><th>Work undertaken</th><th>Report finalised</th></tr>
<tr><td>Performance work:
• Structured Assessment
• Unscheduled Care
• WHSSC
• Local project work</td><td colspan="2">Timescales for individual projects will be discussed with the Health Board and detailed within the specific project briefings produced for each study.</td></tr>
<tr><td>Annual Audit Report for 2020</td><td>October to November 2020</td><td>December 2020</td></tr>
<tr><td>2021 Audit Plan</td><td>December 2020 to January 2021</td><td>February / March 2021</td></tr>
</table>

Future developments to my audit work

25 Details of other future developments, including forthcoming changes to key International Financial Reporting Standards (IFRS), Future changes to UK GAAP, (which are relevant to the Health Board's charitable funds' account), the Wales Audit Office's Good Practice Exchange seminars and my work on the readiness of the Welsh public sector for Brexit, are set out in Appendix 3.

Appendix 1

Respective responsibilities

My powers and duty to undertake your financial audit are set out in the Public Audit (Wales) Act 2004. It is my responsibility to issue a certificate and report on the financial statements which includes an opinion on:

- their 'truth and fairness', providing assurance that they:
  - are free from material misstatement, whether caused by fraud or error;
  - comply with the statutory and other applicable requirements; and
  - comply with all relevant requirements for accounting presentation and disclosure.
- whether the remuneration report is properly prepared.
- the regularity of the expenditure and income.
- the consistency of other information presented with the financial statements.

It must also state by exception if the Annual Governance Statement does not comply with requirements, if proper accounting records have not been kept, if disclosures required for remuneration and other transactions have not been made or if I have not received all the information and explanations I require.

In addition, I may place a substantive report on the financial statements if I wish to make additional observations on any matters within them.

My powers to undertake performance audit work at the Health Board are set out in the Government of Wales Acts 1998 and 2006 and this work also discharges my duty under the Public Audit (Wales) Act 2004 to satisfy myself that the body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

My audit work does not relieve management and those charged with governance of their responsibilities which include:

- the preparation of the financial statements and annual report in accordance with applicable accounting standards and guidance;
- the keeping of proper accounting records;
- ensuring the regularity of financial transactions; and
- securing value for money in the use of resources.

Appendix 2

Performance audit work in last year's audit plan still in progress

Exhibit 7: Performance audit work still in progress

Performance audit project	Status	Comment
Orthopaedic Services (Follow up)	Reporting	Local reports for health boards setting out progress against the issues the Auditor General originally identified in 2015 will be issued during February. A national summary report will also be published in Spring 2020.
Quality Governance arrangements	Set Up	Scoping of this work has been informed by the Joint Review of Quality Governance at Cwm Taf Morgannwg UHB. Wider work across Wales will be undertaken in close collaboration with Healthcare Inspectorate Wales and will be undertaken during Spring and early Summer 2020.
Follow up of previous IM&T recommendations	Reporting	This work has examined progress made against previous recommendations relating to IM&T. The report is due to be issued in February 2020.

Appendix 3

Other future developments

Forthcoming key IFRS changes

Exhibit 8: changes to IFRS standards

Standard	Effective date	Further details
IFRS 16 Leases	2020-21	IFRS 16 will replace the current leases standard IAS 17. The key change is that it largely removes the distinction between operating and finance leases for lessees by introducing a single lessee accounting model that requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. It will lead to all leases being recognised on balance sheet as an asset based on a 'right of use' principle with a corresponding liability for future rentals. This is a significant change in lessee accounting.
IFRS 17 Insurance Contracts	2021-22 at earliest	IFRS 17 replaces IFRS 4 *Insurance Contacts*, which permitted a variety of accounting practices resulting in accounting diversity and a lack of transparency about the generation and recognition of profits. IFRS 17 addresses such issues by requiring a current measurement model, using updated information on obligations and risks, and requiring service results to be presented separately from finance income or expense. It applies to all insurance contracts issued, irrespective of the type of entity issuing the contracts, so not relevant only for insurance companies. Entities will need to consider carefully whether any contractual obligations entered into meet the definition of an insurance contract. If that is the case, entities will need to determine whether they are covered by any of IFRS 17's specific scope exclusions.

Future changes to UK GAAP, which are relevant to the Health Board's charitable funds' account

Following the introduction of the new UK GAAP accounting regime in 2015-16, and the replacement of the Financial Reporting Standard for Smaller Entities (FRSSE) by Section 1A of FRS 102 in 2016-17, there are only limited changes to FRS 102 in 2019-20.

More significant amendments are expected from 2022-23, reflecting recent changes in International Financial Reporting Standards, including accounting for financial instruments and leases.

Good Practice Exchange (GPX)

The Wales Audit Office's GPX helps public services improve by sharing knowledge and practices that work. Events are held where knowledge can be exchanged face to face and resources shared online. Further information, including details of forthcoming GPX events and outputs from past seminars.

Brexit: preparations for the United Kingdom's departure from membership of the European Union

The Auditor General has reported on preparations in Wales for a 'no-deal Brexit', publishing a report in February 2019 and a follow-up letter to the External Affairs and Additional Legislation Committee in September 2019. At the time of reporting, there was a possibility that the UK would leave the EU without a Withdrawal Agreement in place (the no-deal scenario), which would potentially have had significant consequences for Welsh public services and the wider economy and society.

On 31 January 2020 the United Kingdom left membership of the European Union under the terms of the Withdrawal Agreement concluded between the EU and UK in October 2019. The current phase involves negotiating and agreeing the future relationship between the UK and EU.

There is a transition period to 31 December 2020, during which the UK continues to participate in EU programmes and follow EU regulations. The Withdrawal Agreement provides for the transition period to be extended by up to two years, with the agreement of the UK and EU. The deadline for agreeing to extend the transition is 31 June 2020. The UK Government has said that it does not intend to extend the transition period.

Despite there being an agreement on the terms of withdrawal, there remain some significant uncertainties:

- Given the very tight timetable for reaching agreement, there is a possibility of the UK leaving the transition period at the end of 2020 without an agreement about the future relationship in place. In this scenario many of the issues previously identified around a 'no-deal Brexit', such as disruption to supply chains, would arise again.

- The UK Government's position of seeking a future relationship based on a free trade agreement (rather than a closer relationship aligned to the single market) has implications that are not yet clear but which create opportunities and risks for Wales' economy, society and environment.
- There are also significant unresolved constitutional questions around how powers in areas where devolved governments were directly applying EU law, such as regional development and agriculture, will be exercised across the UK after the transition period.

In light of these uncertainties, the Auditor General will continue to keep a watching brief over developments and will make a decision later in the year as to what, if any, further work is required to look at public bodies' preparations for either a new relationship or a no-trade deal exit from the transition period.

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Cardiff & Vale University Health Board

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

Colour	Range	Risk
Green	0-4%	Low risk
Amber	5-9%	Medium risk
Red	10%+	High risk

UHB Claim error % Ave	3.34%
2019/20 recovery amount	£3,971.42

	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**	**Claim error %**	**Recovery**
Practice 1	14/03/2017	Routine	6.57%	£610.59	06/06/2018	Revisit	40.00%	£2,933.18	15/04/2019	Routine	137	6	4.38%	£195.10
Practice 2	12/03/2015	Routine	1.73%	£77.44	21/03/2016	Revisit	14.02%	£115.05	01/04/2019	Routine	290	2	0.69%	£75.00
Practice 3	20/08/2015	Routine	0.00%	£0.00					28/06/2019	Routine	523	18	3.44%	£560.63
Practice 4	19/11/2014	Routine	1.07%	£788.81	05/04/2018	Routine	3.48%	£759.83	06/06/2019	Revisit	297	20	6.73%	£1,762.00
Practice 5	10/10/2013	Revisit	23.51%	£14,718.88	15/02/2018	Routine	2.84%	£129.20	25/07/2019	Revisit	42	2	4.76%	£51.68
Practice 6	26/02/2016	Revisit	4.47%	£1,417.73	25/05/2018	Routine	6.38%	£474.85	10/07/2019	Revisit	96	2	2.08%	£135.00
Practice 7	17/12/2014	Routine	3.57%	£89.33					09/08/2019	Revisit	13	2	15.38%	£19.60
Practice 8	17/02/2015	Routine	9.35%	£4,195.66					30/09/2019	Routine	311	33	4.82%	£292.97
Practice 9	01/07/2015	Revisit	4.98%	£3,100.04					06/09/2019	Routine	336	14	3.87%	£470.06
Practice 10	01/05/2015	Routine	5.71%	£383.74	27/05/2016	Revisit	9.84%	£527.31	04/09/2019	Routine	613	3	1.49%	£57.56
Practice 11	20/11/2015	Revisit	10.07%	£1,500.00	12/07/2018	Routine	5.81%	£1,812.81	31/10/2019	Revisit	10	3	30.00%	£77.49
Practice 12	15/07/2013	Routine	3.46%	£587.45	14/12/2016	Routine	2.15%	£32.76	17/10/2019	Routine	235	0	0.00%	£0.00
Practice 13	05/03/2013	Revisit	35.71%	£121.98	21/04/2015	Routine	10.00%	£300.00	06/11/2019	Extended	File in progress			
Practice 14	13/06/2013	Routine	1.93%	£316.73	12/10/2016	Routine	2.05%	£65.68	21/11/2019	Revisit	276	2	0.72%	£176.20
Practice 15	23/04/2013	Routine	17.04%	£4,563.55	24/03/2017	Routine	0.00%	£0.00	29/11/2019	Routine	File in progress			
Practice 16	02/11/2016	Routine	11.21%	£225.35	18/12/2017	Revisit	20.47%	£6,116.55	22/11/2019	Routine	82	2	2.44%	£98.13
Practice 17					19/06/2015	Revisit	20.73%	£8,042.02	20/12/2019	Routine				
Practice 18	09/10/2012	Extended	27.91%	£33,517.20	06/01/2015	Routine	5.98%	£1,817.48	11/12/2019	Routine				
Practice 19	30/10/2015	Routine	4.65%	£358.35	15/12/2016	Revisit	4.67%	£1,122.95	19/12/2019	Routine				
Practice 20									07/01/2020	Routine				
Practice 21	26/06/2015	Revisit	25.43%	£10,543.43	05/12/2018	Routine	3.52%	£670.08	21/01/2020	Revisit	Files in progress			
Practice 22	20/11/2013	Routine	25.07%	£33,809.24	23/11/2015	Routine	25.98%	£3,107.72	24/01/2020	Routine				
Practice 23	22/10/2012	Routine	7.02%	£2,417.54	14/04/2015	Revisit	27.10%	£6,474.08	Feb-20	Routine				
Practice 24	20/06/2016	Routine	6.12%	£407.39	15/08/2017	Revisit	11.29%	£3,311.90	Feb-20	Routine				
Practice 25	07/10/2015	Revisit	1.78%	£875.26	17/01/2018	Routine	2.60%	£324.76	Mar-20	Routine				
Practice 26	16/02/2017	Routine	4.26%	£1,029.32	14/05/2018	Revisit	18.32%	£4,466.53	Mar-20	Routine				

Report Title:	Declarations of Interest, Gifts, Hospitality & Sponsorship								
Meeting:	Audit & Assurance Committee					Meeting Date:		3rd March 2020	
Status:	For Discussion		For Assurance	X	For Approval		For Information		X
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Corporate Governance Officer								

Background and current situation:

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

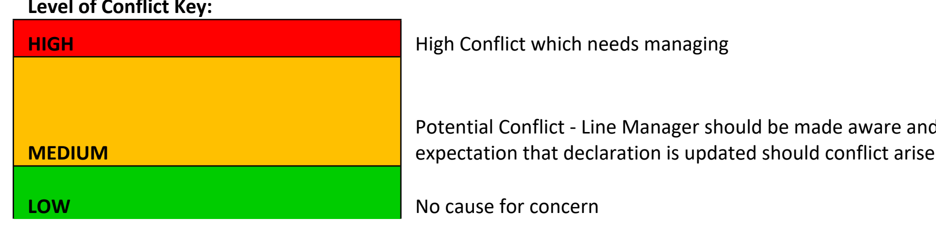
Work has recently been undertaken with the Communications department to raise awareness around Standards of Behaviour, a recent campaign that went out via social media reached 5,799 people, in addition to being featured in CEO connects on a number of occasions.

Corporate Governance have also started working alongside the Counter Fraud Specialist Department, where our declaration register is cross checked with the National Fraud Initiative Database. This alerts us of any high earning staff who have secondary employment, the Counter Fraud department then check if a declaration of secondary employment has been completed and if not, a chase process is triggered to ensure a declaration is submitted as soon as possible for checking.

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

The following number of Declarations have been received and included on the register since the last Committee meeting (3rd December 2019):

- 983 Declarations of Interests, Gifts, Hospitality & Sponsorship Forms
- 40% of staff banded 8a and above have returned their declaration forms, this is an increase from 25.93% since the last meeting.
- The Declarations of Interests G, H&S forms received are RAG rated by the Corporate Governance Officer to ensure appropriate action and monitoring. The RAG rating system is as follows:



- 82.5% of Declarations received are rated **Green**.

- 17.3% of Declarations received are rated **Orange**.

- 0.2% of Declarations are rated **Red.**

In addition, at the time of writing the report we have in excess of 400 declarations that are awaiting RAG rating and adding to the register, this is a back log from the recent communication campaigns and the lack of resource and capacity within the Corporate Governance Department.

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

Work has been carried out with the Improvement & Implementation to create a process map which identifies current issues within the Standards of Behaviour, a copy of the process map can be found attached. The two main issues identified are:

- Single Point of Failure – Due to the size of Cardiff & Vale University Health Board, and the significant work and updating that is required within this area, the Standards of Behaviour work will be moved over to a newly appointed, full time Risk Officer from April 2020 onwards, this will allow RAG rating and inputting onto the register on a more frequent basis.

- IT Delays – Whilst work has been carried out with the IT Department to create Standards of Behaviour Software, the development of this has not been forthcoming, therefore the team are still inputting forms in manually which is an extremely lenghty process, however, it has been suggested that at the end of March 2020 a declaration of interest form will included onto the NHS ESR system, this function will be very welcomed as it will also address the delays in manual input and an update will be provided on this development at the next Committee meeting

We are confident by addressing the issues outlined above a further improvement will be seen in this area.

Recommendation:

The Audit & Assurance Committee is asked to:

- **NOTE** the ongoing work being undertaken within Standards of Behaviour

- **NOTE** the Declarations of Interest, Gifts, Hospitality & Sponsorship Register.

Shaping our Future Wellbeing Strategic Objectives

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention	X	Long term	X	Integration		Collaboration		Involvement	X

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

Level of Conflict	Name	Position held in UHB	a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies	b) Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the UHB	c) A personal or departmental interest in any part of the pharmaceutical/healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	d) Sponsorship or funding from a known NHS supplier or associated company/subsidiary	e) A position of authority in a charity or voluntary body in the field of health and social care	f) Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	g) Employment/self employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	h) I undertake to notify the UHB of any changes which may occur within four weeks from the date of the change, in writing to the Corporate Risk and Governance Office. Please return completed forms to cav.declarations@wales.nhs.uk	i) I confirm that the information accurately reflects my interests and those of my family and understand that relevant information will be included in the Register which is available for public inspection
	Craig Greenstoc	Counter Fraud Manager	N/A	N/A	Wife works as a Procurement Supervisor for the NHS Wales Shared Partnership and is based in the Lakeside Stores at UHW in Cardiff.	N/A	N/A	N/A	I am a Justice of the Peace (Magistrate) and sit twice a month on the Mid Wales Bench in Merthyr Tydfil.	Yes	Yes
	Aron White	Senior Nurse - Standards & Professional Regulation	N/A	N/A	N/A	N/A	N/A	Associate Counsellor/Psychotherapist- Voices From Care Cymru	N/A	Yes	Yes
	Aled Roberts	Interim Clinical Board Director	• Director of PLC - SAGE Roberts PLC. • Wife is also a Director	N/A	N/A	N/A	N/A	N/A	undertake private practice (declared in job plan) at Spire Cardiff Hospital - 0.5 sessions approximately alternate weeks.	Yes	Yes
	Richard Hurton	Head of Financial Accounting & Services	N/A	N/A	N/A	N/A	N/A	Partner is a Financial Manager with WHSCC	N/A	Yes	Yes
	Sridhar Kamath	Consultant Radiologist	• Director of Kamath Medical Services, Sanika Investments Limited • Archana Kamath, Director of Kamath Medical Services, Sanika investments Limited	No Further Information Provided	I occasionally teach at courses sponsored by 'SI Bone'	N/A	N/A	N/A	Private practice at Nuffield Cardiff and Spire hospital Cardiff.	Yes	Yes
	Rhys Morris	Principal Clincal Scientis	N/A	N/A	Department of Medical Physics & Clinical Engineering paid equivalent of half my salary by Arjo for scientific sevices.	N/A	N/A	N/A	N/A	Yes	Yes
	Eileen Brandett	Independent Membembe of the Board	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff University	Yes	Yes
	John Michael Imperato	Independent Membembe of the Board	• Director Association of Personal Injury Lawyers • Director Bevan Foundation Charity • Director Swansea Univerity Childrens Legal Centre	Equity Partner Watkins & Gunn Solicitors	N/A	N/A	N/A	N/A	Spouse is a Flying Start Manager with CVUHB	Yes	Yes
	John Union	Independent Membembe of the Board	• John Union Limited • Swansea Building Society • Cardiff Business Club Director	N/A	N/A	N/A	N/A	Vice Chair, Cadwyn Housing Limited	Blake Morgan Solicitors	Yes	Yes
	Gary Baxtor	Independent Membembe of the Board	N/A	N/A	N/A	N/A	N/A	N/A	Employed by Cardiff University	Yes	Yes
	Nicola Foreman	Director of Corporate Governance	Company Secretary of Husbands Business Safe Ventures (UK) LTD	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Lance Carver	Associate Member	N/A	N/A	N/A	N/A	N/A	Director of Social Services	N/A	Yes	Yes
	Mandy Sara Co	Interim Head of Governance	N/A	N/A	N/A	N/A	N/A	N/A	• Currently on secondment from Powys Teaching Hospital • Husband is a self employed carpenter - 'Nigel Collins' - He is unlikely to tender for UHB work but I wish for the relationship to be declared.	Yes	Yes
	Sara Moseley	Independent Member of the Board - Third Sector	• WCVA Elected Board Member • Executive Director, MIND	N/A	N/A	N/A	• Director, MIND Cymru • Non Executive Director, MIND • WCVA Board	N/A	N/A	Yes	Yes
	Richard Thoma	Chair of Strategic Reference Group	• Care & Repair Home Improvement Services Ltd	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Sharon Hopkins	Director of Transformation, Improvement and Informatics / Dep CEO	N/A	N/A	N/A	N/A	N/A	Chair of a Public Health Advisory Committee for NICE	N/A	Yes	Yes
	Lee Davies	Operational Planning Director	N/A	N/A	N/A	N/A	N/A	N/A	Wife if a Community Locum Pharmacist, working predominantly in the Hywel Dda Health Board Area	Yes	Yes
	Maria Battle	Chair	N/A	N/A	N/A	N/A	Member of Social Care Wales Board	Child Protection Safeguarding Officer for St Teilos Parish Tenby	N/A	Yes	Yes
	Abigail Harris	Executive Director of Strategic Planning	N/A	N/A	N/A	N/A	• Husband - Board Member of Wales Council for Voluntary Action (And Chair of Audit Committee) • Uncle - Trustee of Teenage Cancer Trust	• Non Executice Director of Social Care Wales (A Ministerial Public Appointment) • Husband - Employee of Competition and Markets Authority	N/A	Yes	Yes

	Christopher Howrad Lewis	Deputy Director of Finance	N/A	N/A	N/A	N/A	President of Wales Branch of the Healthcare Financial Management Association (HFMA). HFMA is a registered charity.	Wife is Samantha Lewis, Assistant Director of Finance, Abertawe Bro Morgannwg University Health Board	N/A	Yes	Yes
	Charles Janczev	Vice Chair	N/A	N/A	N/A	N/A	N/A	● WHSSC - Chair of Quality & Patient Safety Committee Swansea University ● Chair of Governance Board for Health & Wellbeing Academy	N/A	Yes	Yes
	Fiona Kinghorn	Executive Director of Public Health	N/A	N/A	N/A	N/A	N/A	Husband is Non-Executive Director of Trivallis Community Mutual Housing Association	Husband is Director of Public Protection in RCT County Borough Council	Yes	Yes
	Fiona Jenkins	Executive Director of Therapies and Health Science	Director JJ Consulting Healthcare Ltd	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Len Richards	Chief Executive	Advisor to the Life Sciences Hub Board	N/A	N/A	N/A	Chairman of Improving Chances	Council Member, Cardiff University	N/A	Yes	Yes
	Ruth Walker	Executive Nurse Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	CLLR Susan Elsr	Independent Member of the Board - Local Authority	N/A	N/A	N/A	N/A	N/A	Welsh Local Government Association Health & Social Care Spokesperson	Cabinet Member: Social Care, Health & Wellbeing	Yes	Yes
	Paula Martyn	Chair of Stakeholder Ref Group (until Dec 2018)	N/A	N/A	N/A	N/A	N/A	Advisor to Care Forum Wales	N/A	Yes	Yes
	Mary Lawrence	Associate Specialist in Psychiatry	N/A	N/A	N/A	N/A	N/A	N/A	I undertake occasional Mental Health Act Assessments and complete occasional private medical reports for which I receive payment. When these are undertaken during my normal working hours I will always have worked sufficient compensatory hours completing NHS duties in my own time (time slipping)	Yes	Yes
	Julie Gittings	Counsellor	N/A	N/A	N/A	N/A	N/A	N/A	Small private practice approx one day a week.	Yes	Yes
	Rebecca Willian	Counsellor	N/A	Owner ASHA Counselling Services	N/A	N/A	Trustee of Bridgend Community Bereavement Service	Ty Elis. Couselling Services, Bridgend Community Bereavement Service. Place 2 Be.	Self Employed Counsellor	Yes	Yes
	Jan Melichar	Counsultant in Substance Misuse Psychiatry (Long-Term Locum)	100% Owner /Director of Limited Company used for any Private Work	N/A	N/A	N/A	Medical Director of DHI - A Charity in the Substance Misuse and Homelessness Sector in the Avon Region of England	N/A	● Private Patients: Spire Hospital, Bristol ● Consultancy Services: Recently includes the States of Guernsey and Indivior PLC	Yes	Yes
	Emily Harringto	Consultant Psychiatrist	N/A	N/A	N/A	N/A	N/A	N/A	Occasional DVLA forms, occasional medical reports (Under £300 worth a year)	Yes	Yes
	Hannah Brayfo	Head of Programme Management Office	● I'm a director of Longford Pugh Properties, a limited company ● Wife is also a Director of Longford Pugh Properties	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Ruth Jordan	Head of Continuous Service Improvement	Spouse is Director of the Plaza Cardiff Bay (Phase 1) Management Company Limited	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Mark Thomas	Senior Service Improvement Programme Manager	N/A	N/A	N/A	N/A	Spouse: Helen Dodoo, Trustee for Diversity Cymru	N/A	N/A	Yes	Yes
	Emma Cooke	Head of Physiotherapy	N/A	Joint Ownership with Husband of Physiotherapy Private Practice	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Claire Gandertc	Senior Appraisal Pharmacist	Director and Spouse is Director too	N/A	N/A	N/A	N/A	N/A	N/A		Yes
	Nia Jones	Specialist Podiadrist	N/A	N/A	Wound Care Consultant	N/A	N/A	N/A	N/A	Yes	Yes
	Rhodri Willmer	Physiotherapist	N/A	N/A	N/A	N/A	N/A	N/A	Cardiff City Academy - Employed on ad-hoc basis for weekend working.	Yes	Yes
	Joanne Moon	Dietitcian	N/A	N/A	N/A	N/A	N/A	GLL (LTD) Fitness Instructor	GLL (LTD) Fitness Instructor	Yes	Yes
	Annie Gover	Weight Management CNS	N/A	N/A	N/A	N/A	N/A	N/A	Bariatric CNS in Spire Hospital, Cardiff	Yes	Yes

	Alexandra Saun	Physiotherapy Team Lead North and West Community Resource Team (Secondment)	N/A	N/A	N/A	N/A	N/A	N/A	I very occasionally (approximately 1-3 times a year) treat private patients in Agile Therapy (my husbands private practice) who are suffering from suspected Benign Positional Paroxysmal Vertigo. This is most often a one-off appointment where I complete a vestibular assessment and carry out an Epley Manoevre if indicated. Agile Therapy is a private practice in Cardiff owned and run by my husband	Yes	Yes
	Claire Bruce	Community Physiotherapist CRT	N/A	Owner of Celtic Community Physio	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Lisa Small	Occupational Therapist	N/A	N/A	N/A	N/A	N/A	N/A	Self Employed Occupational Therapist in Hand Therapy	Yes	Yes
	Aisling Pigott - J	Lead Paediatric Diabetes Dietitian	N/A	N/A	N/A	N/A	N/A	Media Spokesperson for Professional Organisation - British Dietetic Association. Important voluntary role of CPD. Occasional expenses paid from BBC between £20 - £50. Undestand that I cannot receive money during working hours. Occasionally asked to comment on behalf of HB regarding Health Matters. Understands to communicate with communications team appropriatly. To date, not represented the HB in media capacity.	Small amount of private outpatient clinic in physiotherapy setting. Mostly in sports nutrition focusing on endurance nutrition. Current commitment 3-4 hours per month.	Yes	Yes
	Melanie Wilkey	Head of Outcomes Based Commissioning	N/A	Father/brother in law proposing an outsourcing solution for wet AMD	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Jamie Hayes	Director - Welsh Medicines Resource Centre & All Wales Therapeutics & Toxicology Centre	Director, JMH Collaborations LTD	Director, JMH Collaborations LTD	N/A	N/A	N/A	Wife is Medical Director at the Marie Curie Cardiff & Vale Hospice (her terms & conditions are with Velindre NHS Trust)	I have honary contracts with the School of Medicine, Cardiff University and with the School of Pharmacy & Pharmaceutical Sciences, Cardiff University.	Yes	Yes
	Jane Maddison	Community Peadatric Physiotherapy Lead	N/A	N/A	N/A	N/A	N/A	Chartered Society Physiotherapy Welsh Board Member	N/A	Yes	Yes
	Annette Mclear	Dietitcian	N/A	N/A	N/A	N/A	N/A	N/A	Ad hoc private clients with Mental Health Issues	Yes	Yes
	Natalie Roberts	Principal Physiotherapist in Mental Health	N/A	N/A	My husband is the Director of Operations and Delivery for CD&T clinical board and therefore there is a conflict of interest	N/A	N/A	N/A	N/A	Yes	Yes
	Robert Bleehen	Consultant Radiologist	Both Directors of Cardiff Medical Consulting Ltd	Cardiff Medical Consulting 35% owned. Wife owns 65%.	N/A	N/A	N/A	N/A	British Medical Association	Yes	Yes
	Sarah Congreve	Vale Assistant Locality Manager	N/A	N/A	N/A	N/A	N/A	Partner is the Business Manager of West Quay Medical Centre, Barry	N/A	Yes	
	Vanessa Adams	Cluster Pharmacist	N/A	N/A	Spouse: Merck - Serono Advisory Role	N/A	Executive Board South Wales - Suerra Leone Cancer Care. Husband isExpert Advisor Bowel Cancer UK, Cancer Research, Exec Board South Wales Sierra Leone Cancer Care	Spouse - Bowel Cancer UK	N/A	Yes	Yes
	Farzana Mohar	Cluster Pharmacist	N/A	N/A	N/A	N/A	N/A	N/A	Employment at St Josephs Hopital, Newport (Locum)	Yes	Yes
	Sarah Clements	Clinical Lead SLT	N/A	N/A	N/A	N/A	N/A	MacMillan Adoption	N/A	Yes	Yes
	Lorna Bennett	Consultant - Public Health	N/A	N/A	N/A	N/A	N/A	Parent Governor at Victoria Primary School	Locum Contract with Public Health Wales	Yes	Yes
	Michelle Smalle	LATCH Clinical Phychologist	N/A	N/A	N/A	N/A	N/A	N/A	Self employed as a clinical psychologist and hypnotherapist. Curently hold an honorary contract with Velindre NHS Trust to consult on the psychological aspects of a clinical trial (adult population)	Yes	Yes
	Nicholas Grape	Occupational Therapist	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private hand therapy work on a sole trader basis, with a weekly clinic at Spire Hospital, Cardiff.	Yes	Yes
	Dr Kathrin Ham	Consultant	Director MSK Radiology ltd	N/A	N/A	N/A	N/A	N/A	working at Spire Hospital Cardiff and European scanning centre Cardiff	Yes	Yes

	Christopher Ro	Contact Lens Specialist - Opthamology	R. N. Roberts (North Road) Ltd	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Deborah Keogh	Lead Colorectal / Soma CNS	N/A	N/A	N/A	Department is funded by Colplast Ltd	N/A	N/A	N/A	Yes	Yes
	Sharon Iving	Senior Nurse	N/A	N/A	Just offered a position with Health Inspectortae Wales (HIW) as a nurse peer reviewer.	N/A	N/A	Leaves Of Hope charity for a Belarusian children's Orphanage.	Agency work for 18 WEEKS nursing agency to support and facilitate insourcing for Urology.	Yes	Yes
	Andrew Jones	Lead Nurse	N/A	N/A	N/A	N/A	Trustee / Deacon in Heath Evangelical Church (Registered Charity) Providing Spiritual, Social Care and Youth Work	N/A	Agency work for 18 WEEKS nursing agency to support and facilitate insourcing for Urology.	Yes	Yes
	Roger Maggs	Laboratory Manager	Directorship Wife also has Directorship	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Catherine Mars	Physio Clinical Lead	Husband works in CMHT (Mental Health) Son working in Public Health (Dietetics)	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Denise Hayes D	Clinical Specialist Physiotherapis t	N/A	N/A	N/A	N/A	N/A	N/A	Private practises as self employed veterinary physiotherapy. No links with NHS.	Yes	Yes
	George Oliver	Performance and Service Improvement Lead, Outpatient Physiotherapy	N/A	N/A	N/A	N/A	N/A	Spouse employed as Senior Broadcast Journalist at BBC Wales. Potential to cover Health Related Stories	N/A	Yes	Yes
	Claire Butterwo	Clinical Specialist Physiotherapis t	N/A	N/A	N/A	N/A	N/A	N/A	Undertake one session per week of private work. Any patients that are seen find contact details of myself off the ACPIN private physio	Yes	Yes
	Jacqueline Shar	Clinical Service Lead - Physiotherapy (Neuroscience s)	N/A	N/A	N/A	N/A	N/A	N/A	Husband works for a private physiotherapy practice Go Physio based in the Vale of Glamorgan	Yes	Yes
	Ruth Walford	Specialist Speech and Language Therapist	N/A	N/A	N/A	N/A	N/A	N/A	I am self-employed by the Ministry of Justice to act as a registered intermediary for adults with communication needs within the criminal justice system.	Yes	Yes
	Emily Morris	Speciality Doctor	N/A	N/A	N/A	N/A	N/A	Trustee Charity of ACE Cardiff	GP Partner at North Road Medical Practice	Yes	Yes
	Ellen Long	Specialist Physiotherapis t	N/A	N/A	N/A	N/A	N/A	N/A	Llanishen Rugby Club - Pitch side Physiotherapist	Yes	Yes
	Alison Millard	Urology Clinic Sister	N/A	N/A	N/A	N/A	N/A	N/A	As part of the Insourcing initiative, I provide Governance cover for the weekend clinics and receive payment for this	Yes	Yes
	Paul Rogers	Directorate Manager	N/A	Partner: Elaine Law Interiors. Interior Design Business that could potentially quote for UHB work	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Maurice Wentv	Posture & Mobility Centre Business Manager	N/A	Holds shares in Rentokil Initial valued at £3272 (as at 29/05/19). This is below £5000 threshold in policy. Rentokil Initial is a upplier to ALAS	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Shahad Latif	Specialist Information Pharmacist	N/A	N/A	N/A	N/A	N/A	N/A	Presenting at the UK Renal Pharmacy Group Conference, taking place on 27/09/2019. http://www.renalpharmacy.org.uk/	Yes	Yes
	Andrew Sully	Principal Pharmacist Quality Control	N/A	N/A	N/A	N/A	N/A	N/A	M&M Medical - Consultancy Advice	Yes	Yes
		Pharmacist									
	Peter Meades	Manager	N/A	N/A	N/A	N/A	N/A	N/A	Private Psychotherapy Practice	Yes	Yes
	Scott Gable	Cellular Pathology Service Manager	Executive Director - LabXcell Ltd	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Ann Birch	Speech and Language Therapist - Cochlear Implant	N/A	N/A	N/A	N/A	N/A	N/A	I do some Independent Speech and Language Therapy work but I never take clients linked with the Paediatric Cochlear Implant Programme and generally avoid clients within Cardiff and Vale UHB.	Yes	Yes
	Richard Cuddih	Consultant Clinical Psychologist/H ead of Specialty/Lead Psychologist SpSCB	N/A	N/A	N/A	N/A	N/A	N/A	Occasional private practice as a clinical psychologist (however no activity since 2014)	Yes	Yes
	Lucy Wheeler	Pharmacist	N/A	N/A	N/A	N/A	N/A	N/A	Spouse - Private Radiology Practice (Lakeside Diagnostic)	Yes	Yes

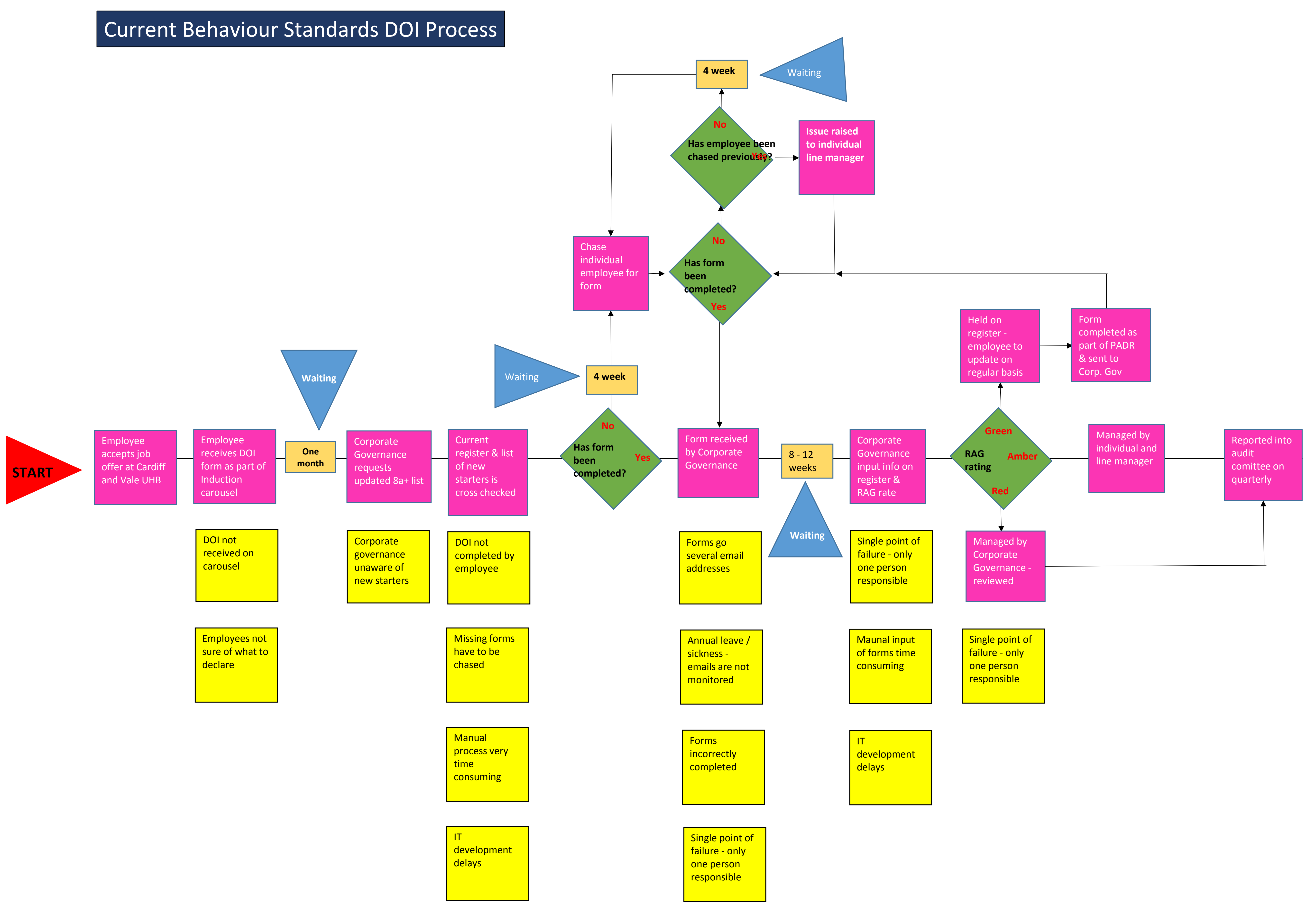
	Aarti Sharma	Consultant	Yes Spouse - Ram Misra	N/A	N/A	N/A	N/A	N/A	Private Practice at Spire Hospital	Yes	Yes
	Abigail Holmes	Consultant Midwife	N/A	Footsteps Womens Fitness and Wellbeing	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Annapurna Dar	Consultant	Darbhamulla Consultancy Limited (10018781)	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Robert Bryan B	Consultant	Founding Director of Innermost Secrets Limited	N/A	N/A	N/A	Founding Chairman of Innermost Learning - Registered Charity Spouse - Trustee of Innermost Learning	Shareholder in Time for Medicine	N/A	Yes	Yes
	Preetkiron Bha	Consultant	Director - Infiniti Healthcare Ltd Spouse - Nadia Bhal Director - Infiniti Healthcare Ltd	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Richard Penket	Consultant O & G	Director - RPSF Ltd Spouse - Director, RPSF Ltd	N/A	N/A	N/A	Trustee - Welsh Institute for Womens Health Spouse - Trustee, Welsh Institue for Womens Health	N/A	N/A	Yes	Yes
	Marc Williams	Clinical Psychologist	N/A	N/A	N/A	N/A	N/A	Work at Cardiff University as Senior Academic Tutor	N/A	Yes	
	Ruth Cann	Senior Nurse	N/A	Husband is a Partner in a law firm. As far as I am aware firm not currently doing business with the UHB. My husband is not personally involved with any.	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Holly Davies	Clinical Psychologist	N/A	N/A	N/A	N/A	N/A	N/A	Undertake Private Practice	Yes	Yes
	Aimee Stimpso	Clinical Psychologist	N/A	N/A	N/A	N/A	N/A	N/A	Occasional Private Clinical Psychology Practice outside of NHS contracted working hours	Yes	Yes
	Bethan Phillips	Clinical Psychologist	N/A	N/A	N/A	N/A	N/A	N/A	Owns a Private Practice that is run outside of NHS hours	Yes	Yes
	Kerry-Ann Hold	Consultant Clinical Psychologist	Bridgeman Psychological Consultancy - I am Director of this company, but all of my private practice is operated out of Talis Consulting Ltd	N/A	N/A	N/A	N/A	I have asked to become a Trustee of St Davids Children's Society (Adoption Agency) from Nov/Dec 2018. I have accepted the post and was recently asked to be on the interviw panel for the CEO of said society (Oct 2018)	YES: private practice: adults and young people with brain injury, medico-legal assessments; cases primarily in England and Wales; TALIS CONSULTING LTD	Yes	Yes
	Kathryn Bond	Peadiatric Neuropsychologist	N/A	N/A	N/A	N/A	N/A	N/A	YES: private practice: private paediatric neuroprehab cases and medico-legal assessments; cases primarily fm England; no current cases in Wales are taken if current patients of Cardiff & Vale	Yes	Yes
	Andrew Vidgen	Consultant Psychologist	N/A	N/A	N/A	N/A	N/A	N/A	Yes - private medico-legal work. Approximately 1-2 sessions / month. Undertaken in Gwent area	Yes	Yes
	Rona Aldridge	Clinical Psychologist	N/A	N/A	N/A	N/A	N/A	N/A	Self Employed in Private Practise	Yes	Yes
	Menna Myfanw	Clinical Lead	N/A	N/A	N/A	N/A	Chair of Trustees of the Vegan Society	N/A	Private Practice as Therapist	Yes	Yes
	Shilbendra Datt	Consultant	Director of 'Urology Solution Cardiff Limited' Wife is Co - Director of 'Urology Solution Cardiff Limited'	N/A	N/A	N/A	N/A	N/A	Consultant Urological Surgeon undertaking private practice	Yes	Yes
	Owen Hughes	Consultant	N/A	N/A	N/A	N/A	SPR Education Lead	N/A	Consultant Urological Surgeon undertaking private practice	Yes	Yes
	Howard Kynast	Consultant	Company Director - Bay Tree Wine Company Wife, Amanda Kynaston - Company Director Bay Tree Wine Company	N/A	N/A	N/A	N/A	N/A	Consultant Urological Surgeon undertaking private practice	Yes	Yes
	Alun Rhys Bone	Physiotherapist	N/A	N/A	N/A	N/A	N/A	N/A	Casual Employment with Cardiff Blues	Yes	Yes
	James Smith	Advanced MSK Physiotherapist	N/A	N/A	N/A	N/A	N/A	N/A	Personal Private Practice	Yes	Yes
	Sarah Alexande	Physiotherapist	N/A	N/A	N/A	N/A	N/A	N/A	Private work for Morrello Clini	Yes	Yes
	Hayley Dalls	Physiotherapist	N/A	N/A	N/A	N/A	N/A	N/A	Morello Clinic LTD	Yes	Yes
	Leanne Matthe	Physio Technici	N/A	N/A	N/A	N/A	N/A	Working at Private Clinic	N/A	Yes	Yes
	Kath Singleton	Dietitcian	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Elizabeth Wildi	Dietitcian	N/A	N/A	N/A	N/A	N/A	N/A	Principality Stadium PLC - Safety Steward Cardiff Blues - Safety Steward	Yes	Yes
	Gary Howell	Macmillan AHP	N/A	N/A	N/A	N/A	N/A	N/A	Private Dietetic Practice	Yes	Yes

	Marzena Zygo	Dietetic Suppor	N/A	N/A	N/A	N/A	N/A	N/A	Wales Intervention and Translation Service	Yes	Yes
	Victoria Chapm	Dietetic Suppor	Father is Director of Nodor International	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Julia Lisa Willia	All Wales Nutri	Director British Dieteic Association	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Gemma Purcell	Community Die	N/A	N/A	N/A	N/A	N/A	N/A	Private Dietetic Work - Occasionally evenings / weekends. 6 weekly supervision for a non NHS Dietitian. Occasional Private Dietetic Work.	Yes	Yes
	Fiona Moore	Community Die	Director GRJM Consultancy Limited Spouse - Director GRJM Consultancy Limited	N/A	N/A	N/A	Spouse - Trustee and Treasurer for Cancer Research Wales	N/A	N/A	Yes	Yes
	Melanie Gray	Community Die	N/A	N/a	N/A	N/A	Representative on the All Wales Diabetes Patient Reference Group, BDA South Wales Branch PR and Social Media Manager, Founder	Novo Nordisk Patient Reference Group Representative, Abbott Diabetes Patient Blogger, International Diabetes Federation Young	N/A	Yes	Yes
	Sally Shand	Counsellor	N/A	Private Counsellor Work in Cyncoed Consulting Rooms	N/A	N/A	N/A	N/A	Self Employed as Counsellor in Cyncoed Consulting Rooms	Yes	Yes
	Conor Dunleav	Physiotherapy	N/A	N/A	N/A	N/A	N/A	N/A	Bridgend RFC - Sports Club	Yes	YEs
	Garwyn Bridge	Physiotherapy,	N/A	N/A	N/A	Advisory Board - CLIESI Ltd - Honararia	N/A	N/A	N/A	Not signed	Not signed
	Georgina Hoop	Physiotherapy	N/A	N/A	N/A	N/A	N/A	Chair of South Wales (ATOCP) Professional Network Group	N/A	Yes	Yes
	Ann Jones	Patient Safety	N/A	N/A	N/A	Annual participation in conference sponsored by Fresenius Medical Care Middle East	N/A	N/A	N/A	Yes	Yes
	Rachael Barlow	Clinical Lead	N/A	N/A	N/A	N/A	N/A	N/A	1 Hour per week of private dietetic clinics	Yes	Yes
	Pippa Mundy	Clinical Psychol	N/A	N/A	N/A	N/A	N/A	N/A	ORBIS EDUCATION & CARE Independent Psychologist	Yes	Yes
	Kathryn Lousie	Community Ph	Davies Homes Ltd	N/A	N/A	N/A	N/A	N/A	Policy and planning manager Company Chemists' Association	Yes	Yes
	Andy Jones	Lead Nurse: Surgery, urology, ophthalmolog y ent, dental wound healing and breast	N/A	N/A	N/A	N/A	Trustee of Heath Evangelical church (registered charity)	N/a	N/A	Yes	Yes
	James Coulson	Honorary Consultant Physician, Clinical Pharmacologis t & Toxicologist	Both Director of Medical, Scientific & Toxicology Consultancy Ltd	Both 50% shareholding in Medical, Scientific & Toxicology Consultancy Ltd	Consultancy for Simbec-Orion Plc, a CRO involved in early phase clinical trials.	N/A	N/A	N/A	Both Director of Medical, Scientific & Toxicology Consultancy Ltd	Yes	Yes
	Jessica Quirke	Consultant Clin	N/A	N/A	N/A	N/A	N/A	N/A	Self Employment in Private Practice	Yes	Yes
	Christopher Ho	Deputy Directo	N/A	N/A	N/A	N/A	President of Wales Branch of the Healthcare Financial Management Association(HFMA) . HFMA is a registered charity.	My wife is Samantha Lewis, Assistant Director of Finance, Abertawe Bro Morgannwg University Health Board	N/a	Yes	Yes
	Christopher An	Clinical Scientis	N/A	N/A	My spouse also works for AWMGS (Sarah Anderson)	N/A	N/A	N/A	N/A	Yes	Yes
	Louise Evans	Clinical Psychol	N/A	N/A	N/A	N/A	N/A	N/A	Private practice within R&R Consulting centre.	Yes	Yes
	Miranda Barbe	Consultant Clin	Director Limited company (not traded on it since April 2018) - end client was not in the business of providing any form of health care	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Rhys Morris	Clinical Scientis	N/A	N/A	Provision of scientific advice and teaching to Eezcare Medical Corp	N/A	N/A	N/A	N/A	Yes	Yes
	Helen Ludlow	CNS	N/A	N/A	N/A	N/A	N/A	N/A	Led on a Pod Cast about living with Crohn's Disease, to educate other CNS's. No medical info given. For Janssen	Yes	Yes
	Catherine Brya	Consultant Clinical Scientist, Head of Non-Ionising Radiation	N/A	N/A	N/A	N/A	N/A	N/A	Lecturing on behalf of Wessex diagnostics	Yes	Yes

	Clare Quinn	Consultant Clin	N/A	N/A	N/A	N/A	N/A	N/A	I am contracted to work for the NHS 30 hours per week. In addition I work privately seeing individuals for therapy. I ensure that this work is undertaken in my own time and does not clash or cause a conflict of interest with my NHS duties and responsilities. I work predominately on a Friday when I do not work for the NHS and also for a maximum of one of two hours on a Monday and Tuesday after week. I try and ensure that I dont work more than 7 hours a week privately. When I work privately I work from a base in St Isan Road Cardiff.	Yes	Yes
	Kim Atkinson	Strategic Lead (	Director of the Royal College of Occupational Therapists	N/A	N/A	N/A	Royal College of Occupational Therapists (Council Member)	N/A	N/A	Yes	Yes
	Julie Highfield	Consultant Clinical Psychologist Critical Care / Asscoaite Director Critical Care	N/A	N/A	N/A	N/A	N/A	N/A	Occasional Private Practise	Yes	Yes
	Lee Davies	Operational Pla	N/A	N/A	N/A	N/A	N/A	N/A	My wife is a locum pharmacist operating within the Hywel Dda and Swansea Bay areas. I personally receive no financial benefit from this work.	Yes	Yes
	Declan Colema	Clinical Scientis	N/A	N/A	N/A	N/A	N/A	N/A	Private practice in a hopital outside C&V NHS trust	Yes	Yes
	Emyr Stephens	Prescribing Adv	N/A	N/A	N/A	N/A	N/A	I have taken part in an Advisory Board for various products over the last 10 years or so. These were all for 1 day only.	N/A	Yes	Yes
	Judy Gaunt	Service Manag	N/A	N/A	N/A	N/A	N/A	N/A	HUSBAND WORKS FOR NWSSP PROCUREMENT SERVICES	Yes	Yes
	Gary Howell	Macmillan AHP	N/A	N/A	N/A	N/A	N/A	N/A	Private Dietetic practice	Yes	Yes
	Annette Mclea	Dietitcian	N/A	N/A	N/A	N/A	N/A	N/A	Ad hoc work with; Orbis education and Care (different clinical area to my current work in NHS so no perceived conflict), Cardiff uni, Medico legal work, dietetic consultancy work	Yes	Yes
	Peter O Callagh	Clinical Directo	N/A	Peter O Callaghan Ltd (Private Practice)	N/A	Medtronic sponsored a alternate year National cardiology meeting organised by Dr Mark Anderson (Morriston) and myself. The meeting is entitled "Electrophysiology and Device therapt - what every cardiologist needs to know". +	N/A	N/A	N/A	Yes	Yes
	Melaine Wilkey	Head of Outco	N/A	Father and brother-in-law doing some exploaratory work with Opthalmology and Surgery Clinical Board to look at providing outsourcing solution for wet AMD. Discussions not currently active.	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Richard Attano	Doctor	Managing Director Spouse is Company Secretary	Spouse is Company Secretary	N/A	N/A	N/A	N/A	SPIRE HEALTHCARE, MEDICOLEGAL EXPERT CONSULTATION	Yes	Yes
	Claire Louise W	Consultant Clin	N/A	N/A	N/A	N/A	CAV UHB 'PROP Appeal' Committee Member	N/A	Self Employment in Private Practice (currently with Positive Neuro Rehab network)	Yes	Yes
	Farzana Mohar	Cluster Pharmacist	N/A	N/A	N/A	N/A	N/A	N/A	Employment at St Josephs Hopital, Newport (Locum)	Yes	Yes
	Sarah Clement	Clinical Lead SLT	N/A	N/A	N/A	N/A	N/A	MacMillan Adoption	N/A	Yes	Yes
	Lorna Bennett	Consultant - Public Health	N/A	N/A	N/A	N/A	N/A	Parent Governor at Victoria Primary School	Locum Contract with Public Health Wales	Yes	Yes
	Michelle Small	LATCH Clinical Phychologist	N/A	N/A	N/A	N/A	N/A	N/A	Self employed as a clinical psychologist and hypnotherapist. Curently hold an honorary contract with Velindre NHS Trust to consult on the psychological aspects of a clinical trial (adult population)	Yes	Yes

Nicholas Grape	Occupational Therapist	N/A	N/A	N/A	N/A	N/A	N/A	I undertake private hand therapy work on a sole trader basis, with a weekly clinic at Spire Hospital, Cardiff.	Yes	Yes
Dr Kathrin Ham	Consultant	Director MSK Radiology ltd	N/A	N/A	N/A	N/A	N/A	working at Spire Hospital Cardiff and European scanning centre Cardiff	Yes	Yes
Christopher Ro	Contact Lens Specialist - Opthamology	R. N. Roberts (North Road) Ltd	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Deborah Keogh	Lead Colorectal / Soma CNS	N/A	N/A	N/A	Department is funded by Colplast Ltd	N/A	N/A	N/A	Yes	Yes
Sharon Iving	Senior Nurse	N/A	N/A	Just offered a position with Health Inspectortae Wales (HIW) as a nurse peer reviewer.	N/A	N/A	Leaves Of Hope charity for a Belarusian children's Orphanage.	Agency work for 18 WEEKS nursing agency to support and facilitate insourcing for Urology.	Yes	Yes
Andrew Jones	Lead Nurse	N/A	N/A	N/A	N/A	Trustee / Deacon in Heath Evangelical Church (Registered Charity) Providing Spiritual, Social Care and Youth Work	N/A	Agency work for 18 WEEKS nursing agency to support and facilitate insourcing for Urology.	Yes	Yes
Roger Maggs	Laboratory Manager	Directorship Wife also has Directorship	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Catherine Mars	Physio Clinical Lead	Husband works in CMHT (Mental Health) Son working in Public Health (Dietetics)	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Denise Hayes D	Clinical Specialist Physiotherapist	N/A	N/A	N/A	N/A	N/A	N/A	Private practises as self employed veterinary physiotherapy. No links with NHS.	Yes	Yes
George Oliver	Performance and Service Improvement Lead, Outpatient Physiotherapy	N/A	N/A	N/A	N/A	N/A	Spouse employed as Senior Broadcast Journalist at BBC Wales. Potential to cover Health Related Stories	N/A	Yes	Yes
Claire Butterwo	Clinical Specialist Physiotherapist	N/A	N/A	N/A	N/A	N/A	N/A	Undertake one session per week of private work. Any patients that are seen find contact details of myself off the ACPIN private physio	Yes	Yes
Jacqueline Shar	Clinical Service Lead - Physiotherapy (Neurosciences)	N/A	N/A	N/A	N/A	N/A	N/A	Husband works for a private physiotherapy practice Go Physio based in the Vale of Glamorgan	Yes	Yes
Ruth Walford	Specialist Speech and Language Therapist	N/A	N/A	N/A	N/A	N/A	N/A	I am self-employed by the Ministry of Justice to act as a registered intermediary for adults with communication needs within the criminal justice system.	Yes	Yes
Emily Morris	Speciality Doctor	N/A	N/A	N/A	N/A	N/A	Trustee Charity of ACE Cardiff	GP Partner at North Road Medical Practice	Yes	Yes
Paul Rogers	Directorate Manager	N/A	Partner: Elaine Law Interiors. Interior Design Business that could potentially quote for UHB work	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Maurice Wentv	Posture & Mobility Centre Business Manager	N/A	Holds shares in Rentokil Initial valued at £3272 (as at 29/05/19). This is below £5000 threshold in policy. Rentokil Initial is a upplier to ALAS	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Shahad Latif	Specialist Information Pharmacist	N/A	N/A	N/A	N/A	N/A	N/A	Presenting at the UK Renal Pharmacy Group Conference, taking place on 27/09/2019. http://www.renalpharmacy.org.uk/	Yes	Yes
Andrew Sully	Principal Pharmacist Quality Control	N/A	N/A	N/A	N/A	N/A	N/A	M&M Medical - Consultancy Advice	Yes	Yes
	Pharmacist									
Peter Meades	Manager	N/A	N/A	N/A	N/A	N/A	N/A	Private Psychotherapy Practice	Yes	Yes
Scott Gable	Cellular Pathology Service Manager	Executive Director - LabXcell Ltd	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Ann Birch	Speech and Language Therapist - Cochlear Implant	N/A	N/A	N/A	N/A	N/A	N/A	I do some Independent Speech and Language Therapy work but I never take clients linked with the Paediatric Cochlear Implant Programme and generally avoid clients within Cardiff and Vale UHB.	Yes	Yes
Richard Cuddih	Consultant Clinical Psychologist/Head of Specialty/Lead Psychologist SpSCB	N/A	N/A	N/A	N/A	N/A	N/A	Occasional private practice as a clinical psychologist (however no activity since 2014)	Yes	Yes
Lucy Wheeler	Pharmacist	N/A	N/A	N/A	N/A	N/A	N/A	Spouse - Private Radiology Practice (Lakeside Diagnostic)	Yes	Yes

	Aarti Sharma	Consultant	Yes Spouse - Ram Misra	N/A	N/A	N/A	N/A	N/A	Private Practice at Spire Hospital	Yes	Yes
	Abigail Holmes	Consultant Midwife	N/A	Footsteps Womens Fitness and Wellbeing	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Annapurna Dar	Consultant	Darbhamulla Consultancy Limited (10018781)	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Robert Bryan B	Consultant	Founding Director of Innermost Secrets Limited	N/A	N/A	N/A	Founding Chairman of Innermost Learning - Registered Charity Spouse - Trustee of Innermost Learning	Shareholder in Time for Medicine	N/A	Yes	Yes
	Preetkiron Bhal	Consultant	Director - Infiniti Healthcare Ltd Spouse - Nadia Bhal Director - Infiniti Healthcare Ltd	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Richard Penket	Consultant O & G	Director - RPSF Ltd Spouse - Director, RPSF Ltd	N/A	N/A	N/A	Trustee - Welsh Institute for Womens Health Spouse - Trustee, Welsh Institue for Womens Health	N/A	N/A	Yes	Yes
	Marc Williams	Clinical Psychologist	N/A	N/A	N/A	N/A	N/A	Work at Cardiff University as Senior Academic Tutor	N/A	Yes	
	Ruth Cann	Senior Nurse	N/A	Husband is a Partner in a law firm. As far as I am aware firm not currently doing business with the UHB. My husband is not personally involved with any.	N/A	N/A	N/A	N/A	N/A	Yes	Yes
	Holly Davies	Clinical Psychologist	N/A	N/A	N/A	N/A	N/A	N/A	Undertake Private Practice	Yes	Yes
	Aimee Stimpso	Clinical Psychologist	N/A	N/A	N/A	N/A	N/A	N/A	Occasional Private Clinical Psychology Practice outside of NHS contracted working hours	Yes	Yes
	Bethan Phillips	Clinical Psychologist	N/A	N/A	N/A	N/A	N/A	N/A	Owns a Private Practice that is run outside of NHS hours	Yes	Yes
	Kerry-Ann Hold	Consultant Clinical Psychologist	Bridgeman Psychological Consultancy - I am Director of this company, but all of my private practice is operated out of Talis Consulting Ltd	N/A	N/A	N/A	N/A	I have asked to become a Trustee of St Davids Children's Society (Adoption Agency) from Nov/Dec 2018. I have accepted the post and was recently asked to be on the interviw panel for the CEO of said society (Oct 2018)	YES: private practice: adults and young people with brain injury, medico-legal assessments; cases primarily in England and Wales; TALIS CONSULTING LTD	Yes	Yes
	Kathryn Bond	Peadiatric Neuropsychologist	N/A	N/A	N/A	N/A	N/A	N/A	YES: private practice: private paediatric neuroprehab cases and medico-legal assessments; cases primarily fm England; no current cases in Wales are taken if current patients of Cardiff & Vale	Yes	Yes
	Andrew Vidgen	Consultant Psychologist	N/A	N/A	N/A	N/A	N/A	N/A	Yes - private medico-legal work. Approximately 1-2 sessions / month. Undertaken in Gwent area	Yes	Yes
	Rona Aldridge	Clinical Psychologist	N/A	N/A	N/A	N/A	N/A	N/A	Self Employed in Private Practise	Yes	Yes
	Menna Myfanw	Clinical Lead	N/A	N/A	N/A	N/A	Chair of Trustees of the Vegan Society	N/A	Private Practice as Therapist	Yes	Yes
	Shilbendra Datt	Consultant	Director of 'Urology Solution Cardiff Limited' Wife is Co - Director of 'Urology Solution Cardiff Limited'	N/A	N/A	N/A	N/A	N/A	Consultant Urological Surgeon undertaking private practice	Yes	Yes
	Owen Hughes	Consultant	N/A	N/A	N/A	N/A	SPR Education Lead	N/A	Consultant Urological Surgeon undertaking private practice	Yes	Yes
	Howard Kynast	Consultant	Company Director - Bay Tree Wine Company Wife, Amanda Kynaston - Company Director Bay Tree Wine Company	N/A	N/A	N/A	N/A	N/A	Consultant Urological Surgeon undertaking private practice	Yes	Yes
	Alun Rhys Bone	Physiotherapist	N/A	N/A	N/A	N/A	N/A	N/A	Casual Employment with Cardiff Blues	Yes	Yes
	James Smith	Advanced MSK Physiotherapist	N/A	N/A	N/A	N/A	N/A	N/A	Personal Private Practice	Yes	Yes
	Sarah Alexande	Physiotherapist	N/A	N/A	N/A	N/A	N/A	N/A	Private work for Morrello Clini	Yes	Yes



Current Behaviour Standards DOI Process
START
Employee accepts job offer at Cardiff and Vale UHB
Employee receives DOI form as part of Induction carousel
Waiting
One month
Corporate Governance requests updated 8a+ list
Current register & list of new starters is cross checked
Waiting
4 week
No
Has form been completed?
Yes
Chase individual employee for form
No
Has form been completed?
Yes
No
Has employee been chased previously?
Yes
Issue raised to individual line manager
4 week
Waiting
Form received by Corporate Governance
8 - 12 weeks
Waiting
Corporate Governance input info on register & RAG rate
Green
RAG rating
Amber
Red
Held on register - employee to update on regular basis
Form completed as part of PADR & sent to Corp. Gov
Managed by individual and line manager
Managed by Corporate Governance - reviewed
Reported into audit comittee on quarterly
DOI not received on carousel
Employees not sure of what to declare
Corporate governance unaware of new starters
DOI not completed by employee
Missing forms have to be chased
Manual process very time consuming
IT development delays
Forms go several email addresses
Annual leave / sickness - emails are not monitored
Forms incorrectly completed
Single point of failure - only one person responsible
Single point of failure - only one person responsible
Maunal input of forms time consuming
IT development delays
Single point of failure - only one person responsible

Report Title:	Legislative and Regulatory Tracker Report							
Meeting:	Audit Committee					Meeting Date:	3rd March 2020	
Status:	For Discussion		For Assurance	X	For Approval		For Information	
Lead Executive:	Director of Corporate Governance							
Report Author (Title):	Director of Corporate Governance							

Background and current situation:

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.

Good progress has been made on the development of a Legislative and Regulatory Tracker and the follow up internal audit report provided 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.

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

Further work will be undertaken to improve the Regulatory and Legislative Compliance Tracker by the new Risk and Regulation Team which comprises a Head of Risk and Regulation plus two Risk and Regulation Officers. The introduction of these new posts means that the Team will have capacity to further improve the work on the 'Tracker' within the organisation in addition to supporting the roll out of the Risk Management.

This in turn will provide further assurance to the Audit Committee and the Board and ensure that any outstanding actions from the Internal Audit on this piece of work are implemented

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

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.

The tracker will continue to updated throughout the organisation and reported to the Audit Committee on a quarterly basis after been presented to HSMB.

Based on the information contained within the tracker there have been 12 inspections undertaken since the 26th November 2019 as follows:

1. An inspection was undertaken by **Cardiff and Vale of Glamorgan of Food Hygiene Ratings** at **Ward Based catering, Brecknock House**.

Outcome: Inspection took place on 2nd December 2019. The outcome of the inspection was a Food Rating of 4.

2. An inspection was undertaken by **Cardiff and Vale of Glamorgan of Food Hygiene Ratings** at **Bwyd Blasus**.

Outcome: Inspection took place on 28th November 2019. The outcome of the inspection was a Food Rating of 4.

3. An inspection was undertaken by **Cardiff and Vale of Glamorgan of Food Hygiene Ratings** at **Aroma Express, Brecknock House**.

Outcome: Inspection took place on 28th November 2019. The outcome of the inspection was a Food Rating of 3.

4. An inspection was undertaken by **Cardiff and Vale of Glamorgan of Food Hygiene Ratings** at **Rookwood Hospital**.

Outcome: Inspection took place on 25th November 2019. The outcome of the inspection was a Food Rating of 5.

5. **Fire and Rescue Services** at **Rhydlafar Ward, St David's Hospital**

Outcome: Inspection took place on 21st January 2020. The outcome was – complied with the requirements of the Regulatory Reform Safety Order 2005

6. **Fire and Rescue Services** at **Lansdowne Ward, St David's Hospital**

Outcome: Inspection took place on 21st January 2020. The outcome was – Failed to comply with the requirements of the safety order. Schedule of works required included 1 x management and 1 x estates.

7. **Fire and Rescue Services** at **Sam Davies Ward, Barry Hospital**

Outcome: Inspection took place on 21st January 2020. The outcome was – Failed to comply with the requirements of the safety order. Schedule of works required included 2 x estates.

8. **HIW** at **Llanishen Court Surgery**

Outcome: Limited processes were in place to support the safe recruitment and training of staff. There was no evidence of Disclosure and Baring Service (DBS) checks.

10. **UKAS** at **Medical Biochemistry and Immunology**

Outcome: Inspection took place between 2nd – 6th December 2019. The outcome was 21 findings with actions to be submitted by 13th January 2020.

11. **UKAS** at **Medical Biochemistry**

Outcome: Inspection took place on 4th December 2019. The outcome was 25 findings with closure due by 16th February 2020.

12. **UKAS** at **Specimen Reception**

Outcome: Inspection took place on 4th December 2019. The outcome was 2 findings and 1 recommendation with inspection closure due by 16th February 2020.

Based upon the information contained within the tracker there are no futher inspections due to be undertaken between 21st February 2020and 14 April 2020.

Recommendation:

For Members of the Audit Committee to:

(a) Note the inspections which have taken place since the last meeting of the Audit Committee in December 2019 and their respective outcomes.

(b) To note the continuing development of the Legislative and Regulatory Compliance Tracker.

Shaping our Future Wellbeing Strategic Objectives

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

1. Reduce health inequalities		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.*

CARING FOR PEOPLE
KEEPING PEOPLE WELL

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
ALL WALES QUALITY ASSURANCE PHARMACIST													
	Pharmacy	All Wales Quality Assurance Pharmacist	Pharmacy SMPU	Medicines Act 1968 (c.67) specific review of section 10	Stuart Walker	QSE Committee	Darrell Baker	annual	01/11/2018	Oct-19	High Risk - resourcing of an accountable pharmacist	01/11/2019	2
	Pharmacy	All Wales Quality Assurance Pharmacist	Pharmacy UHL	Medicines Act 1968 (c.67) specific review of section 10	Stuart Walker	QSE Committee	Darrell Baker	annual	16/07/2019		High Risk - estate and PQS defciencies - link to MHRA inspection	01/01/2019	1
	Pharmacy			Falsifying Medicines Directive	Stuart Walker	QSE Committee	Darrell Baker	n/a	n/a	n/a	no inspection data as yet		
BRITISH													
	Planning	British Standards Institute	Capital, Estates & Facilities	ISO - 14001 Environmental	Abigail Harris	Health and Safety	Jon McGarrigle	6 monthly	01/07/2019	Jan-20	Minor non conformances which will be addressed by next audit		
CARDIFF AND VALE OF GLAMORGAN FOOD HYGIENE RATINGS													
	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Ward Based Catering, Brecknock House	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Keith Prosser		02/12/2019		Food rating 4		
	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Bwyd Blasus	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Ranjith Akkaladevi		28/11/2019		Food rating 4		
	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Aroma Express, Brecknock House	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Stepfanie Burgess		28/11/2019		Food rating 3		
	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Rookwood Hospital	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Andrew Wood		25/11/2019		Food rating 5		
	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Teddy Bear Nursery	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety			04/09/2019		Food rating 4	30/09/2019	
	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Llandough Hospital	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety			19/09/2019		Food rating 5		
	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Hafan y Coed	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety			19/09/2019		Food rating 5		
FIRE AND RESCUE SERVICES													
Specialist Services Clinical Board	Capital and Asset Management	Fire and Rescue Services	C5 UHW	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	12 Months	17/06/2019	Jun-20	Failed to comply with requirements of safety order. Schedule of works required included: 3 x management	IN01: non-compliance but insufficient for enforcement notice.	1
Medicine Clinical Board	Capital and Asset Management	Fire and Rescue Services	B7 UHW	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	12 Months	27/06/2019	Jul-20	Failed to comply with requirements of safety order. Schedule of works required included: 3 x management 1 x compliance	IN01: non-compliance but insufficient for enforcement notice. May return to check	1
Surgery Clinical Board	Capital and Asset Management	Fire and Rescue Services	West 3 Anwen Ward UHL	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	12 Months	09/07/2019	Jul-20	Failed to comply with requirements of safety order. Schedule of works required included: 1 x management	IN01: non-compliance but insufficient for enforcement notice.	1
Surgery Clinical Board	Capital and Asset Management	Fire and Rescue Services	Cerys Ward ICU	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	12 Months	10/09/2019	Sep-20	Failed to comply with requirements of safety order. Schedule of works required included: 1 x compliance 1 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been	1
Surgery Clinical Board	Capital and Asset Management	Fire and Rescue Services	Ward A5	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	12 Months	19/09/2019	Sep-20	Failed to comply with requirements of safety order. Schedule of works required included: 1 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.	1
Specialist Services Clinical Board	Capital and Asset Management	Fire and Rescue Services	Ward B5	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	12 Months	19/09/2019	Sep-20	Failed to comply with requirements of safety order. Schedule of works required included: 1 x compliance 1 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check	1
Surgery Clinical Board	Capital and Asset Management	Fire and Rescue Services	Operating Theatres	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	12 Months	30/09/2019	**Sep-20**	Failed to comply with requirements of safety order. Schedule of works required included: 2 x compliance 1 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been	1
Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Rhydlafar Ward, St David's Hospital	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	12 Months	21/01/2020	Jan-21	Complied with the requirements of the Regulatory Reform Safety Order 2005	IN01: non-compliance but insufficient for enforcement notice. May return to check	1

Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Lansdowne Ward, St David's Hospital	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	12 Months	21/01/2020	Jan-21	Failed to comply with requiremetns of safety order. Schedule of works required included: 1 x management 1 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.	1
Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Sam Davies Ward, Barry Hospital	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	12 Months	27/01/2020	Jan-21	Failed to comply with requirements of safety order. Schedule of works required included: 2 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been	1
HEALTH AND SAFETY EXECUTIVE													
		Health and Safety Executive		Health and Safety at Work Act 1974	Martin Driscoll	Health and Safety							
HEALTH EDUCATION AND IMPROVEMENT WALES													
		Health Education and Improvement Wales											
HEALTH INSPECTORATE WALES													
		HIW	Llanishen Court Surgery	HIW	Ruth Walker	QSE Committee			10/12/2019		Limited processes were in place to support the safe recruitment and training of staff. There was no evidence that Disclosure and Barring Service (DBS) checks		
Specialist	Rehabilitation	HIW (Unannounced)	Rookwood Hospital	HIW	Ruth Walker	QSE Committee	Director of Nursing, Specialist		02/10/2019				
Medicine	Stroke Rehabilitation	HIW (Unannounced)	Stroke Rehabilitation Centre, UHL	HIW	Ruth Walker	QSE Committee	Director of Nursing, Medicine		17 & 18/09/19		Immediate assurance was required in realtion to appropriate checks on resuscitation trolleys. Action plan completed.		
PCIC	Dental	HIW (Announced visit)	BUPA Dental Care, Canton	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		02/09/2019		Non-compliance notice issued regarding incorrect and hazardous storage of healthcare waste and innaccurate dental records. Improvement plan required by 11th September 2019.		
PCIC	Dental	HIW (Announced visit)	Family Dental Care	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		19/08/2019		Areas identified for improvement - Maintenance improvements in some clinical areas, radiology audits must demonstration whether image quality conforms to minimum standards, ensure verbal medical history checks undertaken with patients are recorded in patient records. Regulatory breaches regarding training (Dental Nurse had not undertaken the required number of hours (5) of verifiable training in radiology and radiation protection during their previous 5 year CPD cycle as recommended by the GDC, expired emergency drugs being sorted in draw next to in-date drugs which could potentially get mixed up in an emergency situation.		
PCIC	GP Practice	HIW (GP Announced visit)	Waterfront Medicial Centre	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		12/08/2019				
PCIC	Dental	HIW	Cathays Dental Practice	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		05/08/2019		Non-compliance notice - storage of healthcare waste.		
PCIC	Dental	HIW	High Street Dental Practice, Cowbridge	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		23/07/2019		Non-compliance notice - The service must ensure healthcare waste is being stored appropriately and securely within the dental practice in line with best practice guidelines. HIW found evidence that the practice was not fully compliant with current regulations, standards and best practice guidelines		
PCIC	GP Practice	HIW	Birchgrove Surgery	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		10/07/2019		Area of concern - Findings during the HIW inspection - they considered the pre-employment records of two non-clinical members of staff and there was no evidence that the relevant Disclosure and Barring Service (DBS) checks had been carried out. The Practice Manager confirmed that the DBS checks were not routinely undertaken for any non-clinical members of staff such as Practice management, administrative and reception staff. Improvement required. The Practice must implement a process to ensure that: Pre-employment checks for all staff include the need for a DBS check appropriate to their roles and all current members of staff have a DBS check undertaken urgently, appropriate to their roles. A record must be kept within the Practice.		

PCIC	Dental	HIW (Announced visit)	Penarth Dental Healthcare	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		01/07/2019		HIW found evidence that the practice was not fully compliant with the regulations and other relevant legislation and guidance. HIW recommended improvements be made in the following; Provide more information to patients on how children and adults can best maintain good oral hygiene; the Fire Safety Officer must undertake training by a fire safety expert, make adjustments to the infection prevention and control procedures in place at the practice, provide a baby nappy bin and ensure the waste is disposed of appropriately, staff to receive training on the safeguarding of children and vulnerable adults, unused dental supplies need to be stored in a more secure cupboard, make adjustments to the arrangements for safe storage and use of the emergency drugs and emergency equipment available at the practice. HIW identified regulatory breaches during this inspection – whilst this has not resulted in the issue of a non compliance notice, there is an expectation that the registered person takes meaningful action to address these matters, as a failure to do so could result in non-compliance with regulations.		
PCIC	Dental	HIW (Announced visit)	Llanederyn Dental Practice	Private Dentistry Regulations/All Healthcare Standards	Ruth Walker	QSE Committee	Director of Nursing, PCIC		23/05/2019		HIW found some evidence that they were not fully compliant with Private Dentistry Regulations and all Health and Care Standards. The practice has been recently bought by its current owners and through discussions with them it was clear that they are keen to develop and improve the practice. There were a number of policies and procedures in place, but they were not dated, not version controlled, did not contain a review date and in the majority of instances did not include a staff signature demonstrating that the policies and procedures had been read and understood. HIW recomended that the practice need to ensure that all staff are appropriately trained with evidence of this training held on file. HIW recommended a number of improvements should be made including the review of policies and procedures which should be communicated to staff; training to be given to all staff as required and evidence maintained of this training on a training matrix; introduction of a programme of clinical and quality audits; provision of more information to patients in the reception area; completion of patient clinical records as required by clinical guidelines and the provision of more robust management of the practice going forward. Whislt this has not resulted in the issue of a non compliance notice, HIW expectation is that meaninful action is taken to address these matters as failure to do so could result in non compliance with the regulations		
PCIC	Dental	HIW (Announced visit)	Tynewydd Dental Care	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		13/05/2019		HIW found some evidence that the practice was not fully compliant with Private Dentistry Regulations and all Health and Care Standards and a non compliance issue was issued. Copy of immediate assurance letter dated 24.05.19 received.		
PCIC	Dental	HIW	Park Place Dental	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		01/05/2019		HIW recommend improvements could be made regarding advising patients of the results of their feedback and any changes. Review the management of emergency drugs and ancillary equipment.		
PCIC		HIW (Clinical Review)	Her Majesty's Prison, Cardiff	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		01/05/2019		It was recommended that immediate steps are taken to review, monitor and improve the standards of note keeping in the medical records at HMP Cardiff. Formal Protocols should be devised for chronic disease management of all major chronic diseases as would be the case in community GP monitoring. Formal protocols should be devised for action to be taken after a period of nonattendance for dispensing of medications. A period of non-attendance should be obvious to the staff dispensing medication as they mark the medication charts accordingly. The protocol should include but need not be restricted to : Action to be taken to determine the cause of the non-attendance Note should be made of whether the non-attendance is a free choice made by a patient with full capacity or whether there is some hindrance affecting their ability to attend If there is any hindrance, as was the situation in this case, the nature of this hindrance should be documented Any action that needs to take place to overcome the hindrance should be documented. The situation should be reviewed after a reasonable length of time to ensure that the hindrance had been overcome. In the case of patients who choose not to attend, this should be addressed during routine chronic disease management appointments and opportunistically and should be documented. Appropriate Read Codes should be used for all of the above to enable accurate searches and recalls to take place. These should also allow for comparisons between episodes of a similar nature.		
PCIC	Dental	HIW (Announced visit)	Cathedral Dental Clinic	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		26/03/2019		Due to the CCTV cameras located within the practice, including the surgeries HIW have asked for CCTV signage to be clear and prominent to all patients and visitors attending the practice. Policies and procedures need to be updated to reflect current CCTV guidelines. The patient records HIWreviewed were detailed, but they identified some areas where improvement is required.		

Medicine	Emergency Care	HIW (Unannounced)	Emergency Unit/Assessment Unit	HIW	Ruth Walker	QSE Committee	Director of Nursing, Medicine		25/03/2019		28th March 2019 - immediate improvement plan required - letter; response 05-04-19; HIW response 11-04-19 - immediate assurance plan not accepted; 2nd UHB reponse 29th April 2019; HIW response accepting immediate assurance. Response sent 07.06.19. HIW assurance received 20.06.19.		
Mental Health		HIW (Unannounced)	Hafan Y Coed	HIW	Ruth Walker	QSE Committee	Director of Nursing, Mental Health		18/03/2019		HIW found the Health Board did not always meet all standards required within the Health and Care Standards (2015), the Mental Health Act (1983), Mental Health (Wales) Measure (2010) and the Mental Capacity Act (2005). HIW recommended that the service could improve upon: Areas of Mental Health Act documentation require improvement Garden areas on all wards are in need of maintenance and the responsibility for this, needs to be confirmed Inconsistency of information displayed for patients and relatives across the wards Page 7 of 34 HIW report template version 2 Areas of good practice employed on some wards are not shared with others to maintain consistency Some patients are sleeping out1 from their designated ward due to additional demand and clinical need		
PCIC	Dental	HIW (Announced visit)	Danescourt Dental Practice	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		18/03/2019		The practice has conducted an internal audit and has addressed the gaps in fridge temperature readings by updating the record sheet used, and developed a process to handover responsibilities during staff absences. The Primary Care team has also audited fridge temperature logs and noted that temperatures were recorded on all working days.		
PCIC	Dental	HIW (Announced visit)	Alison Jones, Barry	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		17/12/2018		HIW identified areas for improvement with regards to arrangements for checking of emergency drugs and equipment, first aid equipment and dental materials.Improvements were required with regards to some fire safety arrangements.More detailed patient records were needed in some areas to evidence the care and treatment provided to patients.The practice needed to implement a number of policies and procedures, and some were also in need of updating. Regular appraisals for staff needed to be introduced.		
PCIC	Community	HIW	Mental Health Team, Western Vale	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		04/12/2018				
PCIC	Dental	HIW (Announced visit)	Penylan Dental Practice	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		28/11/2018		HIW recommended that the practice move its emergency drugs and equipment to a place that is more accessible. Improvements recommended included: the practice are to ensure that all staff have completed appropriate safeguarding training, a feminine hygiene bin is to be installed in the staff toilet, emergency drugs with their appropriate algorithms to be stored in separate and labelled containers/bags. There were no areas of non compliance identified at this inspection		
PCIC	GP Practice	HIW (Announced visit)	Pontprennau Medical Centre	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		05/11/2018		HIW found that the practice was not fully compliant with the Health and Care Standards in all areas of service provision. HIW did make a number of recommednations for improvements which included that they review and update written policies and procedures to ensure they all accurately reflect current arrangements at the practice, that they demonstrate that suitable staff recruitment checks have been conducted and ensure all staff have received up to date mandatory training and that records for this are kept within the practice. They further recommended that practice meetings should be formalised utilising agendas, and developing meeting minutes to aid communication throughout the teams.		
PCIC	Dental	HIW	Windsor Road Dental Care, Cardiff	HIW	Ruth Walker	QSE Committee	Director of Nursing, PCIC		29/10/2018		This will be managed directly with the primary care contractor by HIW. We will only see final response from the practice when it is published with the report. We will however ask for specific assurance on this particular inspection when PCIC report to QSE Committee in December 2018.		
	Radiology	HIW	Radiology	The Ionising Radiation (Medical Exposure) Regulations 2017	Ruth Walker	QSE Committee	Andrew Wood/Kathy Ikin	ad hoc	04/10/2017		3 non conformances	28/02/2018	1
	Medical Physics	HIW - MARS associated with IR(ME)R	Medical Physics	The Medicines (Administration of Radioactive Substances) Regulations 1978	Ruth Walker	QSE Committee	Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years		n/a	n/a	

HEALTH AND SAFETY EXECUTIVE

REGULATORY BODY REVIEW TRACKER - September 2019

	Radiology	HSE	Radiology	The Ionising Radiations Regulations 2017	Martin Driscoll	Health and Safety	Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years		last inspections pre 2004, no inspeciton data currently available		
	Medical Physics	HSE	Medical Physics	Control of Artificial Optical Radiation at Work Regulations 2010	Martin Driscoll	Health and Safety	Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years		last inspections pre 2004, no inspeciton data currently available		
	Medical Physics	HSE	Medical Physics	The Control of Electromagnetic Fields at Work Regulations 2016	Martin Driscoll	Health and Safety	Andrew Wood/Kathy Ikin	ad hoc	not inspected in the last 10 years		last inspections pre 2004, no inspeciton data currently available		

HUMAN TISSUE AUTHORITY

Specialist Services	N&T	HTA	South Wales Transplant and NORS programme	Human Tissue Act	Fiona Jenkins	QSE Committee	Rafael Chavez	Every 2 years	01/10/2019 - self assessment compliance update	01/10/2021	Number of areas of good practice noted from inspection in 2016/17. Self assessment compliance update provided in September 2019 which demonstrated evidence and compliance with the updated questions	n/a	1
CD&T	Haematology	HTA	South Wales BMT Programme	Human Tissue Act	Fiona Jenkins	QSE Committee	Xiujie Zhao	730	22-23/01/2019		1 minor	06/09/2019	1
CD&T	Haematology	HTA	Stem Cell processing Unit (HTA)	Human Tissue Act	Fiona Jenkins	QSE Committee	Alun Roderick/Sarah Phillips	730	22/01/2019		1 major 4 minors	06/09/2019	1
CD&T	Cellular Pathology	HTA	Mortuary (Cell Path - HTA)	Human Tissue Act	Fiona Jenkins	QSE Committee	Adam Christian/Scott Gable	730	22/11/2018		3 criticals, 14 majors, 9 minor	31/01/2019	1

JOINT EDUCATION ACCREDITATION COMMITTEE

Specialist Services	Haematology	JACIE	South Wales BMT Programme	6th edition of JACIE standards	Stuart Walker	QSE Committee	Keith Wilson	Every 4 years	4-5/02/2019	Feb-23	Minor deficiencies noted	01/10/2019	1

MHRA

Specialist Services	ALAS	MHRA	ALAS (CAV)	Managing Medical Devices 2015	Fiona Jenkins	QSE Committee	Paul Rogers	ad hoc					
CD&T	Lab Med	MHRA	Blood transfusion (BSQR)	Blood and Safety Quality Regulations	Fiona Jenkins	QSE Committee	Andrew Gorringe/Alun Roderick	365	13/12/2018		2 majors 1 other	28/02/2019	1
CD&T	Pharmacy	MHRA	Pharmacy SMPU	Good manufacturing practice (GMP) and good distribution practice (GDP)	Stuart Walker	QSE Committee	Darrel Baker	365	23/07/2019		3 majors 2 others	03/12/2019	2
CD&T	Pharmacy	MHRA	Pharmacy UHL	Good manufacturing practice (GMP) and good distribution practice (GDP)	Stuart Walker	QSE Committee	Darrel Baker	730	21/01/2015		2 majors 6 minors	30/06/2015	2
CD&T	Medical Physics	MHRA	radiopharmacy	Good manufacturing practice (GMP) and good distribution practice (GDP)	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	730	23/07/2019		5 majors, 2 others	tbc with regulator	1
	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	QSE Committee	Andrew Wood/Kathy Ikin	ad hoc	02/01/2011	no inspection notified	No inspection to date in this area	n/a	n/a
	Medical Physics	MHRA	Medical Physics	Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use 2015.	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	ad hoc	03/01/2011	no inspeciton notified	no inspection to date in this area	n/a	n/a
	Medical Physics	MHRA	Medical Physics	Managing Medical Devices 2015	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	ad hoc	05/01/2011	no inspeciton notified	no inspection to date in this area	n/a	n/a

NATURAL RESOURCES WALES

	Haematology	Natural Resources Wales	Medical Physics UHL	The Environmental Permitting (England and Wales) Regulations 2010 (EPR 2010)	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	annual	26/01/2018	01/11/2019	1 action, 1 reccomendation	28/02/2018	1

	Medical Physics UHW	Natural Resources Wales	Medical Physics UHW	The Environmental Permitting (England and Wales) Regulations 2010 (EPR 2010)	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	annual	30/04/2019		0	n/a	1
		Natural Resources Wales	Radiopharmarcy Laboratory	The Environmental Permitting (England and Wales) Regulations 2010 (EPR 2010)	Fiona Jenkins	QSE Committee	Matthew Talboys / Nicola O'Callaghan		24/09/2019		This is approved until 31/12/2019		
OFFICE FOR NUCLEAR REGULATION													
	Medical Physics	Office for Nuclear regulation	Medical Physics	The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009	Fiona Jenkins	QSE Committee	Andrew Wood/Kathy Ikin	biannual	17/03/2017		4 non conformances, 3 recommendaitons	01/05/2017	1
QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES													
Specialist Services	Immunology	QPIDS	Immunology	Quality in Primary Immunodeficiency Services Standards	Stuart Walker	QSE Committee	Stephen Jolles/Richard Cousins	365		01/10/2019			
		Quality in Primary Immunodeficiency Services (QPIDS)			Stuart Walker	QSE Committee			01/10/2019		Accreditation declined		
	RESEARCH AND DEVELOPMENT												
	Haematology	Research and Development			Stuart Walker	QSE Committee							
UKAS													
In	Biochemistry	UKAS	Medical Biochemistry & Immunology	ISO 15189:2012	Fiona Jenkins	QSE Committee	Alison Borwick		2/12/2019 - 6/12/2019		SU3: 21 Findings - Actions to submitted by 13 January 2020 ETS: 15 - Evidence to be submitted by 11 March 2020		
Specialist Services	ALAS	SGS/UKAS	ALAS (CAV)	ISO 9001:2015	Fiona Jenkins	QSE Committee	Paul Rogers	185 (Twice Yearly)		Jan-20	2 x Major Corrective Actiions, 1 X Minor Corrective Action, Several Opportunities for Improvement	06/09/2019	1
Surgical Services	Perioperative	SGS/UKAS	SSSU	ISO 13485:2016	Fiona Jenkins	QSE Committee	Clare Jacobs	annually	01/01/2019	Sep-19	3 minors	01/01/2020	1
Surgical Services	Perioperative	SGS/UKAS	HSDU	ISO 13485:2017	Fiona Jenkins	QSE Committee	Mark Campbell	annually	07/08/2019	Aug-20	2 minors	07/08/2020	1
Specialist Services	Haematology	SGS/UKAS		ISO 15189:2012	Fiona Jenkins	QSE Committee	Alun Roderick		06/11/2019		Accreditation extra visit: Action Mandatory x 2 Require Evidence to UKAS x 1 Action Recommended x 1	6.12.19	
Specialist Services	Medical Genetics	SGS/UKAS		ISO 15189:2012	Fiona Jenkins	QSE Committee	Peter Thompson		2 and 5/11/19		Action Mandatory x 14 Require Evidence to UKAS x 14 Action Recommended x 5	5.12.19	
CD&T	Haematology	UKAS	Haematology/Blood Transfusion (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Andrew Gorringe/Alun Roderick	365	02/05/2019		25 findings	05/05/2019	1
CD&T	Haematology	UKAS	Phlebotomy (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Andrew Gorringe/Alun Roderick	365	02/05/2019		included in Haematology findings above	05/05/2019	1
CD&T	Cellular Pathology	UKAS	Cellular Patholgy/ (Mortuary - UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Adam Christian/Scott Gable	365	27/02/2019		14 findings	27/03/2019	1
CD&T	Biochemistry	UKAS	Biochemistry (UKAS)	ISO 15189	Fiona Jenkins	QSE Committee	Carol Evans/Nigel Roberts	365	04/12/2019		25 findings	16/02/2020	1
CD&T	Biochemistry	UKAS	Specimen Reception (UKAS)	ISO 15189		QSE Committee	Carol Evans/Nigel Roberts	365	04/12/2019		2 findings and 1 reccomendation Included in findings of Biochemistry UKAS	16/02/2020	1
WELSH WATER													
		Welsh Water			Abigail Harris								
WSAC													

	Audiology	WSAC	audiology - adults	audiology quality standards	Fiona Jenkins	QSE Committee	Lorraine Lewis	3 yearly	01/06/2019	Jun-22	compliant with 8 of 9 standards and meeting 85% target	12/07/1905	1
	Audiology	WSAC	Newborn hearing screeing wales	audiology quality standards	Fiona Jenkins	QSE Committee	Jackie Harding	2 yearly	01/06/2018	Jun-20	80% target met in all standards and 85% overall target met	01/01/2019	1
	Audiology	WSAC	audiology - paediatrics	audiology quality standards	Fiona Jenkins	QSE Committee	Jackie Harding/Rhian Hughes	2 yearly	01/06/2018	Jun-20	80% target met in all standards and 85% overall target met	12/07/1905	1
WEST MIDLANDS QRS													
Specialist Services	Haematology	West Midlands QRS	Red Cell Service (Clinical Haematology)	Published by Thalassaemia and Sickle Cell Society (2018)	Medical Director	QSE Committee	Jonathan Kell (Lead) Clare Rowntree (Clinical Director)	3 years	01/10/2019	Oct-22	In need of investment from WHSSC and ini stafff	01/12/2019	1

Report Title:	Internal Audit Recommendation Tracker Report							
Meeting:	Audit Committee					Meeting Date:	3rd March 2020	
Status:	For Discussion		For Assurance	X	For Approval		For Information	
Lead Executive:	Director of Corporate Governance							
Report Author (Title):	**Director of Corporate Governance**							

Background and current situation:

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

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

The tracker goes back 2 financial years and shows progress made against recommendations from 17/18 and18/19. It also show recommendations which have been made during 19/20.

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

As can be seen from the attached summary tables the overall number of outstanding recommendations has reduced from 336 individual recommendations to 212 individual recommendation which is 37% completed actions since the previous meeting of the Audit Committee in December 2019. The actions for 2019/20 will increase until the end of the financial year and until all recommendations have been approved and signed off by the Audit Committee.

It should also be noted that the quality of the data within the tracker will improve from April onwards when there will be more resources in place to drive this area of work forward.

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

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

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

	Substantial Assurance	Reasonable Assurance	Limited Assurance	Total
Internal Audits 17/18	7	25	5	37
Internal Audits 18/19	10	26	7	43
Internal Audits 19/20	4	6	-	10

Attached at Appendix 1 are summary tables which provide an update on the December 2019 position.

As can be seen from the attached tables significant progress has been made in the amount of recommendations which have been completed since the last review.

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

Recommendation:

The Audit Committee Members are asked to:

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

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click [here](#) for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	~~Yes / No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*								

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

	Update March 2020				Update March 2020				Update March 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Complete												
Overdue under 3 months					1			1				
Overdue over 6 months under 12 months					5		1	4				
Overdue more than 12 months	9		2	7	25	3	4	18	13	1	2	10
Superseded	1		1									
Total	**10**		**3**	**7**	**31**	**3**	**5**	**23**	**13**	**1**	**2**	**10**

Total number of recommendations outstanding as on 21st March 2020 for financial year 2017/18 is **54** compared to the position in December which was a total number of outstanding recommendations of **127**

INTERNAL AUDIT REPORT RECOMMENDATION FOR 2018/19

	Update March 2020				Update March 2020				Update March 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached	12	1	1	10	24		4	20	6			6
Complete	1	1			5	5			5	1		4
Overdue under 3 months	7		4	3	12		2	10	10	1	1	8
Overdue by over 3 months under 6 months	5		2	3	13		2	11	2	1		1
Overdue over 6 months under 12 months	4			4	16	1	3	12	8		1	7
Overdue more than 12 months					1		1					
Superseded					2	2						
Total	**29**	**2**	**7**	**20**	**73**	**8**	**12**	**53**	**31**	**3**	**2**	**26**

Total number of recommendations outstanding as on 21st March 2020 for financial year 2018/19 is **133** compared to the position in December which was a total number of outstanding recommendations of **193**

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2019/20

	Update March 2020				Update March 2020				Update March 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached	1			1	1			1				
Complete					2	2						
Overdue under 3 months					2			2				
Overdue by over 3 months under 6 months	2		1	1	8			8	2			2
Overdue over 6 months under 12 months	2			2	3		3		2			2
Overdue more than 12 months												
Superseded												
Total	**5**		**1**	**4**	**16**	**2**	**3**	**11**	**4**			**4**

Total number of recommendations outstanding as on 21st March 2020 for financial year 2019/20 is **25** compared to the position in December which was a total number of outstanding recommendations of **16**

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	No. of Recs Made	Rec No.	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date	Recommendation Status [RAG Rating]
IA 1718	01/04/2018	Progress against findings from the Human Tissue Authority (HTA) Inspection of UHW	Chief Operating Officer	Substantial	1	R1/1	L	Management must ensure that the terms of reference of the HTA Licence Compliance Group are formally agreed and that the Group effectively operates as planned.	The Human Tissue Authority compliance group is currently running in parallel to HTA Gold command. The terms of reference for the HTA compliance group have been positively reviewed by the HTA and added to the agenda of the next HTA compliance group (22nd May 2018) for ratification and acceptance ready for eamless transition between the two governance groups.	Chief Operating Officer	22/05/2018	Overdue more than 12-months
IA 1718	01/04/2018	Action plan on Deloitte Financial Governance Review	Director of Finance	Substantial	2	R1/2	M	The Health Board should ensure that the Action Plan details realistic timescales for implementing the agreed actions.	A further progress report will be taken to the April meeting of the Finance Committee and any actions not implemented by then will be reassessed and revisions made to the timescale for implementation.	Director of Finance	01/05/2018	Overdue more than 12-months
IA 1718	01/04/2018	Action plan on Deloitte Financial Governance Review	Director of Finance	Substantial		R2/2	L	The Health Board should ensure that the reported status recorded on the action plan accurately reflects the actual progress made towards implementing the agreed actions.	The Terms of Reference of the Finance Committee will be amended to reflect agreed changes.	Director of Finance	01/05/2018	Overdue more than 12-months
IA 1718	01/09/2017	Statutory Compliance	Director of Planning	Substantial	1	R1/1	M	Processes will be implemented to reduce the exposure to human/transposition errors in monitoring and reporting outputs.	Agreed. As outlined, a software solution is presently being piloted through August and will be reviewed for adequacy in September 2017.	Director of Planning	01/09/2017	Overdue more than 12-months
IA 1718	01/02/2018	WLI Payments Follow-Up	Chief Operating Officer	Reasonable	2	R1/2	M	The UHB has produced a WLI Payments Policy /Procedure and this has been disseminated to Directorates, but has yet to be finalised and approved by the organisation. Additionally, there are no local Directorate procedures in place for the management of WLI payments as they will work to the UHB Payments Policy/Procedure (Finding 1 – Partially Actioned).	Not Provided	Chief Operating Officer	01/06/2018	Overdue more than 12-months
IA 1718	01/02/2018	WLI Payments Follow-Up	Chief Operating Officer	Reasonable		R2/2	M	Testing identified that whilst Cardiac Surgery make the appropriate checks and accurately record and approve submitted claims, they do not retain copies of the fully authorised WLI Claim Forms as they are sent directly to Payroll. Therefore, at the present time a full audit trail does not currently exist and it is ecommended that upon authorisation by the Clinical Board Director of Operations a copy should be taken and provided to Cardiac Surgery management for retention (Finding 10 – Partially Actioned).	Not Provided	Chief Operating Officer		Overdue more than 12-months
IA 1718	01/02/2018	Residences	Director of Planning	Reasonable		R6/10	L	The UHB should document future plans for the provision and utilisation of residences.	The UHB is currently embarking on a significant master planning exercise for the UHB site and an estate rationalisation programme across the UHB. The provision of accommodation will be considered as part of this exercise. This process will likely take in excess of 12 to 18 months. Progress will be reported as part of the verall master planning exercise.	Director of Planning		Overdue more than 12-months
IA 1718	01/02/2018	Residences	Director of Planning	Reasonable		R10/10	L	The UHB should refer to the PFI contract/SLA to consider whether expectant vacant rooms must be communicated by Charter Housing to the Health Board within a certain timescale if void rents are to become chargeable.	Currently being reviewed by PFI Manager.	Director of Planning	01/04/2018	Overdue more than 12-months
IA 1718	01/02/2018	Surgery Clinical Board - Anaesthetist Rota Management	Chief Operating Officer	Reasonable	1	R1/1	H	Standard Operating Procedure notes covering the administration of the CLW rota system should be developed and made available to all relevant staff.	It is accepted by the Directorate that there is no written SOP for staff, although all three rota masters currently in post have been formally and comprehensively trained by the CLWRota team to carry out processes within the system. The CLWRota team provide remote and on-site support as requested/required. The rota masters are overseen by the Clinical Director and Deputy Clinical Directors who are also rota masters. There is a workflow chart for writing a weekly rota currently in	Chief Operating Officer		Overdue more than 12-months
IA 1718	01/03/2018	Pilot Model Ward Review	Director of Planning	Reasonable		R2/5	L	For future projects the plans for financial costing should be more detailed within the project outline.	As this was a clear pilot and proof of concept. Costings were genuinely not known. We had agreed "success" criteria, which, we met for patients eating and drinking more. (Being hydrated and had improved nutritional status) This was always the main aim. The third one was improvement in patient flow. This could not be quantified over a period of 6 weeks (which was discussed). Only after the pilot, could we see what happened during this period and start to look at costs for further development and detailed costing for the elements the teams felt worthwhile keeping as part of the model. We changed and tweaked aspects of the model each week to ensure we made efficient use of resource whilst maximising patient experience and matched our success criteria. Only after a review following completion could we accurately sit down and look at lessons learnt and see what	Director of Planning		Overdue more than 12-months
IA 1718	01/03/2018	Pilot Model Ward Review	Director of Planning	Reasonable		R3/5	L	For future projects a defined terms of reference that identifies membership, frequency of meetings, roles and responsibilities will be incorporated from the outset.	Agreed for applicable future projects.	Director of Planning		Overdue more than 12-months

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	No. of Recs Made	Rec No.	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date	Recommendation Status [RAG Rating]
IA 1718	01/04/2018	Wellbeing of Future Generatior	Director of Public Health	Reasonable	5	R1/5	M	The Health Board/ Management should produce an Action Plan to provide a cohesive approach on how it plans to embed the obligations of the Act within the Health Board. The Action Plan should detail/include columns for: The Key priorities required to embed the WFGA obligations within the Health Board; The Actions required to achieve the key priority; The responsibility for each of the actions; The target date for implementation; and The status of implementing the action. The WFG Steering Group would be the appropriate forum for monitoring any progress against the Action Plan.	The Steering Group agreed the need to develop an Action Plan at its meeting on 12 March 2018. A task and finish group is being established to develop a first draft to discuss with the wider group at the next meeting of the Steering Group on 4 June 2018.	Director of Public Health	04/06/2018	Overdue more than 12-months
IA 1718	01/04/2018	Wellbeing of Future Generatior	Director of Public Health	Reasonable		R2/5	M	The Terms of Reference for the WFG Steering Group should be formalised and appropriately approved.	Draft Terms of Reference were discussed at the meeting of the Steering Groupon 12 March 2018 and amendments agreed. Final draft ToR to be submitted to HSMB for sign-off.	Director of Public Health	01/05/2018	Overdue more than 12-months
IA 1718	01/04/2018	Wellbeing of Future Generatior	Director of Public Health	Reasonable		R3/5	M	The Health Board should formalise and approve the role and responsibility of the 'WFG Champion'.	A draft WFG Champion role was discussed at the Steering Group on 12 March. Final role description to be agreed between the Chair of the Steering Group, Vice Chair, Chair and Board's Director of Governance.	Director of Public Health	01/04/2018	Overdue more than 12-months
IA 1718	01/04/2018	Wellbeing of Future Generatior	Director of Public Health	Reasonable		R4/5	M	The Health Board must ensure that its obligations in respect of the Act are appropriately communicated to all staff within the Health Board. We recommend that the	The Chair of the Steering Group met with UHB Director Communications and the UHB Engagement Lead in March to discuss the approach to raising awareness within the UHB. Draft Communications Plan to be brought to the next Steering Group on 4 June.	Director of Public Health	01/06/2018	Overdue more than 12-months
IA 1718	01/04/2018	Wellbeing of Future Generations Act	Director of Public Health	Reasonable		R5/5	M	The Health Board should update their WFG internet page to ensure that it provides clear and cohesive information on the Health Board's responsibility in respect of the WFGA including how the Health Board's wellbeing	UHB WFG Internet page to be updated to reflect the recommendations.	Director of Public Health	30/04/2018	Overdue more than 12-months
IA 1718	01/09/2017	Children & Women Clinical Board – Medical Staff Rotas and Study	Chief Operating Officer	Reasonable	7	R1/7	H	The Clinical Board will monitor the number of study days taken by medical staff in order to ensure that there is an improvement in the percentage uptake. Controls will also be established to prevent individuals exceeding their allowances.	Directorate Management Teams will be reminded to monitor the requests and approval of study leave for all medical staff. This will be reviewed as part of the monthly Directorate Performance Reviews and will provide an opportunity for Clinical Board involvement as necessary.	Chief Operating Officer	01/10/2018	Overdue more than 12-months
IA 1718	01/09/2017	Children & Women Clinical Board – Medical Staff Rotas and Study	Chief Operating Officer	Reasonable		R2/7	M	The profile and accountabilities in relation to study leave requirements needs to be reinforced.	Updated study leave procedures will be circulated to DMT and onwards to all medical staff in the Clinical Board. All staff will be reminded of their responsibilities in relation to this policy.	Chief Operating Officer	01/11/2017	Overdue more than 12-months
IA 1718	01/09/2017	Children & Women Clinical Board – Medical Staff Rotas and Study	Chief Operating Officer	Reasonable		R3/7	M	Staff will be reminded of their responsibilities when requesting and approving study leave.	Updated study leave procedures will be circulated to DMT and onwards to all medical staff in the Clinical Board. All staff will be reminded of their responsibilities in relation to this policy.	Chief Operating Officer	01/11/2017	Overdue more than 12-months
IA 1718	01/09/2017	Children & Women Clinical Board – Medical Staff Rotas and Study	Chief Operating Officer	Reasonable		R4/7	L	Proactive monitoring will be undertaken to ensure all appropriate staff are utilising the Intrepid system.	Assurance to be provided through Directorate Performance Reviews from each DMT that Intrepid is being used appropriately throughout each Directorate	Chief Operating Officer	01/11/2017	Overdue more than 12-months
IA 1718	01/09/2017	Children & Women Clinical Board – Medical Staff Rotas and Study	Chief Operating Officer	Reasonable		R5/7	M	Staff will be reminded of the procedural requirements and updates to standard forms will be undertaken, where appropriate.	A review of the format of the claims forms used within C&W Clinical Board will be undertaken and changes made as required. All staff within the Clinical Board and Directorates will be reminded of the need to comply with procedures.Directorates have already been asked to remind all consultants to comply with timescales and a reminder will also be sent to junior staff reiterating the need to comply with timescales.	Chief Operating Officer	01/11/2017	Overdue more than 12-months
IA 1718	01/09/2017	Children & Women Clinical Board – Medical Staff Rotas and Study	Chief Operating Officer	Reasonable		R6/7	M	Guidance should be produced and made available throughout the Clinical Boardand this should reflect minimum personnel per shift and skill mix requirements.	The current document will be reviewed and consideration given to broadening its scope to include all specialties within the Clinical Board. This will cover the skill mix and number of personnel required per shift.	Chief Operating Officer	01/11/2017	Overdue more than 12-months
IA 1718	01/09/2017	Children & Women Clinical Board – Medical Staff Rotas and Study	Chief Operating Officer	Reasonable		R7/7	M	Management should remind staff around the requirements of the working time policy.	The current requirements of the working time policy will be shared with all DMT and compliance will be managed through Directorate Performance Reviews.	Chief Operating Officer	01/11/2017	Overdue more than 12-months

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	No. of Recs Made	Rec No.	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date	Recommendation Status [RAG Rating]
IA 1718	01/11/2017	Serious Incidents Management	Executive Nurse Director	Reasonable	5	R1/5	H	Management must ensure that closure forms are submitted to WG within the required timescales.	NHS Wales Audit & Assurance Services Page 11 of 17 Management Response Responsible Officer/ Deadline Welsh Government have set an All Wales target of 90% compliance in closing all Serious Incidents within the prescribed timescales. The UHB had made significant progress in reducing its backlog over the last 12 months from a position where we were reporting 230 serious incidents open in October 2016 to a position where we now have 74 open. The UHB has an agreed trajectory for improvement and each Clinical Board has agreed targets for serious incident closures which is	Director or Nursing	01/12/2017	Overdue more than 12-months
IA 1718	01/11/2017	Serious Incidents Management	Executive Nurse Director	Reasonable		R4/5	M	The Patient Safety team should communicate the importance of uploading the action plans onto Datix so that they are easily accessible. All action plans should have an identified lead and signed approval.	Action plans will have been developed and signed off as part of the investigation process and these will be held within the Clinical Boards. However we agree that the complete audit trail needs to be maintained within the Datix system. Action: The Clinical Boards will be reminded of the importance of uploading associated action plans for all Sis Action: The Patient Safety team will put in place a programme of quarterly audits to ensure that all Sis that have been closed in the previous quarter have the associated action plan uploaded on Datix. Results of the audit will be shared with Clinical Boards for discussion at QSE meetings Action: The team will consider, in the medium term, whether the action planning field becomes mandatory on Datix.	Director of Nursing	31/01/2018	Overdue more than 12-months
IA 1718	01/11/2017	Serious Incidents Management	Executive Nurse Director	Reasonable		R5/5	L	Management should ensure that SIs are reported to WG within the required 24 hours wherever possible.	Whenever possible the Patient Safety team will attempt to report within 24 hours. The Datix system has been set up to trigger an email to the Patient Safety team if anything reported is graded at severity of 4 or 5 or is flagged as a potential SI. There are many easons why this is often not possible: Delay in reporting from the clinical area	Director of Nursing		Overdue more than 12-months
IA 1718	01/11/2017	Serious Incidents Management	Executive Nurse Director	Reasonable			L	The Patient Safety Team should encourage management to use the feedback field within Datix to ensure an audit trail is available to show feedback has been provided. The Patient Safety Team may want to consider changing this to a mandatory field.	It is well recognised that the success of a reporting system depends on the level of feedback given to staff who report incidents so this is an important area for attention. The Patient Safety team have audited 20,267 reported patient safety incidents over a 12 month period; of those 17,614 indicated that staff had received feedback (86%) which we consider to be very high compliance. The Patient Safety team will consider whether to make the relevant field mandatory or not and this will be added to the Datix workplan The Patient Safety team will consider whether to carry out a random survey of staff who have reported incidents to validate they have had the feedback as indicated.	Director of Nursing	31/03/2018	Overdue more than 12-months
IA 1718	01/10/2017	Research & Development	Executive Medical Director	Reasonable		R3/6	M	Management will ensure data protection checks are undertaken by appropriate individuals. This will be increasingly important as the new general data protection regulations come into force (May 2018).	A guidance document written by the R&D Office on how the data protection checks will be undertaken, has been approved by the Data Protection Manager (DPM) and is an agenda item for the October Research Governance Group. The data protection checks will be undertaken by R&D Office staff (Band 6 and Band 7 grade) in accordance with the guidance document. Any concerns or issues with studies will always be escalated to the DPM for review. The DPM will check a random selection of 10% of projects on a monthly basis to ensure thedata protection checks are being carried out appropriately by R&D Office staff. If the DPM has any concerns, re-training will take place, and the percentage of projects selected on a monthly basis will be increased. In the medium	Medical Director	31/11/2017	Overdue more than 12-months
IA 1718	01/10/2017	Research & Development	Executive Medical Director	Reasonable		R5/6	M	Management will ensure that all clinical boards have appropriate leads for R&D.	The Medical Director has written to the Children and Womens Clinical Board Director to remind them of their obligation to appoint a Clinical Board R&D Lead with the expectation that this position will be appointed to by December 2017. The Job Descriptions for both Directorate and Clinical Board R&D Leads have been updated and are an Agenda item at October Research	Medical Director	31/12/2017	Overdue more than 12-months
IA 1718	01/09/2017	Mental Health Sickness Management and Rostering	Chief Operating Officer	Reasonable	5	R1/5	H	Management should ensure that all sickness episodes are managed and documentation is completed in accordance with the Sickness Policy.	The MHCB has seen significant changes to the inpatient ward management structures within recent months, with several internal secondments into managerial positions. In order to equip the new managers the Practice Development Team have devised a leadership and Management Skills training programme for the existing and new managers. This programme covers good practice with regards to staff management. In addition the Operational HR team conduct sickness surgeries with	Chief Operating Officer	01/06/2018	Overdue more than 12-months
IA 1718	01/09/2017	Mental Health Sickness Management and Rostering	Chief Operating Officer	Reasonable		R2/5	H	Ward Managers should ensure that recommended breaks are factored in when drawing up staff rotas and times of shifts.	The MHCB have been working alongside staff side colleagues to agree a process and timeframe to enforce changes to shift patterns to facilitate compliance with the EWTD, factoring in an unpaid break. The process was agreed in early September. All staff will eceive notification during September 2017, with revised rotas commencing w.c 31/12/2017. MHSOP Directorate will be	Chief Operating Officer	01/10/2017	Overdue more than 12-months
IA 1718	01/09/2017	Mental Health Sickness Management and Rostering	Chief Operating Officer	Reasonable		R4/5	M	Nursing staff should be reminded that all bank and agency time sheets should be retained on file. Management to issue reminder to all Nursing staff that all bank and agency shifts worked must be verified.	It was evidenced from our testing that there were a number of inconsistencies across all 4 wards with the recording of start and end sickness dates. There were different start and end sickness dates recorded on sickness documentation, ESR and Rosterpro. The majority of differences were only 1 or 2 days which suggests that there is an issue with correctly and consistently recording the dates that sickness ends and the actual dates of return to work.	Chief Operating Officer	01/09/2017	Overdue more than 12-months
IA 1718	01/09/2017	Mental Health Sickness Management and Rostering	Chief Operating Officer	Reasonable		R5/5	L	NHS Wales Audit & Assurance Services Page 16 of 17 Recommendation Priority level Management should remind ward staff that the recording of sickness dates	This issue will be monitored via the sickness surgeries.	Chief Operating Officer	01/06/2018	Overdue more than 12-months
IA 1718	01/11/2017	Nurse Revalidation	Executive Nurse Director	Reasonable		R2/3	M	The C&V UHB PADR form should be revised for Nursing Staff to include an appendix to ensure Nurse revalidation portfolio completion is discussed at each annual appraisal during the 3 year cycle.	The Senior Nurse for Nurse Education will work with the lead for PADR to create a section for revalidation for nurses within the pay progression document. Pay progression training continues, to assist nurses in the completion of documentation (through enhanced communication and coaching workshops).	Director of Nursing	01/03/2018	Overdue more than 12-months
IA 1718	01/11/2017	Nurse Revalidation	Executive Nurse Director	Reasonable		R3/3	L	Where nurses are using their line manager as their confirmer, the confirmers should be reminded of ESRs capability to make them aware that staff members in their hierarchy are approaching their nurse revalidation date.	An email via the Directors of Nursing will be issued to remind staff of ESR capability re revalidation/registration.	Director of Nursing	01/01/2018	Overdue more than 12-months
IA 1718	01/04/2018	University Hospital of Wales Neo Natal Development	Director of Planning	Reasonable	7	R1/7	H	The design for the MRI new build will be concluded and frozen as soon as possible, including affirmation of structural issues and design elements for the MRI installation, so that the total costs and affordability of the project can be confirmed.	The design solution has been informed, as far as is practicable, by considering the specification information provided by potential MRI suppliers.	Director of Planning	31/05/2018	Overdue more than 12-months

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IA 1718	01/04/2018	University Hospital of Wales Ne	Director of Planning	Reasonable		R6/7	L	The Capital Procedures Manual should be revised to include the requirement for a Project Director's Acceptance Certificate signed by the Chief Executive and Project Director.	Agreed	Director of Planning	31/05/2018	Overdue more than 12-months
IA 1718	01/04/2018	University Hospital of Wales Ne	Director of Planning	Reasonable		R7/7	M	Requests for 'Single Tender Action' should be approved and reported to the Audit Committee in accordance with Standing Financial Instructions and the current UHB Scheme of Delegation. The Estates Department's Capital Projects Manual pro forma, Single Tender Action Request	Agreed	Director of Planning	31/05/2018	Overdue more than 12-months
IA 1718	01/05/2018	Business Continuity Planning Fo	Director of Planning	Reasonable	1	R1/1	H	The significant, high priority, issue that remains from the original review can be summarised as follows: The EPRR team have begun to accumulate BCPs from across the Health Board, but at the time of fieldwork these	Not Provided	Director of Planning		Overdue more than 12-months
IA 1718	01/05/2018	Mortality Reviews	Executive Medical Director	Reasonable		R2/3	M	The Health Board must ensure that level 1 mortality reviews are completed for all inpatient deaths.	A review of the current paper trail will be undertaken and improved as necessary. Clinical Boards will be reminded of the need to complete the level one reviews at the time of death certification as acquiring the notes afterwards is often difficult due to the current process of managing case notes of deceased patients in medical records. A meeting will take place with the CD for Internal Medicine to review their processes as they have the most deaths in the UHB. The Medical Director will note the findings of the Internal Audit in the June HSMB Meeting to ensure the Clinical Boards are reminded of their responsibility to complete level one reviews.	Medical Director	01/06/2018	Overdue more than 12-months
IA 1718	01/05/2018	Mortality Reviews	Executive Medical Director	Reasonable		R3/3	M	The Universal Mortality Review form question pertaining to the need to trigger a Level 2 review should be revised and re-written to improve clarity and remove ambiguity as to its application.	The wording on the form and subsequent IT development was so that any 'yes' answer would trigger a level 2 review. The double negative was a calculated risk. Given this feedback we will review and revise it.	Medical Director	01/07/2018	Overdue more than 6-months
IA 1718	01/06/2018	RTT Performance Reporting	Director of Transformation and Informatics	Reasonable	4	R1/4	M	The Health Board should ensure there is a formalised policy that encompasses the operational procedures for data collection, monitoring and reporting of RTT.	We accept that there is a need to review the appropriateness of our RTT policy, ensuring it is live and covers our developing processes for managing patients as well as any rule and definitional changes. At the present time WG are reviewing RTT measures and we have received requirements from WG that have material impact and conflict with existing guidance, primarily around ophthalmology measures, but there are also changes to diagnostics, sleep, cancer and cardiac. Whilst we will review and approve a local policy, the use of our limited resources will be directed	Director of Transformation & Informatics	01/09/2018	Overdue by over 6 months under 12 months
IA 1718	01/06/2018	RTT Performance Reporting	Director of Transformation and Informatics	Reasonable		R2/4	M	The Health Board should consider validating data of patients that are 'in target' due to the potential that these patients may have incorrectly applied suspensions and thus overall understating the amount of breaches.	We accept the point made in the context that data quality audits should extend to reported cancer waiting times – periodic audit of RTT pathways does already occur. Validation of all cancer pathways open and closed does occur at the weekly tracking meetings, and teams are reminded of the requirement to ensure that all management actions are accurately captured on the PMS system. A periodic audit, which will not be monthly, of data quality for cancer patients will be put in place as part of the new member of the cancer services team.	Director of Transformation & Informatics	01/11/2018	Overdue by over 6 months under 12 months
IA 1718	01/06/2018	RTT Performance Reporting	Director of Transformation and Informatics	Reasonable		R3/4	M	The Performance Report should include a note next to the SCP compliance figures to ensure the Board understands that these figures are not necessarily accurate and are not a true reflection of performance as data collection systems are currently not fit for purpose and data sets have not been defined.	Accepted	Director of Transformation & Informatics	01/05/2018	Overdue more than 12-months
IA 1718	01/06/2018	RTT Performance Reporting	Director of Transformation and Informatics	Reasonable		R4/4	L	The Performance Report should include data on the related Cancer patient volumes in addition to percentage compliance as this will be a useful metric to aid the Board's understanding of scope (eg. Total number of USC/Non-USC and corresponding number of patients 'in	The reporting of volumes occurs infrequently. There is a balance to be had in the detail presented within the board report. The board have asked that they receive less granular information on the operational performance of the board and more detail on the strategic and tactical performance of the board. As such we will partially accept the recommendation and provide an infrequent update on volumes, unless of course it is a material factor in explaining performance.	Director of Transformation & Informatics		Overdue more than 12-months
IA 1718	01/08/2018	Costing Review	Director of Finance	Reasonable	6	R1/6	H	Management will look to increase the level of clinical engagement throughout the costing process.	The PCB platform provides the UHB with an effective dashboard for analysing costing data at a component level. Whilst the UHB can make greater use of the PCB tool, its utilisation is complex, requiring statistical, financial and service knowledge and the associated resource to support this level of analysis. Data and analysis outputs are used by the organisation to inform the transformation and CRP opportunities agenda and our IMTP. Evidence of this is available. The new osting system and efficiency framework provides the opportunity to re-engage with interested clinicians and efforts are ongoing to achieve this this through evised performance management processes. Finance delivery unit dashboard	Director of Finance Bob Chadwick, Director of Finance, will lead dissemination of Costing info including highlighting areas for potential improvement. This should lead to greater Clinical Engagement	01/04/2018	Overdue more than 12-months
IA 1718	01/08/2018	Costing Review	Director of Finance	Reasonable		R2/6	M	The concerns highlighted will be further investigated to ensure appropriate remedial action is taken and that there is increased accuracy to the costs that are allocated to individual HRGs.	Agreed. Costing is an exercise of mass data linkage reliant on basic administrative functions being undertaken to avoid numerous, single points of failure in record keeping systems. The prosthetic example relies on a single person in theatres keeping timely, accurate records and making them available. The accuracy of osting at an HRG level is dependent on multiple variables :- Good quality data coding at source Good quality data sources for cost inputsRobust allocation of cost to activity within the costing environment The costing team will continue to work with information and service colleagues to improve the quality and regularity of coding and other cost input data.	Director of Finance Bob Chadwick, Director of Finance & Sharon Hopkins, Director of Transformation & Informatics	01/12/2018	Overdue by over 6 months under 12 months

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IA 1718	01/08/2018	Costing Review	Director of Finance	Reasonable		R4/6	M	Management will ensure the future accuracy of costing return.	We agree that the statement was misleading as submitted, indicating that aspecific internal audit review had been carried out. We will ensure that future statements within submissions are more accurate. There is a comprehensive suite of validation checks performed by the Costing Team to test the validity of the costing returns before submission and this will be clarified in future	Director of Finance	01/12/2018	Overdue more than 12-months
IA 1718	01/08/2018	Costing Review	Director of Finance	Reasonable		R5/6	M	Wider verification should be sought to ensure accuracy and increase engagement.	Agreed.There is an ongoing engagement with Clinical Boards to better understand costing methodologies which are relevant to Clinical Board service areas. We recognise that more value could be added with formal engagement throughout the year. Submission timescales and available resources mean that engagement immediately prior to	Director of Finance	01/12/2018	Overdue more than 6-months
IA 1718	01/08/2018	Costing Review	Director of Finance	Reasonable		R6/6	M	Mechanisms will be established to monitor and report more widely on costing data.	This point is noted and it is accepted that the relationship between the UHB IMTP and its Transformational Programme, including use of costing and benchmarking, should be better described. Costing information was used to support benchmarking and dentification of opportunities, which have been incorporated in to the plan.	Director of Finance	01/03/2019	Overdue by under 3 months
IA 1718	01/11/2017	Internal Medicine Directorate Mandatory Training and PADRs	Chief Operating Officer	Limited	6	R1/6	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	The Directorate has developed a Project Outline Document to support ward areas to complete PADR. This POD included timelines. The directorate has provided a trajectory of expected completion of PADRs. The directorate will share best practice to ensure learning. Bi-weekly	Chief Operating Officer	01/03/2018	Superseded
IA 1718		Neurosciences - Patient Care IT System		Limited								Superseded
IA 1718	01/05/2017	Continuing Health Care (CHC)	Chief Operating Officer	Limited		R2/8	H	A timescale should be set to ensure the Head of Service Agreement is agreed promptly.	The Heads of Service agreement is being reviewed following the Operation Jasmin work (Flynn Report). The review is being led by the joint Cardiff and Vale Local Authorities, timescales are currently unclear, the PCIC Director of Nursing will write to the LA leads and ask for an agreed timescale for conclusion of the work.	Chief Operating Officer		Overdue more than 12-months
IA 1718	01/05/2017	Continuing Health Care (CHC)	Chief Operating Officer	Limited		R4/8	M	The Children CHC team should develop a local procedure that sets out how they adopt the WG guidance.	The Community Child Health Directorate will develop a local Operational Policy based on WG CC Guidance for Children. The policy will include: ▯ The CVUHB Appeals Process as WG Children's Guidance is not specific; and ▯ Recommendation of key performance indicators for children's CHC.	Chief Operating Officer	01/10/2017	Overdue more than 12-months
IA 1718	01/05/2017	Continuing Health Care (CHC)	Chief Operating Officer	Limited		R5/8	M	Individual Service User Agreements should be produced to cover health aspectsof child residential placements and KPIs developed/expanded to monitor performance internally.	The Community Child Health Directorate will agree a process for KPI's to be measured and reported on in line with other Directorate Performance Management.	Chief Operating Officer	01/10/2017	Overdue more than 12-months
IA 1819	10/09/2017	Charitable Funds	Director of Finance	Substantial	2	R1/2	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	01/12/2018	Overdue by over 6 months under 12 months
IA 1819	10/09/2017	Charitable Funds	Director of Finance	Substantial		R2/2	M	Dormant Fund balances should be periodically reported to the Charitable Funds Committee.	Agreed	Director of Finance	01/12/2018	Overdue by over 6 months under 12 months
IA 1819	03/10/2018	Specialist Services Follow up - Patientcare IT System	Chief Operating Officer	Substantial	1	R1/1	M	A process should be established to periodically test the backups.	Discussions are underway with IM&T and a test of the backup is due to be scheduled and undertaken following these.	Chief Operating Officer	01/11/2018	Overdue by over 6 months under 12 months
IA 1819	21/11/2018	Cost Improvement Programme	Director of Finance	Substantial	3	R1/3	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	01/04/2019	Overdue by under 3 months
IA 1819	12/02/2019	Performance Reporting Data Q	Director of Public Health	Substantial	3	R1/3	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		Overdue by under 3 months

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IA 1819	12/02/2019	Performance Reporting Data Q	Director of Public Health	Substantial		R2/3	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		Overdue by under 3 months
IA 1819	12/02/2019	Performance Reporting Data Q	Director of Public Health	Substantial		R3/3	L	Consideration should be given to re-formatting the Performance Report to improve usability.	Accept	Director or Transformation and Informatics		Overdue by under 3 months
IA 1819	14/04/2019	Delayed Transfers of Care Reporting	Chief Operating Officer	Substantial	2	R1/2	L	The Medically Fit spreadsheet used to identify DToCs weekly is updated using the comments column. However, it is not always clear from this what date certain process started, eg, funding authorised, housing confirmation, package of care agreement. It therefore makes it difficult to decipher whether a DToC is apparent.	The date of referral and compliance with time scales is checked verbally within the weekly scrutiny meetings and is often times included in the clinical workstation entries. The spread sheet will be altered to include the agreed timescales and any divergence clearly noted	Chief Operating Officer	01/04/2019	Overdue by under 3 months
IA 1819	14/04/2019	Delayed Transfers of Care Reporting	Chief Operating Officer	Substantial		R2/2	L	Due to the patient impact of delayed discharge, it would be beneficial to include DToC in the information presented to the Clinical Board's Quality, Safety and Patient Experience Groups.	Clinical Boards will be provided with the monthly DToC report Clinical Board Directors of Operations will be reminded of the necessity to include in Quality and Governance agenda	Chief Operating Officer	01/04/2019	Overdue by under 3 months
IA 1819	15/05/2019	Strategic Planning/IMTP	Director of Planning	Substantial	1	R1/1	M	Management should ensure that the plans for Clinical Boards are produced on a timely basis to enable the Clinical Boards to report on their projects in a consistent manner and allow them to monitor them appropriately.	A revised monitoring process for reporting clinical board progress on IMTPs will be in place for 2019/20. This will utilise the Shaping Our Future Wellbeing- Annual Plan (X-Matrix) methodology to provide clarity on performance and accountability arrangements. Progress against key IMTP priorities as captured in the annual plan document will be reported to Management Executives on a monthly basis as agreed at Management Executives on 09/05/19.	Director of Planning	01/07/2019	Agreed date not reached
IA 1819	30/08/2018	Dental CB – Theatre Sessions	Chief Operating Officer	Reasonable	3	R1/2	H	The Dental administration staff should ensure that Patient Dental files contain copies of all necessary documentation relating to the procedures undertaken.	Urgent meeting to be arranged with Clinical Lead and Peri-Operative Care Manager to define a process to manage documentation	Chief Operating Officer	01/09/2018	Overdue by over 6 months under 12 months
IA 1819	30/08/2018	Dental CB – Theatre Sessions	Chief Operating Officer	Reasonable		R2/3	M	The majority of patients cancelled by Dental staff are due to oversubscribed and overrun lists. Therefore, list management should be monitored and improvements made where necessary.	Reviewed PasPlus regarding start and finish times. Clinical Lead to speak with Maxillofacial Consultants	Chief Operating Officer	01/09/2018	Overdue by over 6 months under 12 months
IA 1819	30/08/2018	Dental CB – Theatre Sessions	Chief Operating Officer	Reasonable		R3/3	M	Dental management should ensure that cancelled operations are re-bookedwithin the required timescales.	Where possible this is always the case but many lists are held only on a monthly basis. Dental are limited in the number of lists that are dedicated to Dental Patients and therefore if a cancer patient requires theatre we have to utilise a dedicated list and cancelled patients will be re-listed at the next scheduled list.	Chief Operating Officer	01/09/2018	Overdue by over 6 months under 12 months
IA 1819	30/08/2018	Dental CB – Dental Nurse Provision	Chief Operating Officer	Reasonable	6	R1/6	M	The Dental Nurse Management team should consider formalising ratios of Dental Nurse staff per operators /patients/procedures. This should include reevaluation of any ratios that are currently in place in agreement with the University. When these ratios have been produced they should ensure that weekly numbers allocations are adhering to these staffing levels.	To reduce duplication of lists, a meeting will be set up with Senior Dental Nurse's and colleagues working in medical records to review the current clinical staffing allocated to each department on PMS.Once complete work will begin on allocating core numbers of DN to each department.	Chief Operating Officer	01/10/2018	Overdue by over 6 months under 12 months
IA 1819	30/08/2018	Dental CB – Dental Nurse Provision	Chief Operating Officer	Reasonable		R2/6	M	The Dental Nurse Management team should consider bringing forward the numbers allocation to mid-week. Consideration should be given to producing fortnightly numbers with weekly review once patient lists stabilise closer to the scheduled date.	To reduce duplication of lists, a meeting will be set up with Senior Dental Nurse's and colleagues working in medical records to review the current clinical staffing allocated to each department on PMS. Once complete work will begin on allocating core numbers of DN to each department.	Chief Operating Officer	01/10/2018	Overdue by over 6 months under 12 months
IA 1819	30/08/2018	Dental CB – Dental Nurse Provision	Chief Operating Officer	Reasonable		R4/6	L	It is recommended that the Senior Dental Nurses maintain a log that documents changes to schedules or nursing allocations as they occur and discuss these at the Senior Dental Nurse meeting to establish patterns or identify root causes. These can also be escalated to the weekly meetings with Medical records, ie. Clinical Staffing and Performance Group.	Implement feedback tool; that will be used to collect weekly changes that take place on each department. This information will form part of the weekly SDN staff discussion meeting	Chief Operating Officer	01/10/2018	Overdue by over 6 months under 12 months
IA 1819	30/08/2018	Dental CB – Dental Nurse Provision	Chief Operating Officer	Reasonable		R5/6	L	The Senior Dental Nurse weekly meeting should continue to function in order to force justification of requested allocation by each clinic.	The weekly Senior Dental Nurse meeting will continue to function, chaired by the Dental Nurse manager /Deputy Dental Nurse Manager A records of attendance will also be kept.	Chief Operating Officer	01/09/2018	Overdue by over 6 months under 12 months

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IA 1819	30/08/2018	Dental CB – Dental Nurse Provision	Chief Operating Officer	Reasonable		R6/6	L	Consideration should be given to adding in the Senior Dental Nurses into the ESR hierarchy to delegate responsibility and distribute the administrative task of approving and recording annual leave. The use of ESR self-service by Dental Nurses should be enforced.	Where appropriate, work will begin on rolling out ESR hierarchy access to Senior Dental Nurses	Chief Operating Officer	01/12/2018	Overdue by over 6 months under 12 months
IA 1819	23/08/2018	Environmental Sustainability Re	Director of Planning	Reasonable	4	R1/4	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	01/04/2019	Overdue by under 3 months
IA 1819	23/08/2018	Environmental Sustainability Re	Director of Planning	Reasonable		R4/4	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	01/04/2019	Overdue by under 3 months
IA 1819	10/09/2018	Management of the Disciplinar	Director of Workforce and Organisational Development	Reasonable	6	R1/6	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	Director of Workforce and Organisational Development	30/09/2018	Overdue by over 6 months under 12 months
IA 1819	10/09/2018	Management of the Disciplinar	Director of Workforce and Organisational Development	Reasonable		R2/6	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	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	Director of Workforce and Organisational Development	31/03/2019	Overdue by under 3 months
IA 1819	10/09/2018	Management of the Disciplinar	Director of Workforce and Organisational Development	Reasonable		R3/6	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 Organisational Development	31/03/2019	Overdue by under 3 months
IA 1819	10/09/2018	Management of the Disciplinar	Director of Workforce and Organisational Development	Reasonable		R4/6	M	Management will identify trends in delays and take appropriate action in order that performance improves.	The organisation of Appeals will be centralised within the HR Operations Centre in the Autumn with the ongoing support of the HR Governance Team; Greater focus has been placed on arranging appeal hearings in the last 2 months which has resulted in an improvement in timescales; The new HR Case Manager system will improve the Appeal process and ensure consistency and follow through. The way in which the HR administrator arrange both appeal and disciplinary hearings has been streamlined and we anticipate that this will result in timescale improvements.	Director of Workforce and Organisational Development	30/10/2018	Overdue by over 6 months under 12 months
IA 1819	10/09/2018	Management of the Disciplinar	Director of Workforce and Organisational Development	Reasonable		R5/6	M	Training will be undertaken by all investigators to help with the efficient running of the disciplinary process. A review of the roles the coaches play in investigation will be undertaken to ensure the most effective use of resource.	The HR team are currently reviewing the UHB list of IO's to ascertain their status, i.e. have they been trained, how experienced are they, have they completed an investigation recently, etc. This will ensure that we have an accurate list of both trained and xperienced IO's to choose from; The IO training is currently being enhanced to ensure that following the training IO's are capable to undertake investigations; It was evident following the review that HR practitioners are too involved in the investigation process. This has been rectified and roles have been clarified.	Director of Workforce and Organisational Development	30/11/2018	Overdue by over 6 months under 12 months

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IA 1819	10/09/2018	Management of the Disciplinar	Director of Workforce and Organisational Development	Reasonable		R6/6	M	Management should review their performance/ summary documents to ensure all information is included appropriately and a focus on outcomes.	The main ER tracker is being updated to ensure that we capture the performance data in a more streamlined way; ⍰ Employee Relations reports will be reviewed to ensure that they are meaningful and outcome focused; ⍰ The appeals monitoring spreadsheet has een amended and now captures the timescales; ⍰ The department are currently exploring the implementation of an ER Tracker. There will be a system demonstration on 26th September, following which we will determine whether the system can deliver significant efficiency improvements and proceed to a business case proposal.	Director of Workforce and Organisational Development	30/10/2018	Overdue by over 6 months under 12 months
IA 1819	21/11/2018	National Standards for Cleaning	Director of Planning	Reasonable	6	R1/6	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	01/01/2018	Overdue more than 12-months: Follow up Audit confirmed partially completed
IA 1819	21/11/2018	PCIC CB – District Nursing Rotas	Chief Operating Officer	Reasonable		R2/5	L	District Nurses should work in conjunction with the Rosterpro team to ensure details in Rosterpro are correct to enable use of the automated generation of rotas. Rotas should be entered into Rosterpro prior to shifts being worked.	District Nursing sisters will be expected to use Rosterpro to roster all staff, this will be reviewed through regular 1-1's with them and the Locality senior nurse.	Chief Operating Officer	28/11/2019	Overdue by over 6 months under 12 months
IA 1819	21/11/2018	PCIC CB – District Nursing Rotas	Chief Operating Officer	Reasonable		R3/5	L	District Nurse Sisters should ensure rotas are prepared on a timely basis. Where rotas are prepared manually, these should be formally signed and the date of preparation recorded.	District Nursing sisters will be expected to use Rosterpro to roster all staff, rosters will be audited quarterly to ensure that rosters are provided 4-6 weeks in advance, and signed off, this will be reviewed through regular 1-1's with them and the Locality senior nurse	Chief Operating Officer	28/11/2019	Overdue by over 6 months under 12 months
IA 1819	16/11/2018	Mental Health Clinical Board – Section 17 Leave	Chief Operating Officer	Reasonable	4	R1/4	M	The Guideline for Section 17 Leave of Absence Mental Health Act 1983 should be approved as soon as possible.	The Guideline for Section 17 Leave of Absence Mental Health Act 1983 will be presented for approval at the Clinical Board Quality and Safety Committee in December 2018.	Chief Operating Officer	13/12/2018	Overdue by over 6 months under 12 months
IA 1819	16/11/2018	Mental Health Clinical Board – Section 17 Leave	Chief Operating Officer	Reasonable		R2/4	M	The Health Board should clarify if there is a requirement for specific risk assessments and intervention plans to be produced before patients go on leave. The Guideline should then be updated to reflect the clarified requirements and management should ensure that these are followed in all instances. Risk assessments and intervention plans should be updated and reviewed on a regular basis.	Consideration of the risk assessment and care and treatment plan will have taken place during a review with the Responsible Clinician prior to any Section 17 leave being granted. This is documented on the CPA 3 Review record and in the relevant case note entry. The Guideline for Section 17 Leave will be updated to remove the requirement for a specific Section 17 risk assessment and care plan. Wards have been reminded to ensure current contact details are correct prior to a patient commencing Section 17 leave.	Chief Operating Officer	01/12/2018	Overdue by over 6 months under 12 months
IA 1819	16/11/2018	Mental Health Clinical Board – Section 17 Leave	Chief Operating Officer	Reasonable		R4/4	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	Complete
IA 1819	01/12/2018	Renal IT system	Chief Operating Officer	Reasonable	10	R1/10	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	01/06/2019	Agreed date not reached
IA 1819	01/12/2018	Renal IT system	Chief Operating Officer	Reasonable		R2/10	M	The minimum password length should be set to 8 and all users have a forced password change enacted.	The minimum length has now been amended to 8. With regard to forced change, this will be required when VitalData v1.7 is implemented across Wales this financial year. v1.7 has Active Directory authentication, which will mean Users will be required (and forced) to change their VitalData password every 90 days – the same as is required with User's everyday NADEX domain login.	Chief Operating Officer	01/06/2019	Agreed date not reached
IA 1819	01/12/2018	Renal IT system	Chief Operating Officer	Reasonable		R3/10	M	Recommendation: The backups should be subject to periodic testing.	This has been brought to the attention of the IT Server Team but is outside of the Directorate's direct control. We will continue to seek an appropriate response	Chief Operating Officer	01/04/2019	Overdue by under 3 months

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IA 1819	01/12/2018	Renal IT system	Chief Operating Officer	Reasonable		R4/10	M	The DR plan should be revised to include contact details of support organisations, user departments and management. The DR plan should be tested and subject to subsequent review.	Dialogue with the Vendor parties has already started regarding the failback process. Action is underway to test and resolve, and identify an appropriate timetable for follow-up to ensure regular review. The BCP will be revised with immediate attention	Chief Operating Officer	01/04/2019	Overdue by under 3 months
IA 1819	01/12/2018	Renal IT system	Chief Operating Officer	Reasonable		R5/10	M	A review of users should be undertaken to ensures that leavers access is revoked.	Action has been taken as identified and a process implemented to regularly review leavers. This will ensure access is revoked at the earliest opportunity.	Chief Operating Officer	01/04/2019	Overdue by under 3 months
IA 1819	01/12/2018	Renal IT system	Chief Operating Officer	Reasonable		R7/10	M	The local user group should seek to identify fields which could benefit from improved entry controls.	Communication with users is ongoing and agreed changes will be actioned where appropriate.	Chief Operating Officer	01/06/2019	Agreed date not reached
IA 1819	01/12/2018	Renal IT system	Chief Operating Officer	Reasonable		R8/10	M	A local user group should be established with leads from each of the user departments with the remit to: - Share knowledge over how departments use the system; - Identify areas where improvements to design or functionality could be made; - Identify areas where additional training should be provided to users. - identify areas where poor or late data entry has impacts on downstream departments.	Partially agree. There is an all Wales VitalData Group to which Users can feed into via their Renal IT lead or via each Health Board Clinical IT Lead. As the VitalData system is use within four out of the five Renal Units in Wales any developments or suggestions to change are to benefit all the renal community and a Request for Change process is in place in relation to any system improvements. In Cardiff, local drop-in How-To sessions were established but with little buy-in; they were soon disbanded.	Chief Operating Officer	01/06/2019	Agreed date not reached
IA 1819	01/12/2018	Renal IT system	Chief Operating Officer	Reasonable		R9/10	L	The ROOT account should be renamed and the anonymous account deleted.	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	Complete
IA 1819	01/12/2018	Renal IT system	Chief Operating Officer	Reasonable		R10/10	L	The UHB should consider enabling logging	Database enables logging of every action, be it viewing, editing, deleting etc. all stored in an Activity Log table, where identification of Users can be analysed. The Activity audit facility can be used for system screens, or in the case of the binary logs, can focus on specific screen fields.	Chief Operating Officer	Closed	Complete
IA 1819	14/02/2019	Contract Compliance	Director of Finance	Reasonable	4	R1/4	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	01/08/2019	Agreed date not reached
IA 1819	14/02/2019	Contract Compliance	Director of Finance	Reasonable		R3/4	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	01/04/2019	Overdue by under 3 months
IA 1819	14/02/2019	Contract Compliance	Director of Finance	Reasonable		R4/4	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	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	01/01/2019	Overdue by over 3 months but under 6 months
IA 1819	15/02/2019	Clinical Diagnostic and Therape	Chief Operating Officer	Reasonable		R1/4	H	The Clinical Board should develop a process to ensure that all overtime sessions worked in excess of 6 hours include a clearly documented 30 minute unpaid break. This process should then be communicated to all relevant managers and consistently implemented in the future.	All departments have received a communication instructing them to amend their current processes to include a documented 30 min break. This was done in advance of the production of a new Standard operating procedure which will include this guidance and elevant recording mechanisms as per finding 2	Chief Operating Officer	15/03/2019	Overdue by over 3 months but under 6 months

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IA 1819	15/02/2019	Clinical Diagnostic and Therape	Chief Operating Officer	Reasonable	Medium	R2/4	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	Closed	Complete
IA 1819	15/02/2019	Clinical Diagnostic and Therape	Chief Operating Officer	Reasonable	Medium	R3/4	M	The department should ensure that all agency shifts worked are appropriately authorise prior to payment and evidence of authorisation should be retained.	The management team associated with this department has been requested to provide the relevant recording to the clinical board for review and the need for this on an ongoing basis will for part of the SOP.	Director of Planning	01/06/2019	Agreed date not reached
IA 1819	15/02/2019	Clinical Diagnostic and Therape	Chief Operating Officer	Reasonable	Low	R4/4	L	Where staff work less than the Agenda for Change hours of 37.5 hours any additional hours worked must be recorded as 'Additional Hours' on the Pay Card returned to Payroll Delegated Budget Holders should review the pay-cards submitted to Payroll to establish whether additional hours have been incorrectly classed as overtime.	This will form part of the SOP, and a reminder email will be sent to all departments	Director of Planning		Agreed date not reached
IA 1819	15/02/2019	Kronos Time Recording System	Director of Planning	Reasonable	6	R1/6	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	01/06/2019	Agreed date not reached
IA 1819	15/02/2019	Kronos Time Recording System	Director of Planning	Reasonable		R4/6	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	The issue will be considered as part of the system review although all overtime is authorised and recorded therefore the risk is low. Kronos has been updated to include overtime reasons.	Director of Planning	01/06/2019	Agreed date not reached
IA 1819	15/02/2019	Kronos Time Recording System	Director of Planning	Reasonable		R5/6	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	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.	Chief Operating Officer	01/03/2019	Overdue by under 3 months
IA 1819	01/04/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable	9	R1/9	H	Plan should be devsed for the proposed roll out of Datix to GPs, this should include, but not be limited to: ŸEstablishing 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	Closed	Complete
IA 1819	01/04/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable		R2/9	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	Complete
IA 1819	01/04/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable		R6/9	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	Closed	Complete
IA 1819	01/04/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable		R7/9	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	Complete

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IA 1819	01/04/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable		R8/9	L	Regular communicatoin with GPs should be undertaken to make them aware of the actions taken following their reporting of interface incidents. This will inform them of improvements ot processes as a result and encourage future engagement	A paragraph in relation to the interface process was included in the winter Patient Safety and Quality newsletter. The UHB Medical Director and LMC are kept up to date with the interface incident process through the regular Primary / Secondary Care interface meetings.	Chief Operating Officer	12/03/2019	Overdue by under 3 months
IA 1819	01/04/2019	PCIC Interface Incidents	Chief Operating Officer	Reasonable		R9/9	L	Consideration should be given to how feedback and incident reporting can be made a two way process with continued engagement between primary and secondary care. This will need to include training of secondary care professionals in the current process of interface incidents reporting	PCIC does not receive incident notification from internal depts within the UHB which are managed in line with the agreed UHB process for incident management/ PST - this issue has also been presented at the Datix Super User Gropu. Further information will be included on the Datix Intranet page.	Chief Operating Officer	01/04/2019	Overdue by under 3 months
IA 1819	09/04/2019	Medicine CB - Sickness Absence Management	Chief Operating Officer	Reasonable	5	R1/5	H	Management must ensure that all future sickness episodes are managed and documentation is completed in accordance with the requirements of the All Wales Managing Attendance at Work Policy. Management should ensure that a self-certificate is completed correctly and a return to work interview is held with the employee including the completion of the return to work form. Clinical Board management should consider introducing further periodic training on the sickness management process in order to increase awareness and compliance levels.	Re-circulate the All Wales Managing Attendance at Work Policy. Support and appraises have been set up for A6 South to ensure consistency in completing Self-certification. Review Ward Base sickness processes to ensure that they reflect current policy and provide efficiency to complete necessary actions.	Chief Operating Officer	01/04/2019	Overdue by under 3 months
IA 1819	09/04/2019	Medicine CB - Sickness Absence Management	Chief Operating Officer	Reasonable		R2/5	M	Management should ensure that the sickness triggers are being managed correctly and all future required informal discussions and formal sickness interviews are carried out in accordance with the requirements of the All Wales Managing Attendance at Work Policy.	Support and appraises have been set up for A6 South to ensure consistency in completing Self-certification. Confirm management expectations with Ward Managers in following the All Wales Managing Attendance at Work Policy. Review Ward Base sickness processes to ensure that they reflect current policy and provide efficiency to complete necessary actions.	Chief Operating Officer	01/04/2019	Overdue by under 3 months
IA 1819	09/04/2019	Medicine CB - Sickness Absence Management	Chief Operating Officer	Reasonable		R3/5	M	Management should ensure that the sickness triggers are being managed correctly and all future required informal discussions and formal sickness interviews are carried out in accordance with the requirements of the All Wales Managing Attendance at Work Policy.	Support and appraises have been set up for A6 South to ensure consistency in completing Self-certification. Confirm management expectations with Ward Managers in following the All Wales Managing Attendance at Work Policy. Review Ward Base sickness processes to ensure that they reflect current policy and provide efficiency to complete necessary actions.	Chief Operating Officer	01/05/2019	Overdue by under 3 months
IA 1819	09/04/2019	Medicine CB - Sickness Absence Management	Chief Operating Officer	Reasonable		R4/5	M	Management should ensure that all current ward managers are provided with appropriate training to enable them to effectively manage sickness absence. A robust process should also be implemented to ensure that timely training is provided to any new ward managers. Regular information on sickness absence levels should be consistently provided to all ward managers.	Within Stroke Services, engaged with Human resources to provide further training for all members of the Leadership team. Discussed with HR and now regularly circulating sickness data. HR currently undertaking deep dives with high rate areas to provide useful supportive information about absence.	Director of Planning	22/05/2020	Overdue by over 3 months but under 6 months
IA 1819	15/02/2019	CRI Safeguarding Works	Director of Planning	Reasonable	5	R1/5	M	Progression at risk should be fully documented, approved and recorded at the risk register (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Planning	22/05/2020	Overdue by over 3 months but under 6 months
IA 1819	15/02/2019	CRI Safeguarding Works	Director of Planning	Reasonable		R2/5	L	A Project Execution Plan should be prepared at the outset of a project, in accordance with the Capital Projects Manual and best practice (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Planning	22/05/2019	Overdue by over 3 months but under 6 months
IA 1819	15/02/2019	CRI Safeguarding Works	Director of Planning	Reasonable		R3/5	M	Sufficient contractual arrangements should be in place to safeguard the Health Board interests (O).	Agreed. **ALL FUTURE PROJECTS**	Director of Planning	01/06/2019	Agreed date not reached
IA 1819	15/02/2019	CRI Safeguarding Works	Director of Planning	Reasonable		R4/5	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 Transformation	01/05/2019	Overdue by under 3 months
IA 1819	15/02/2019	CRI Safeguarding Works	Director of Planning	Reasonable		R5/5	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 Transformation	01/04/2020	Agreed date not reached

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IA 1819	11/04/2019	Commissioning	Director of Transformation and Informatics	Reasonable	3	R1/3	H	Strategic Commissioning Group Terms of Reference document should be revised and updated to state the quorate attendance level and its current membership. Additionally, its membership should include representation from the Clinical Boards to ensure a broad contribution and as such an improved strategic approach in full alignment with the Group's Terms of Reference.	The Strategic Commissioning Groups Terms of Reference, including membership was reviewed at a facilitated workshop on 20th Feb 2019. The first draft of a refreshed Terms of reference is scheduled for discussion at the May 2019 meeting of the Strategic Commissioning and Finance Group. Clinical Board representation will be fully considered.	Director of Transformation	01/04/2019	Overdue by under 3 months
IA 1819	11/04/2019	Commissioning	Director of Transformation and Informatics	Reasonable		R2/3	M	The Commissioning Team should as part of its ongoing programme of work publicise their presence via their intranet pages and create an internet page thereby promoting the Commissioning Framework and Commissioning Intentions so as to maximise awareness of content to both internal/external stakeholders and the wider general public.	The development of the commissioning intranet pages, alongside commissioning toolkits, and awareness raising remains on the Commissioning Team's work plan. These actions were not progressed following publication of the Framework due to capacity of the team, and other urgent priorities. Progression of these actions will be included in the team's work plan for 2019-20, but capacity to implement remains an issue.	Director of Transformation	01/09/2019	Agreed date not reached
IA 1819	12/04/2019	E IT Training	Director of Transformation and Informatics	Reasonable	7	R1/7	M	An assessment of the impact of these measures should be carried out and procedures developed for actions in similar circumstances in the future.	An assessment of the reduced course duration is to be undertaken by the PARIS training senior officer at the point the team regain their second training staff member (long term sick, meant the two person PARIS training complement was reduced by half). The PARIS programme has service representation embedded in its 'change structure'. These staff have been asked for concerns and feedback regularly (to the fortnightly MHCS team meetings) since this 'new training model' was made necessary (due to long term loss of staff). No operational risks or concerns have been raised from scoped services to date.	Director of Transformation	30/06/2019	Agreed date not reached
IA 1819	12/04/2019	E IT Training	Director of Transformation and Informatics	Reasonable		R2/7	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'.	Director of Transformation	01/09/2019	Agreed date not reached
IA 1819	12/04/2019	E IT Training	Director of Transformation and Informatics	Reasonable		R3/7	L	To introduce a relevant pre-assessment process and procedures to ensure that staff with learning difficulties are able to learn the systems to the required level.	The Health Board will: 1. Agree a process for ensuring any LD is captured. 2. Develop the Training Booking system to include a mandatory Learning Difficulties field within the user profile screen. The LD will automatically display against the user when booking them in for training sessions. Initially the LD field will default to NONE however the IT Trainers are to check/update the LD field when requests for training received.	Director of Transformation	01/09/2019	Agreed date not reached
IA 1819	12/04/2019	E IT Training	Director of Transformation and Informatics	Reasonable		R4/7	L	Document control information to be standardised and completed in full on training documents.	Training documents are currently version controlled but not standardised. Standardising them would be a very low priority within the current resource.	Director of Transformation	01/09/2019	Agreed date not reached
IA 1819	12/04/2019	E IT Training	Director of Transformation and Informatics	Reasonable		R5/7	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	Closed	Complete
IA 1819	12/04/2019	E IT Training	Director of Transformation and Informatics	Reasonable		R6/7	L	An impact assessment process should be introduced in order to gather and evaluate the feedback from training attendants after they have had the opportunity to use the relevant systems. The feedback emails should be reviewed on a regular basis.	An impact assessment process is in draft but has been suspended due to the Work Life Balance absence of the WCP trainer. This and the regular review of feedback emails will recommence once the trainer has returned to post.	Director of Planning	30/06/2019	Agreed date not reached
IA 1819	12/04/2019	E IT Training	Director of Transformation and Informatics	Reasonable		R7/7	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	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	Director of Planning	30/06/2019	Agreed date not reached
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable	7	R1/7	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	30/07/2019	Agreed date not reached
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R2/7	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	30/06/2019	Agreed date not reached
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R3/7	M	Training should be updated for all key staff with assigned water management responsibilities (O).	Agreed	Director of Planning	30/07/2019	Agreed date not reached
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R4/7	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	Agreed	Director of Planning	01/11/2019	Overdue by over 3 months but under 6 months

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IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R5/7	H	a) For those clinical boards identified in this audit as being non-compliant with required flushing practices, the Chair of the WSG should request assurance from the clinical boards that practices have been improved.	Agreed	Director of Planning	01/11/2019	Overdue by under 3 months
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R6/7	H	The risk assessment process, including preparation of appropriate prioritised action plans to address the identified risks, should be completed as soon as possible (D).	Agreed	Director of Finance	30/07/2019	Agreed date not reached
IA 1819	15/05/2019	Water Safety	Director of Planning	Reasonable		R7/7	M	Progress, including highlighting of any delays, should be regularly reported to the Water Safety Group (O).	Agreed	Director of Finance	31/10/2019	Agreed date not reached
IA 1819	15/05/2019	UHB Core Financial Systems	Director of Finance	Reasonable	5	R1/5	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	31/07/2019	Closed
IA 1819	15/05/2019	UHB Core Financial Systems	Director of Finance	Reasonable		R2/5	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	31/07/2019	Closed
IA 1819	15/05/2019	UHB Core Financial Systems	Director of Finance	Reasonable		R3/5	M	Management should inform responsible staff to promptly notify eEnablement of changes to the Purchasing Oracle hierarchy list. The required forms should be completed to process updates.	Recommendation Accepted. The UHB's current procedure will be updated to clarify the responsibility to review approvers at the Clinical Board level and within Corporate Finance.	Director of Finance	31/07/2019	Agreed date not reached
IA 1819	15/05/2019	UHB Core Financial Systems	Director of Finance	Reasonable		R4/5	M	Management should ensure that a standard procedural guide is produced to support staff in the maintenance of the Oracle Purchasing hierarchy. The guide should also state an appropriate agreed period for the review of the hierarchy.	Recommendation accepted. The UHB's current procedure will be updated to clarify respective responsibilities at the Clinical Board level and within Corporate Finance. The minimum expectation is that purchasing hierarchies will be reviewed quarterly.	Chief Operating Officer	01/04/2020	Agreed date not reached
IA 1819	15/05/2019	UHB Core Financial Systems	Director of Finance	Reasonable		R5/5	M	Management should ensure that the required forms are completed, signed and forwarded to eEnablement for all additions to the Oracle Hierarchy. Management should also liaise with eEnablement to ensure there is an organised system for storing the Financial limit forms so they can be easily retrieved here an audit trail is required.	Recommendation accepted. The UHB's revised procedure will be updated to clarify respective responsibilities for establishing approvers and maintaining appropriate records for additions to the Oracle Hierarchy.	Chief Operating Officer	31/08/2019	Agreed date not reached
IA 1819	17/05/2019	Specialist Services Clinical Board – Medical Finance Governance	Chief Operating Officer	Reasonable	2	R1/2	H	Management should carry out a comprehensive review of the current and future consultant staffing levels to ensure that the Critical Care service can be sustainably delivered in the future. This should include review of the current service model.		Chief Operating Officer	01/04/2019	Overdue by under 3 months
IA 1819	17/05/2019	Specialist Services Clinical Board – Medical Finance Governance	Chief Operating Officer	Reasonable		R2/2	L	Each 20 week Consultant rota should be subject to formal approval by the Clinical Director and evidence of this approval should be retained on file.	A process to sign off the rota by the Clinical Director will be developed by the Directorate Management Team, and a record of which will be retained on file along with existing job planning information.	Director of Corporate Governance	31/12/2018	Overdue by over 6 months under 12 months
IA 1819	30/10/2018	Mental Health Clinical Board – Sickness Management	Chief Operating Officer	Limited		R3/4	L	Long term sickness meetings should be held as required to ensure that the employee is receiving support and help.	Directorates to send all managers a general reminder of the need for formal sickness letters to be sent and for LTS forms to be signed and copied. Managers to be asked to ensure that where conversations have been held with HR / OH re: additional triggers, these are to be more clearly noted in sickness files	Director of Corporate Governance	31/12/2018	Overdue by over 6 months under 12 months

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IA 1819	Director of Corporate Governance	Limited		R2/6	H	The Corporate Team must put processes in place to help raise awareness of the policy to ensure that all employees within	H	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.	Head of Corporate Governance	01/02/2019	Overdue by over 6 months under 12 months	Overdue by over 6 months under 12 months
IA 1819	15/11/2018	Standards of Business Conduct	Director of Corporate Governance	Limited		R6/6	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	01/02/2019	Overdue by over 3 months but under 6 months
IA 1819	18/01/2019	Legislative/Regulatory Complai	Director of Corporate Governance	Limited	7	R1/7	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 Governance	01/02/2019	Overdue by over 3 months but under 6 months
IA 1819	18/01/2019	Legislative/Regulatory Complai	Director of Corporate Governance	Limited		R3/7	H	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 Governance	01/02/2019	Overdue by 6 months under 12 months
IA 1819	18/01/2019	Legislative/Regulatory Complai	Director of Corporate Governance	Limited		R4/7	H	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 Governance	01/02/2019	Overdue by over 3 months but under 6 months
IA 1819	18/01/2019	Legislative/Regulatory Complai	Director of Corporate Governance	Reasonable		R5/7	H	The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Agreed	Director of Corporate Governance	01/02/2019	Overdue by over 3 months but under 6 months
IA 1819	18/01/2019	Legislative/Regulatory Complai	Director of Corporate Governance	Limited		R6/7	H	The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers.	Agreed	Director of Transformation and Informatics	30/06/2019	Agreed date not reached
IA 1819	18/01/2019	Legislative/Regulatory Complai	Director of Corporate Governance	Limited		R7/7	H	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 Transformation and Informatics	30/06/2019	Agreed date not reached

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IA 1819	01/02/2019	Information Governance: Gene	Director of Transformation and Informatics	Limited	12	R1/12	H	The UHB should consider establishing a GDPR group with representation from all clinical boards. The function of the group should be to ensure appropriate compliance actions are taken and to provide assurance that the UHB has good processes to ensure compliance with the GDPR.	The UHB has adapted the all Wales IG policy. As part of the process to formal adoption, consultation and impact assessment will be taking place through which we anticipate identification of all clinical board requirements and prioritised action. The UHB sees placing responsibility and accountability as close as possible to the operational front line as the key to having an empowered and engaged workforce. Thus we see that the role of the corporate IG department is to design delivery of compliance and to provide specialist advice, rather than co-ordinate and deliver. It is accepted that as resources and expertise accumulate in line with expectation, there is more the central team can do on communication and engagement including the creation of a virtual mutually supporting networking of IAOs / IAAs. As recommended this will include setting up a GDPR group for a year.	Director of Transformation and Informatics	01/03/2019	Overdue by under 3 months
IA 1819	01/02/2019	Information Governance: Gene	Director of Transformation and Informatics	Limited		R2/12	H	The resource requirement for the Information Governance team should be fully assessed and resource provided appropriately.	In the context of the UK wide economy growing at a lower rate than: patient expectation, demand and health care cost inflation, the UHB has had to take business decisions in order to deliver a financially balanced plan. We recognise these have had significant consequences on many of our staff and resulted in high levels of sickness which have only made the position harder for all. We fully appreciate that a once in a generational change to IG legislation coincided with difficult financial circumstances has presented us with a challenge, but we would contend that this was a short sharp shock to the system which is now being adopted into routine ways of working as knowledge and awareness builds from experiential learning. As such we anticipate that by the end of Q1 2019/20 we will have increased the number of whole time equivalents in place and working by a whole time equivalent, taking the operational staffing levels to 4.8 wte, which will continue to be complimented by specialist advice from both Welsh Health Legal and Risk and a local legal firm. To confirm the financial resource for this external support is available within the UHB's budget.	Director of Transformation and Informatics	30/09/2019	Agreed date not reached
IA 1819	01/02/2019	Information Governance: Gene	Director of Transformation and Informatics	Limited		R3/12	H	A revised Subject Access Procedure should be completed, placed on the intranet and flagged to all staff.	Accepted	Director of Transformation and Informatics	itional Implementati	Overdue by over 6 months under 12 months
IA 1819	01/02/2019	Information Governance: Gene	Director of Transformation and Informatics	Limited		R4/12	M	The IG webpages should be updated to ensure they present current, accurate information.	The contact details will be updated shortly. As noted above the department has been short staffed and there has needed to be a prioritisation between designing and mitigating significant risks to noncompliance and making general information available. The UHB has engaged widely on the DPA 2018 and is intending to use the consultation on the IG policy as a further vehicle for promoting awareness and setting out	Director of Transformation and Informatics	01/03/2019	Overdue by under 3 months
IA 1819	01/02/2019	Information Governance: Gene	Director of Transformation and Informatics	Limited		R5/12	M	The UHB should seek to ensure all staff complete the IG training module.	Management Response Accept – The UHB is engaged nationally in the development of the e-learning package and has licenses for its use. We intend to make use of this national initiative in line with its roll out plan.	Director of Transformation and Informatics	30/09/2019	Agreed date not reached
IA 1819	01/02/2019	Information Governance: Gene	Director of Transformation and Informatics	Limited		R6/12	M	Training on GDPR should be enhanced and provided to all staff acting in an IAO or IAA role. Further information should be passed to Directorates on the specific actions to be undertaken following GDPR.	Training is via the mandatory training route described in recommendation 5. The UHB will take actions to ensure we have asset registers and awareness of GDPR within dermatology and across the medicine clinical board as an early priority. Within clinical boards there will be further emphasis and engagement on the responsibilities and requirements for IAO/IAA roles, in order to enable appropriate senior staff to be allocated/trained, following implementation of enhanced training programme	Director of Transformation and Informatics	30/09/2019	Agreed date not reached
IA 1819	01/02/2019	Information Governance: Gene	Director of Transformation and Informatics	Limited		R7/12	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		Superseded
IA 1819	01/02/2019	Information Governance: Gene	Director of Transformation and Informatics	Limited		R8/12	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	30/09/2019	Agreed date not reached
IA 1819	01/02/2019	Information Governance: Gene	Director of Transformation and Informatics	Limited		R9/12	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		Overdue by 6 months under 12 months
IA 1819	01/02/2019	Information Governance: Gene	Director of Transformation and Informatics	Limited		R10/12	M	The IAR process should pick up information flows and also consider the basis for processing.	In line with the approach taken across NHS Wales which has been discussed openly with the ICO's office a phased approach to the development of IARs has been adopted. Presently the UHB is in the process of mapping flows, with the initial focus having been on mapping new flows, those concerning R&D (potentially higher risk) and those into NWIS. The legal basis for processing in the majority of cases is patient care as set out in our privacy notice. The UHB is using the requirement to get the documentation right for all new flows as a tool for	Director of Transformation and Informatics	26/02/2019	Overdue by over 3 months but under 6 months

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IA 1819	01/02/2019	Information Governance: Gene	Director of Transformation and Informatics	Limited		R11/12	M	The UHB should make clear the requirement to gain explicit consent for these transfers.	As above – there is no requirement for consent where the data processing by a non EEA 3rd party has a EEA 'kitemark'. Information around this is being shared and informed by work reporting into IG MAG **Continuation of existing practice**	Chief Operating Officer	30/03/2019	Overdue by under 3 months
IA 1819	01/02/2019	Information Governance: Gene	Director of Transformation and Informatics	Limited		R12/12	L	Directorates should be reminded to display the GDPR information.	Accept – SIRO will write to Directorate Managers & CDs to remind them of this requirement	Chief Operating Officer	30/03/2019	Overdue by under 3 months
IA 1819	12/02/2019	Surgery Clinical Board – Medical Finance Governance	Chief Operating Officer	Limited	6	R1/6	H	The Directorate should ensure that consultants carry out all planned sessions wherever possible and appropriate reasons are recorded for the cancellation of clinics and theatres. Colorectal Consultants should ensure that they cover and backfill the other Consultants lists if they are unable to carry out the planned session.	A new system to accurately record consultant activity in theatre is being developed with a clear desktop procedure. Through job planning each consultants expected activity will be agreed in weeks and monitored accordingly by the Directorate Expectation around backfill sessions will be agreed and signed by consultants and a system to monitor this will be managed by the Directorate team Systems will be put in place by end of March 2019	Chief Operating Officer	30/03/2019	Overdue by under 3 months
IA 1819	12/02/2019	Surgery Clinical Board – Medical Finance Governance	Chief Operating Officer	Limited		R4/6	M	Management should produce desk top procedures to ensure that Consultants medical staff time and costs are being managed appropriately and consistently	Standardised procedure notes to be created and shared with key personnel (March 2019)	Chief Operating Officer	01/09/2019	Agreed date not reached
IA 1819	12/02/2019	Surgery Clinical Board – Medical Finance Governance	Chief Operating Officer	Limited		R5/6	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	N/A	Superseded
IA 1819	14/02/2019	Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up	Chief Operating Officer	Limited		R2/6	H	Management should ensure that all members of staff within the directorate are fully compliant and up to date with their mandatory training. If staff members believe that ESR is not tracking when a module is completed, staff should print out the certificate available to provide proof and store it within their personal file.	Improved compliance for 85% of staff with completion of 100% mandatory and statutory training modules (44% improvement over 6 months). Staff to be allocated onto study leave planner and compliance monitored monthly via ESR and discussed with ward managers at 121s.	Director of Transformation and Informatics	01/07/2019	Agreed date not reached
IA 1819	14/02/2019	Internal Medicine Directorate – Mandatory Training & PADRs Follow-Up	Chief Operating Officer	Limited		R5/6	M	Management must ensure that the staff database is regularly maintained, with the deletion of staff that have left the directorate and the inclusion of new employees. Management must look to tie in the mandatory training dates with the ESR matrices to ensure they tie back to LED.	No Longer Applicable No database is maintained by the directorate office. They are now reliant on reports from ESR therefore consistent figures are being used and reported.	Director of Transformation and Informatics	01/09/2019	Agreed date not reached
IA 1819	01/05/2019	Cyber Security	Director of Transformation and Informatics	Limited	8	R1/8	H	A review of the resources available within IM&T and the requirements of the organisation should be undertaken to ensure that the department can appropriately meet the demands. Additional investment should be considered in order to provide a cyber security function.	A review of the current IT and Information departments has been completed and a restructure proposal created. This includes additional cyber security resources to manage and deliver the NESSUS and SIEM requirements, utilising the additional funding being made available by Welsh Government.	Director of Transformation and Informatics	01/09/2019	Agreed date not reached
IA 1819	01/05/2019	Cyber Security	Director of Transformation and Informatics	Limited		R2/8	H	An active monitoring process which feeds into KPI reporting should be developed and maintained within IM&T.	The restructure of the directorate includes additional resource to manage cyber security issues. A key role for this function will be the development of a monitoring system that supports the KPI reporting against cyber security.	Director of Transformation and Informatics	01/09/2019	Agreed date not reached
IA 1819	01/05/2019	Cyber Security	Director of Transformation and Informatics	Limited		R3/8	H	Resources should be provided to allow for a cyber security role to be properly defined and operating appropriately.	The restructure of the IT and information functions being proposed will result in the establishment of cyber security roles which will monitor and respond to cyber incidents and will develop policy, processes and procedures to reduce the likelihood of a cyber security incident	Director of Transformation and Informatics	01/09/2019	Agreed date not reached
IA 1819	01/05/2019	Cyber Security	Director of Transformation and Informatics	Limited		R4/8	H	Active monitoring should be established. A Cyber response plan should be developed.	The creation of new cyber security roles in the restructured directorate will mean that a proactive stance on monitoring of cyber security is created as part of a wider Cyber response plan, which will also incorporate use of the NESSUS and SIEM solutions.	Director of Transformation and Informatics	01/09/2019	Agreed date not reached
IA 1819	01/05/2019	Cyber Security	Director of Transformation and Informatics	Limited		R5/8	M	A formal, resourced plan for the removal of old software and devices should be established.	A formal plan is in the early stages of production and will address removal of aged and insecure software as well as devices. This will be implemented by the cyber security team proposed in the new directorate structure.	Director of Transformation and Informatics	01/07/2019	Agreed date not reached

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IA 1819	01/05/2019	Cyber Security	Director of Transformation and Informatics	Limited		R6/8	M	A formal patch management procedure should be developed that sets out the mechanisms for patching / updating all items within the Health Board.	Patching of PCs is being investigated as time allows to identify the scale of the risk. A patch management procedure will be developed to address patching of all devices. This procedure will describe how patches and updates will be managed, with reference to the national standards and alerts managed through NWIS.	Director of Transformation and Informatics	01/09/2019	Agreed date not reached
IA 1819	01/05/2019	Cyber Security	Director of Transformation and Informatics	Limited		R8/8	M	The IT Security Policy should be reviewed and updated.	The current IT security policy is scheduled to be reviewed to reflect changes in legislation, IT architecture and national policy.	Chief Operating Office	30/06/2019	overdue over 3 months under 6 months
IA 1819	22/05/2019	MHRA Compliance	Chief Operating Officer	Reasonable	4	R1/4	H	The current tracker should be effectively updated to ensure that the outstanding deficiencies are retified and an appropriate audit trail is maintained	The UHL (PSU) tracker has now been updated (3 June 2019) in future, accepted practice will be for any deficiencies identified through self-inspection, audit or via business inelligence e.g. regulatory inspection of other units or via a formal directice from MHRA (where new standards are implemented) will be raised as a new issue and tracked accordingly	Chief Operating Office	30/06/2019	overdue over 3 months under 6 months
IA 1819	22/05/2019	MHRA Compliance	Chief Operating Officer	Reasonable		R2/4	M	Management will amend the tracker to ensure an appropirate audit trail on how actions are progressing.	The SMPU internal tracker has been amended to include the revised target date(s) for the 6 deficiences noted above. They will be annotated to include narrative for the reasons for delay and updated target date.	Chief Operating Office	31/07/2019	overdue over 3 months under 6 months
IA 1819	22/05/2019	MHRA Compliance	Chief Operating Officer	Reasonable		R3/4	M	The terms of reference should be reviewed for appropriateness and staff should be reminded of the importance of attending and contributing to the compliaince and governance meetings. Management should also consider setting up an equivalent meeting for the Llandough site or extending the remit of the current meeting to cover SMPU and Llandough.	A single Compliance and Governance group for Pharmacy Technical Service i.e. UHL and SMPU had been agreed. The terms of refernce were orginally agreed before the establishment of a Clinical Diagnostic and Therapeutics	Director of Transformation and Informatics	01/06/2019	overdue over 3 months under 6 months
IA 1819	22/05/2019	MHRA Compliance	Chief Operating Officer	Reasonable		R 4/4	M	The risk register should be assessed for appropriateness and updated accordingly.	The Pharmacy Directorate Risk Register has been reviewed and ownership of individual sections clarified. This includes the technical services components and a monthly review/update included in the senior team meeting agenda. In addition, our internal process for handling and escalating risks associated with pharmacy and medicines management activities and review through the Clinical Board has been agreed.	Director of Transformation and Informatics	01/07/2019	overdue over 3 months under 6 months
IA 1819	30/06/2019	E-Advice	Director of Transformation and Informatics	Reasonable	4	R1/4	M	Management should undertake an exercise to review and quantify benefits from the ongoing use of the e-Advice system to ensure benefits are maximised and the system is sufficiently supported and resourced.	With the resource available an exercise will be carried out to review and quantify the original key benefit identified in the project outline document 'a minimum of 10% avoidance of attendance in Outpatients is likely to be achieved by GPs implementing an e-advice service'. As part of the restructure process of the wider Digital team, we will look to increase our capacity for benefits realisation and evaluation. A wider benefits review will be carried as our service users recognise the benefits that e-Advice brings.	Director of Transformation and Informatics	01/07/2019	overdue over 3 months under 6 months
IA 1819	30/06/2019	E-Advice	Director of Transformation and Informatics	Reasonable		R2/4	M	Management should document the approach to testing and implementing changes. This should include documentation of requirements around change categorisation, the extent of testing required, the approval process, the approach to rolling back changes, and criteria to be used when assigning a severity to changes.	There are processes in place to manage testing, approvals, roll back and assigning a severity to changes which allow for a quick response. It is recognised that these processes have lacked some formality due to the resource available. However work has already started on formal cumentation to support ease of handover to other members of the department. This will be light-touch, with minimum documentation, aimed at supporting the change and testing process without being overly bureaucratic.	Director of Transformation and Informatics	01/06/2019	overdue 3 months under 6 months
IA 1819	30/06/2019	E-Advice	Director of Transformation and Informatics	Reasonable		R3/4	M	A regular, at least annual, exercise should be undertaken to confirm the validity of user accounts and ensure any leavers accounts are identified and disabled.	A report to identify account inactivity of 90 days will auto-run daily following which inactive accounts will be closed. Accounts can be reactivated on request.	Director of Digital and Health Intelligence	24/05/2019	overdue over 6 months under 12 months
IA 1819	30/06/2019	E-Advice	Director of Transformation and Informatics	Reasonable		R4/4	L	Management should consider the use of local e-Advice super users.	The team are looking at ways to relieve the administration workload on them. A service announcement will be sent out to all super users reminding them of the actions that they can carry out e.g. authorising of accounts, closing accounts. New users are now able to self-register. Super users will be encouraged to take an increased role in user acceptance testing.	Director of Digital and Health Intelligence	30/09/2019	overdue over 6 months under 12 months
IA 1819	12/09/2019	UHB Transformation Process	Director of Digital and Health Intelligence	Reasonable	3	R1/3	M	The Transformation Enabler Steering Group should consider including nominated Clinical Board Leads to contribute directly into each Enabler where appropriate and actively inform the development of progress.	Each enabler task and finish group links with Clinical Boards and have involvement of staff . We will review this with the Boards in order to improve engagement. We will consider whether a lead or link person from each Board would improve engagement.	Director of Digital and Health Intelligence	24/05/2019	overdue over 6 months under 12 months
IA 1819	12/09/2019	UHB Transformation Process	Director of Digital and Health Intelligence	Reasonable		R2/3	M	The Accessible Information Enabler should implement a formal Task and Finish Group that oversees and provides governance of delivery of the Enabler's objectives and interfaces with the Transformation Enablers Steering Group.	The Accessible information enabler work is being reported to a number of different groups, which ensures oversight and assurance. These include HSMB, the "signals from Noise" steering group chaired by the CEO and the new Digital Design Group being established in October 2019 which will include membership from the Executive Management team and Clinical Boards. In addition, the accessible information enabler work will be reported into the new Digital & Health Intelligence committee, a new formal committee of the Board.			overdue over 3 months under 6 months
IA 1819	12/09/2019	UHB Transformation Process	Director of Digital and Health Intelligence	Reasonable		R3/3	M	Progress relating to the Accessible Information Enabler should be recorded and reported via a monthly Highlight Report to the Transformation Enablers Steering Group in parity with the four other Enablers.	Following discussion between the ADI of Information and the steering group project manager, it is proposed that given the breadth and complexity of the accessible information enabler, the monthly reporting continues to be provided in the format that conveys the issues, actions and updates previously shared. This has been agreed with the AD of organisational change/transformation.	Director of Nursing	31/12/2019	overdue over 3 months under 6 months

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	No. of Recs Made	Rec No.	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date	Recommendation Status [RAG Rating]
IA 1920		Standards of Business Conduct (DoI & GH&S) Follow-up	Director of Corporate Governance	Substantial		0				Director of Planning	30/09/2019	
IA 1920	22/05/2019	Annual Quality Statement	Executive Nurse Director	Substantial	1	R1/1	L	The department should consider incorporating an accuracy check of all data into the AQS timetable, which should be done as late as possible in the AQS process.	The Patient Safety and Quality team will introduce a process whereby there is time set aside (and included within the timetable) to undertake all the necessary data quality checks, before the final version is agreed. This will be included in the paper to the December 2019 QSE Committee.	Chief Operating Officer	01/04/2019	Overdue by over 6 months
IA 1920	16/08/2019	Carbon Reduction Commitment	Director of Planning	Substantial	1	R1/1	M	The UHB should ensure that the strategy is agreed as soon as possible so that the surplus allowances can be sold for the best achievable price.	The UHB will be agreeing the strategy regarding the course of action to be adopted for surplus allowances during August 2019.	Director of Planning	Immediately	Overdue under 3 months
IA 1920	22/07/2019	Mental Health Clinical Board - Sickness Management Follow-up	Chief Operating Officer	Reasonable	4	R2/4	H	Management should ensure that the sickness triggers are being managed correctly with informal discussions and formal sickness interviews being carried out in accordance with the All Wales Sickness Policy.	Directorates to send "trigger table" out to all managers, reminding them to check with line managers if they have any doubt or queries with individual cases. Senior Nurse Managers to conduct random sickness file checks as part of 1:1 with managers.	Director of Planning	31/10/2019	Overdue under 3 months
IA 1920	12/09/2019	Specialist Clinical Board - Rosterpro	Chief Operating Officer	Reasonable	5	R1/5	H	Management should ensure employees contracted hours are managed appropriately.	As a Directorate Management Team we welcome the audit and accept its recommendations. As we recognise we can't change some of the findings detailed above, our focus has been upon implementing new systems and 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.	Chief Operating Officer	01/09/2019	Overdue under 3 months
IA 1920	12/09/2019	Specialist Clinical Board - Rosterpro	Chief Operating Officer	Reasonable		R2/5	M	Appropriate staff will be reminded of the procedural requirement for drawing up rotas 6 weeks in advance and timely signing off within Rosterpro.	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 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.	Chief Operating Officer	Completed	Complete
IA 1920	12/09/2019	Specialist Clinical Board - Rosterpro	Chief Operating Officer	Reasonable		R3/5	M	A process map should be devised and distributed to appropriate staff. This should include a robust system for utilising staff with negative balances prior to booking bank or agency staff.	Process map will be devised and distributed to all Critical Care Flow Coordinators by Lead / Senior Nurse.	Chief Operating Officer	27/08/19 30/09/19	Overdue under 3 months
IA 1920	12/09/2019	Specialist Clinical Board - Rosterpro	Chief Operating Officer	Reasonable		R4/5	M	Management should remind staff that accurate and up to date records are to be kept at all times.	New ways of working have been instigated across Critical Care since May 2019, with Band 7's having clearly defined duties and accountability for the production and maintenance of accurate records. Oversight of the records and rostering is now a key component of the Senior Nurse and Band 7 1:1 meetings that occur on a monthly basis, with review of the efficacy and impact of the new system scheduled for December 2019.	Director of Corporate Governance	01/02/2019	Overdue by 6 months under 12 months
IA 1920	12/09/2019	Specialist Clinical Board - Rosterpro	Chief Operating Officer	Reasonable		R5/5	L	Optimum requirements for Llandough will be reviewed and if necessary updated appropriately.	Staffing levels at Llandough have been reviewed since the time of the audit. As a result a 1wte Band 7 has been added to the establishment for UHL.	Director of Corporate Governance	01/02/2019	Overdue by 6 months under 12 months
IA 1920	23/09/2019	Legislative / Regulatory Compliance	Director of Corporate Governance	Reasonable		R3/7	H	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 Governance	01/02/2019	Overdue by 9 months but under 12 months
IA 1920	23/09/2019	Legislative / Regulatory Compliance	Director of Corporate Governance	Reasonable		R4/7	H	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	Director of Corporate Governance	01/02/2019	Overdue by 9 months but under 12 months
IA 1920	23/09/2019	Legislative / Regulatory Compliance	Director of Corporate Governance	Reasonable		R5/7	M	The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Agreed	Director of Corporate Governance	01/02/2019	Overdue by 9 months but under 12 months
IA 1920	23/09/2019	Legislative / Regulatory Compliance	Director of Corporate Governance	Reasonable		R6/7	M	The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers.	Agreed	Chief Operating Officer	01/05/2019	Overdue by over 6 months

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IA 1920	23/09/2019	Legislative / Regulatory Compliance	Director of Corporate Governance	Reasonable		R7/7	M	The Corporate Team should re-evaluate the Report to ensure that all the necessary information required to maintain a comprehensive list is in place. The Corporate Team should also review the standard email that is sent out to ensure that all the required information is requested. They should also pursue those who have not provided the relevant information.	Recommendation agreed	Director of Planning	Immediately	Over due by 3 months but under 6 months
IA 1920	22/07/2019	Mental Health Clinical Board - Sickness Management Follow-up	Chief Operating Officer	Reasonable	4	R2/4	L	Management should remind ward staff that the recording of sickness dates should reconcile between sickness documentation and ESR, and all sickness dates should be accurately and consistently recorded.	All band 6 / 7 managers to attend refresher sickness training.	Director of Planning	31/10/2019	
IA 1920	16/08/2019	Sustainability Reporting	Director of Planning	Reasonable		R1/3	M	Evidence of the retrospective approval of the sustainability report by the Environmental Steering Group / Health & Safety Group and sign off by the Director of Capital Estates and Facilities should be provided to audit each year. The documented procedural guidance should be updated to reflect the actual review and approval process currently in place.	Future Sustainability reports will be approved and signed off at the Capital Estates and Facilities Health & Safety Group. Depending on timescales retrospective approval may need to be provided, however the approval and sign off of the report shall be documented in the relevant minutes of the group.	Director of Planning	Immediately	Over due by 3 months but under 6 months
IA 1920	16/08/2019	Sustainability Reporting	Director of Planning	Reasonable		R2/3	M	The staff roles and responsibilities highlighted in the procedural guidance should be reviewed and updated as necessary. The guidance should be supplemented with detailed information on how to prepare each of the three mandatory tables.	Future Sustainability report guidance will be reviewed and updated for staff roles and responsibilities as necessary. Where necessary guidance will be supplemented with detailed information on how to prepare each of the three mandatory tables.	Chief Operating Officer	Completed	Complete
IA 1920	16/08/2019	Sustainability Reporting	Director of Planning	Reasonable		R3/3	M	Management should draw up a timetable each year to help ensure appropriate time is allocated for the sustainability report preparation, review process, audit, approval and submission to the Communications Team. The requirement to produce a timetable each year should be incorporated into the procedural guidance.	Once the timescale for the Sustainability report submission is known an indicative timetable will be developed. Timings however may change depending on when information is available for inclusion in the report and the availability of Officers to verify and audit information and data.	Chief Operating Officer	01/06/2020	Not due
IA 1920	31/10/2019	Mental Health CB - Third Sector Contractors	Chief Operating Officer	Reasonable		R1/2	M	Third Sector Mental Health Providers – Contracting and Performance Management Arrangements' document and 'Mental Health Third Sector Commissioning Guide' should be revised to state the processes in place in respect of escalation of unresolved performance and/or service delivery issues in the event of non-compliance of terms stated within provider contacts.	Third Sector Commissioning Guide and Framework (revised) to reflect recommendation (Attached with this report)			
IA 1920	31/10/2019	Mental Health CB - Third Sector Contractors	Chief Operating Officer	Reasonable		R2/2	L	All future stakeholder engagement and consultation documentation should be retained and held with the contract specification documentation.	A new cycle of commissioning will begin in 2020 and the recommendation is noted and will be included in all future commissioning/tender processes. Commissioning tender process June 2020	Executive Medical Director	01/12/2019	
IA 1920	25/11/2019	Claims Reimbursement	Executive Nurse Director	Sustainable	0					Executive Medical Director	01/11/2019	
IA 1920	21/10/2019	Private and Overseas Patients	Executive Medical Director	Reasonable	7	R1/7	H	All Directorates should be informed of the current Private Patient Agreement and Charging Forms that include 2019/20 tariffs and ensure that their respective Consultants who undertake private work should be using these forms and not those that relate to previous financial years so as to ensure accurate billing and recovery of Directorate costs incurred.	The UHB updates the private patient tariffs and agreement forms on its intranet and internet sites on an annual basis. Past changes to private patient requirements have been communicated through the UHB News Service and the Medical Directors Bulletin. The UHB's internet page has recently been updated to include the 2019/20 Private Patient Tariff. Moving forwards all Directorates will be notified of the current Private Patient Agreement and Charging Forms that include up to date tariffs on an annual basis to ensure that their respective Consultants who undertake private work are using the correct forms and not those that relate to previous financial years. A note will be relayed to all Directorates and the UHB News Service by the end of December 2019 to confirm where the relevant private patient forms and tariffs for 2019/20 can be found.	Executive Medical Director	01/03/2020	
IA 1920	21/10/2019	Private and Overseas Patients	Executive Medical Director	Reasonable	7	R2/7	M	The Private and Overseas Patients Office should promote and increase awareness relating to the existence of its intranet and internet web pages if it is to ensure that all UHB Directorates/Departments are conversant with the contents of its policy, procedures and their supporting documentation.	The Private and Overseas Patients Office will promote the existence of its intranet and internet web pages directly to Directorates by the end of November 2019 and annually thereafter. In addition a short note providing an overview of policy and procedures will be produced by the end of 2019/20 for distribution to Directorates on an annual basis.	Executive Medical Director	01/12/2019	overdue by over 3 months but under 6 months

Audit	Final Report Issued on	Audit Title	Executive Lead for Report	Audit Rating	No. of Recs Made	Rec No.	Rec. Rating	Recommendation Narrative	Management Response	Executive Lead for Recommendation	Agreed Implementation Date	Recommendation Status [RAG Rating]
IA 1920	21/10/2019	Private and Overseas Patients	Executive Medical Director	Reasonable	7	R3/7	M	The UHB Overseas and Private Patient internet pages should be updated to include the 2019/20 Private Patient Tariffs. and Given that a review of overseas and private patient tariffs has not been completed for a number of years, it is advisable that the UHB's Costing Team and Clinical Boards should liaise to undertake this exercise as soon as is practicable so as to ensure that service delivery costs are fully recovered.	The UHB Overseas and Private Patient internet page has now been updated to include the 2019/20 Private Patient Tariffs. The UHB's Costing Team and Clinical Boards should will be engaged so that a scope for the review of all tariffs can be agreed by the end 2019/20 with the aim of implementing the reviewed tariffs at the beginning of 2020/21.	Executive Medical Director	01/11/2019	overdue by over 3 months but under 6 months
IA 1920	21/10/2019	Private and Overseas Patients	Executive Medical Director	Reasonable	7	R4/7	M	Private and Overseas Patients Office should ensure that fee information is made known to Directorates/Department at the commencement of each new financial year so as to maximise an increased awareness of its existence and use when required.	Moving forwards all Directorates will be notified of the current Private Patient Agreement and Charging Forms that include up to date tariffs on an annual basis ensure that their respective Consultants who undertake private work are using the correct forms and not those that relate to previous financial years. In addition a general notice will be published via the UHB news service.	Executive Medical Director	01/12/2019	overdue by over 3 months but under 6 months
IA 1920	21/10/2019	Private and Overseas Patients	Executive Medical Director	Reasonable	7	R5/7	M	The Private patient office should ensure that the Dermatology Directorate introduce formal processes to identify, ascertain and confirm overseas patient eligibility to access healthcare if they attend the clinics.	The Private patient office should ensure that the Dermatology Directorate introduce formal processes to identify, ascertain and confirm overseas patient eligibility to access healthcare if they attend the clinics.	Executive Medical Director	01/12/2019	overdue by over 3 months but under 6 months
IA 1920	21/10/2019	Private and Overseas Patients	Executive Medical Director	Reasonable	7	R6/7	M	The Private and Overseas Patients Office should remind Directorates that an Overseas Patients Notification Form must be completed by the Consultant and submitted to the Private and Overseas Patients Office for each overseas patient seen, supported with documentary evidence of their residency entitlement to access free NHS treatment. The Private and Overseas Patients Office should formalise and regularly timetable the current processes to monitor and follow up on letters sent to those overseas patients that have received treatment and have not provided appropriate residency documentation to evidence their entitlement to free NHS care.	The Private and Overseas Patients Office will write to remind all Directorates that an Overseas Patients Notification Form along with any documentary evidence of their residency entitlement or insurance details must be completed by the Care Team and submitted to the Private and Overseas Patients Office for each overseas patient seen. The Private and Overseas Patients Office will formalise and regularly timetable the current processes to monitor and follow up on letters sent to those overseas patients that have received treatment and have not provided appropriate residency documentation to evidence their entitlement to free NHS care.			
IA 1920	21/10/2019	Private and Overseas Patients	Executive Medical Director	Reasonable	7	R7/7	M	The Private and Overseas Patients Office should implement and evidence documented quarterly reconciliation exercises in respect of its MS Access database to PMS and the debtors' ledger and of the database to activity data or review of aged debt statements as per the stated requirements of the Private Patients Procedure.	The Private and Overseas Patients Office will implement a Control Pack that evidences: quarterly reconciliation exercises in respect of the MS Access database; PMS and the debtors' ledger; the database to activity data; and a review of aged debt statements.			

Report Title:	External Audit Recommendation Tracking Report and Regulatory Tracker Report						
Meeting:	Audit Committee					Meeting Date:	3rd March 2020
Status:	For Discussion		For Assurance	X	For Approval		For Information
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	**Director of Corporate Governance**						

Background and current situation:

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

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

The External Audit tracker is demonstrating that actions are being completed within a timely manner with 48% of actions now complete with a further 23% not yet due for completion.

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

A review of all outstanding recommendations has been undertaken since December 2019 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 Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken in **17/18, 18/19 and 19/20** as at 21st February 2020.

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

Recommendation:

The Audit Committee Members are asked to:

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

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

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

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

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

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

CARING FOR PEOPLE
KEEPING PEOPLE WELL

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

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

External Audit	Complete	Not due	In progress	< 3 mths	> 3 mths	+6 mths	+ 1 year	Total
Structured Assessment 2018	13	5	6	-	1	2	-	27
Clinical Coding Follow Up	1	3						4
Discharge Planning	5	-	1	-	-	-	-	6
Primary Care Service	14	-	-	-	-	-	-	14
Review of GP Out of Hours Service	10	-	-	-	-	-	-	10
Review of Medical Equipment	-	-	-	-	-	5	3	8
Audit of Financial Statements	-	6	-	2	-	1	-	9
Structured Assessment 2019	1		1					2
Implementation of the Wellbeing of Future Generations Act		7	3					10
Total	**44**	**21**	**11**	**2**	**1**	**8**	**3**	**90**

From the above table it can be seen that after tracking these recommendation that 49% of actions currently on the WAO are complete and 23% are not yet due meaning that 28% are either in progress or overdue.

Audit Log Ref No.	Audit Reference	Financial Year Fieldwork Undertaken	Final Report Issued on	Audit Title	Executive Lead for Report	No. of Recs Made	Rec No.	Recommendation Narrative	Risk Identified/Intended Outcome	Management Response	Executive Lead for Recommendation	Operational Lead for Recommendation	Agreed Implementation Date	Committee Implementation Monitored by	Updated Implementation Date	Recommendation Status [RAG Rating]
WAO 1	1025A2019-20	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.	Not Provided	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		Agreed date not reached
WAO 1	1025A2019-20	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.	Not Provided	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	Head of Corproate Governance	Dec-16	Audit and Assurance Committee	Dec-19	Complete
WAO 1	1025A2019-20	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.	Not Provided	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	Head of Corproate Governance	Dec-16	Audit and Assurance Committee	Dec-19	Partially complete
WAO 1	1025A2019-20	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.	Not Provided	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	Head of Corproate Governance	Dec-16	Audit and Assurance Committee	Dec-19	Partially complete
WAO 1	1025A2019-20	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.	Not Provided	At December 2018, the October 2018 Finance Committee papers were not available on the Health Board's website.	Director of Governance	Head of Corproate Governance	Dec-16	Audit and Assurance Committee	Dec-19	Complete
WAO 1	1025A2019-20	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.	Not Provided	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	Head of Corproate Governance	Dec-16	Audit and Assurance Committee	Dec-19	Complete
WAO 1	1025A2019-20	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.	Not Provided	Progress to date: An up-to-date Information Governance strategy does not yet exist. The Health Board has drafted its strategic approach in the Information Governance Policy. The Health Board plans to agree and implement this approach later in 2018. NWIS has developed the information governance toolkit for primary care GP's and intend to monitor compliance at a GP cluster level. These compliance monitoring arrangements for are still being developed. The Primary Care Clinical Board is liaising with the NHS Wales Informatics Service to confirm and agree these arrangements. Information asset registers have been developed within the corporate directorates and clinical boards, but further work is required to fully complete this. The Health Board is planning further work to: identify personal information held; identify information flows; and identify information sharing arrangements. An interim Data Protection Officer (DPO) is in post as required under the GDPR. The Health Board expects to appoint an experienced and senior information governance manager to the statutory DPO function in early 2019. More staff have completed information governance training. However, compliance with information governance training (69%) is well below the national target (95%).	Director of Transformation and Informatics		Dec-16	Audit and Assurance Committee	Dec-19	Agreed date not reached
WAO 1	1025A2019-20	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R1g/11	R7 [2017] The Health Board needs to ensure that the level of information reported to the Resource and Delivery Committee on its performance is sufficient to enable the Committee to scrutinise effectively. This should include: ensuring that the Committee receives more detailed performance information than that received by the Board. Consideration should be made to including a summary of the Clinical and Service Board dashboards used in the monthly executive performance management reviews; expanding the range of performance metrics to include a broader range of key performance indicators relating to workforce. Consideration should be made to revisiting the previous workforce KPIs reported to the previous People, Planning and Performance Committee.	Not Provided	Overall this recommendation has been partly addressed. The S&D Committee continues to receive a high-level performance dashboard, which is less detailed than the performance report received by the Board. Since September 2018, the S&D Committee receives six-monthly updates against the workforce plans, including key workforce metrics.	Director of Transformation and Informatics		Dec-16	Audit and Assurance Committee	Dec-19	Partially complete

WAO 1	1025A2019-20	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.	Not Provided	In early 2018, the Health Board received an external review of cyber security arrangements. The review recommended improvements to cyber security arrangements. In response the Health Board is developing a formal cyber security improvement action plan. It plans to bring in specialist cyber security skills in early 2019 to address these recommendations and establish a specialist cyber security team.	Director of Transformation and Informatics		Dec-16	Audit and Assurance Committee	Dec-19	Agreed date not reached
WAO 1	1025A2019-20	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.	Not Provided	The Health Board plans to review in early 2019 the structure and governance of its information and information technology functions to deliver the digital strategy.	Director of Transformation and Informatics		Dec-16	Audit and Assurance Committee	Dec-19	Agreed date not reached
WAO 1	1025A2019-20	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;	N/A	Agreed this will be presented to the next Audit Committee	Director of Corporate Governance	Head of Corproate Governance	Feb-19	Audit and Assurance Committee		Complete
WAO 1	1025A2019-20	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	Head of Corproate Governance	Feb-19	Audit and Assurance Committee		Complete
WAO 1	1025A2019-20	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	Head of Corproate Governance	Feb-19	Audit and Assurance Committee		Complete
WAO 1	1025A2019-20	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		Complete
WAO 1	1025A2019-20	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R3b/11	b. Review and update the Standing Orders and Standing Financial Instructions, ensuring these documents are reviewed and approved on an annual basis;		Agreed and timetabled to be undertaken on an annual basis going forward	Director of Corporate Governance		Mar-19	Audit and Assurance Committee		Partially complete
WAO 1	1025A2019-20	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	1025A2019-20	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R3d/11	d. Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date;		Agreed	Director of Corporate Governance		Oct-19	Audit and Assurance Committee		Partially complete
WAO 1	1025A2019-20	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	1025A2019-20	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	1025A2019-20	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R4/11	The Health Board should update its performance management framework to reflect the organisational changes that have taken place since 2013.		We accept that the performance management framework should be reviewed to ensure it fully supports the organisational business.	Director of Transformation and Informatics		Sep-19	Audit and Assurance Committee		Partially complete
WAO 1	1025A2019-20	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	Audit and Assurance Committee		Complete
WAO 1	1025A2019-20	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	Audit and Assurance Committee		Complete

WAO 1	1025A2019-20	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R7/11	The Health Board should complete the outstanding actions from the Information Commissioner's Office (ICO) 2016 review of the Health Board's data protection arrangements.		CAV UHB is committed to continually improving mitigation of its risks of non-compliance. We are taking an improvement approach in line with the rest of Wales and in regular discussion with the ICO's office. Progress has been made on the registering of major assets and new flows of information. We intend to progress the assessment of our existing significant flows, adopting a risk based approach.	Director of Transformation and Informatics		Jun-19	Audit and Assurance Committee		Overdue by over 3 months but under 6 months
WAO 1	1025A2019-20	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R8/11	The Health Board should achieve full compliance with the General Data Protection Requirement by May 2019.		Delivery of the CAV UHB's updated action plan will reduce the risks we carry in relation to noncompliance with GDPR. Prioritisation of risks and mitigating actions are part of our continuous improvement plan, aimed at achieving full GDPR compliance during 2019.	Director of Transformation and Informatics		Dec-19	Audit and Assurance Committee		Agreed date not reached
WAO 1	1025A2019-20	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R9/11	The Health Board should improve its response times to requests for information from Freedom of Information Act and Data Protection Subject Access Requests.		CAV UHB has recently appointed additional staff resulting in a positive impact on response times for FOI and Subject Access Requests. This will be monitored as we continue to move towards achieving fully compliant response times.	Director of Transformation and Informatics		Mar-19	Audit and Assurance Committee		Overdue by over 6 months
WAO 1	1025A2019-20	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	Audit and Assurance Committee		Complete
WAO 1	1025A2019-20	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer		R11/11	The Health Board should routinely update IT Disaster Recovery plans after key changes to IT infrastructure and networks and at scheduled intervals and test plans to ensure they are effective		The CAV IT Disaster Recovery plan is reviewed annually at a minimum and in response to specific circumstances. Testing is undertaken (both Check list and Technical) and multiple system restores are performed successfully annually. Additional infrastructure and software have been put in place to improve this process. A schedule of testing is being developed as part of the technical roadmap work.	Director of Transformation and Informatics		Mar-19	Audit and Assurance Committee		Overdue by over 6 montyhs
	333A2017	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.	Appropriate, sustainable funding for the GP out-of-hours service.	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	Jane Brown	Oct-17			complete
	333A2017	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.	Better strategic and workforce planning to ensure appropriate staffing levels to cope with demand.	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	Jane Brown	Nov-17			complete
	333A2017	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.	Improved service performance and patient experience.	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	Ailsa Pritchard	Sep-17			complete
	333A2017	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.	Assurance that clinical contacts are of high quality.	Agreed audit process in place; feedback to OOHs QSE meeting.	Chief Operating Officer	Helen Earland/ Sherard Lemaitre	Sep-17			complete
	333A2017	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	Better data quality, leading to better performance management.	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	Ailsa Pritchard	Oct-17			complete

	333A2017	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.	Better public understanding and use of GP out-of-hours services.	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	Ailsa Pritchard	Dec-17			complete
	333A2017	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.	Better public understanding and use of GP out-of-hours services.	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	Jane Brown	Oct-17			complete
	333A2017	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.	Better public understanding and use of GP out-of-hours services.	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	Jane Brown	Nov-17			complete
	333A2017	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.	Reduced demand on GP out-of-hours from certain GP practices.	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	Jane Brown	Sep-17			complete
	333A2017	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.	Better clinical information to inform contacts within the GP out-of-hours service.	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	Jane Brown/ Gareth Bulpin	Aug-17			complete
WAO 14	614A2018-19	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			overdue by over 12 months
WAO 14	614A2018-19	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			Overdue by over 6 months
WAO 14	614A2018-19	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science		R3/8	R3 Review medical equipment risk management throughout the organisation, ensuring alignment between the corporate and operational approach.		Ensure CBs capture medical equipment risks as part of their risk management processes. These will be monitored via MEG, and escalated through relevant strategic committees, eg Strategy and Resources/Capital Management/QSE/Management Executive as required.	Director of Therapies & Health Science	Deputy Director of Therapies & Health Science	Apr-19			Overdue by over 6 months
WAO 14	614A2018-19	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			Overdue by over 6 months
WAO 14	614A2018-19	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science		R5/8	R5 The Medical Equipment Group should assure itself that clinical boards operate effective systems and processes for the monitoring, purchase and replacement of medical equipment below £5,000.		Ensure MSDOs include key under £5,000 items on their risk log and escalate replacement needs within the CB. Ensure medical devices procurement officer scrutinises under £5,000 items to identify opportunities for standardisation and efficiency	Director of Therapies & Health Science	MSDOs Medical devices procurement officer	Jan-19			Overdue by over 6 months
WAO 14	614A2018-19	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science		R6/8	R6 Ensure that Clinical Boards include the Medical Device Safety Officer report as a standing agenda item at the Quality, Safety and Experience meetings to discuss and address any medical equipment risks and incidents that arise.		Develop MDSO metrics for reporting to their CB QSE meetings, and MEG reporting.	Director of Therapies & Health Science	Director of Therapies & Health Science	Nov-18			overdue by 12 months

WAO 14	614A2018-19	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science		R7/8	R7 Ensure all relevant service areas collaborate, consult and engage on medical equipment issues. It should give particular attention to the arrangements in place for maintenance and replacement of beds and hoists.		Monitor attendance and engagement of CB MSDOs and other members at MEG, escalate non-attendance or lack of engagement. Monitor progress of action plan developed by Health and Safety Advisor following the Arjo Proact 2017 survey Health and Safety Committee 18/005 minute (25 January 2018). Maintain hoists within the Clinical Engineering Department at the end of external supplier contract. Ensure Clinical Engineering is represented at the Bed Management Group	Director of Therapies & Health Science	Deputy Director of Therapies & Health Science	Dec-18			overdue by over 6 months
WAO 14	614A2018-19	2018-19	Jun-18	Review of Medical Equipment: Update on Progress	Director of Therapies & Health Science		R8/8	R8 Evaluate the medical equipment arrangements in place within Pathology Services (Laboratory Medicine).		Agree Pathology MDSO role with CD&T with same CB functions at a directorate level reporting through to CB MDSO.	Director of Therapies & Health Science	Director of Therapies & Health Science	Nov-18			overdue by over 12 months
WAO 15	276A2019-20	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.	To ensure plans are able to meet population projections.	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			Complete
WAO 15	276A2019-20	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.	To encourage public support for the 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	Director of Operations, PCIC	Dec-18			Complete
WAO 15	276A2019-20	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.	To establish a baseline from which to measure the resource shift towards primary 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	Assistant Director of Finance	Oct-18			Complete
WAO 15	276A2019-20	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.	To understand progress made in moving resources from secondary to primary care.	Build into IMTP annual review process.	Director of Finance	Assistant Director of Finance	Mar-20			Complete
WAO 15	276A2019-20	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. .	To establish a robust evidence base of benefits to help inform decision making.	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	Director of Operations, PCIC	Mar-20			Complete
WAO 15	276A2019-20	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.	To support development of the 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	Director of Operations, PCIC	Nov-18			Complete
WAO 15	276A2019-20	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.	To help ensure a long-term future for new models of care.	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	Assistant Director of Finance	Mar-19			Complete
WAO 15	276A2019-20	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.	To educate the public about alternative first points of contact available.	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	Director of Operations, PCIC	Dec-18			Complete

WAO 15	276A2019-20	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.	To support development of the clusters.	Continue to prioritise the OD (Organisational Development) programme for cluster development.	Chief Operating Officer	Director of Operations, PCIC	Mar-19			Complete
WAO 15	276A2019-20	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.	To ensure clusters have the right representation.	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	Director of Operations, PCIC	Nov-18			Complete
WAO 15	276A2019-20	2018-19	May-19	Primary care services	Chief Operating Officer		R5c/6	c. Ensure all cluster leads attend the Confident Primary Care Leaders course	To strengthen cluster leadership.	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	Director of Operations, PCIC	Dec-18			Complete
WAO 15	276A2019-20	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. .	To increase the Board's understanding of primary care performance.	Review currently being undertaken of Performance reporting to the Board and its Committees.	Director of Transformation and Informatics		Nov-18			Complete
WAO 15	276A2019-20	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.	To increase the Board's understanding of primary care performance.	See R6a	Director of Transformation and Informatics		Nov-18			Complete
WAO 15	276A2019-20	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	To raise Board awareness of the impact of primary care transformation on patients	See R6a	Director of Transformation and Informatics		Nov-18			Complete
WAO 16	166A2017-18	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.	Wider and up to date information on community services to help patients on discharge.	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.	Chief Operating Officer	Head of Integrated Care	Dec-18			Complete
WAO 16	166A2017-18	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.	Ward staff are better informed and know where to find information about community services.	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	Head of Integrated Care	Dec-18			Complete
WAO 16	166A2017-18	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.	Patients and carers have a say in policy reviews and development meaning they are equal partners in the process.	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	Head of Integrated Care	Oct-17			Complete

WAO 16	166A2017-18	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.	Staff are well informed, leading to a consistent application of the discharge policy and pathways across the Health Board.	There is now a well-developed 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 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. (160 session delivered to date 280 staff attended) Longer-term Plan Work ongoing with Learning and Development department to facilitate Discharge Planning within undergraduate Therapy and Nurse training programmes. Work is progressing with LED colleagues to formalise the monthly	Chief Operating Officer	Head of Integrated Care	Nov-17			Complete
WAO 16	166A2017-18	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.	Training delivery method, which is convenient for ward staff with limited time.	Work is ongoing with LED colleagues to develop a discharge planning focused e-learning resource.	Chief Operating Officer	Head of Integrated Care	Dec-18			Partially complete
WAO 16	166A2017-18	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.	Better discharge planning because staff are well trained, offered regular refresher courses and the Health Board has a record of training compliance.	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	Head of Integrated Care/CBs	Dec-18			Complete
WAO 16	1185A2019-20	2019-20	Jun-19	Clinical Coding Follow-up	Director of Transformation and Informatics	1	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	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	Director of Digital Healthcare and Informatics	Sep-19	Audit and Assurance		Complete
WAO 17	1185A2019-20	2019-20	Jun-19	Clinical Coding Follow-up From 2014 not yet completed	Director of Transformation and Informatics		R1	**Clinical Coding Resources:** Strengthen the management of the clinical coding team to ensure that good quality clinical coding data is produced. This should include: c) ensuring that there is capacity to allow band 4 coders to undertake mentoring and checking of coding of band 3 staff in line with job descriptions; d) revisiting the allocation of specialities across staff to ensure that there is sufficient flexibility within the existing capacity to cover periods of absence and succession planning is in place for staff who are due to retire in the next five to ten years; g) increasing levels of engagement between the different teams within the Health Board, to provide opportunities to raise issues, develop peer support arrangements and share knowledge; h) updating the clinical coding policy to reflect the current operational management arrangements; and k) increasing the range of validation and audit processes, including the consideration of the appointment of an accredited clinical coding auditor.								

WAO 17	1185A2019-20	2019-20	Jun-19	Clinical Coding Follow-up From 2014 not yet completed	Director of Transformation and Informatics		R2	**Medical Records:** R2 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include: a) reinforcing the Royal College of Physician (RCP) standards across the Health Board and developing a programme of audits which monitors compliance with the RCP standards; b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS); c) putting steps in place to ensure that notes that require coding are clearly identified at ward level and that clinical coding staff have early access to medical records, particularly at UHW; e) reducing the level of temporary medical records in circulation; f) considering the roll out of the digitalisation of health records to the Teenage Cancer Unit to allow easier access to clinical information for clinical coders; and g) revisiting the availability of training on the importance of good quality medical records to all staff.								
WAO 17	1185A2019-20	2019-20	Jun-19	Clinical Coding Follow-up From 2014 not yet completed	Director of Transformation and Informatics		R3	Board Engagement: Build on the good level of awareness of clinical coding at Board to ensure members are fully informed of the Health Board's clinical coding performance. This should include: c) raising the awareness amongst Board members of the wider business uses of clinically coded data.								
WAO 18	1391A2019-20	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R1	**1: the 'retire and return' arrangements require strengthening** The Health Board should strengthen its current guidance so that it clearly sets out all the key elements of the DoH guidance. The revised guidance should include all the DoH's employer-checks, which the Health Board should always apply and clearly evidence when assessing a business case for an employee to retire and return. The Health Board should ensure that its updated guidance is shared with all Clinical Boards and Departmental Heads.		The Health Board is currently reviewing the Retire and Return Procedure in partnership with Trade Unions. The purpose of this review is to reduce inconsistencies in the way that it is applied across the UHB by reducing the level of manager's discretion involved and ensuring that applications can only be rejected for robust business reasons. Reference will be made to the DoH guidance and checklist as appropriate. Reference will also be made to the other flexible retirement options to raise awareness of the flexibilities available.			Feb-20			
WAO 18	1391A2019-20	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R2	**2: the quality of the draft 'Remuneration and Staff Report' requires improvement** The Health Board should review why the level of error increased for 2018-19; and it should strengthen the management review and 'sign-off' of the Remuneration and Staff Report prior to its submission to us for audit.		Prior to the end of the financial year a co-ordinating meeting will be held between the appropriate staff in finance, governance and HR to ensure that the information presented in all sections of the annual report is consistent and accurate.			Mar-20			
WAO 18	1391A2019-20	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R3	**3: the Annual Governance Statement requires a revamp** The Health Board should review the style, structure and content of its 2019-20 AGS. The Health Board should look to complete the review by early 2020 so that it has an agreed basis for its preparation and submission for audit. If the Health Board wishes, we could provide audit input into its early review of the style, structure and content of the 2019-20 AGS.		Accept this finding and agreed to do a much more concise document for 2019/20 and also agree to get early input from WAO into the document. It would be useful if WAO could sign post Cardiff and Vale to a LHB who have developed a good document which meets all the requirements			May-20			
WAO 18	1391A2019-20	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R4	**4: the Phase 2 and Phase 3 continuing healthcare claims require concluding** The Health Board should establish the reason for the ongoing delay with each of the remaining Phase 2 and Phase 3 claims and it should seek to conclude them promptly		Phase 2 – awaiting grant of probate for one claim. Face to face meetings required for both claims Phase 3 –Work during the first quarter of 2019-20 has left 61 cases open; 6 are planned for reimbursement imminently, 25 have been reviewed but are not yet ready for reimbursement due to requiring further meetings, negotiation, panels etc.,30 are not yet reviewed, Good progress continues to be made as agreed within the available resource which includes additional staff employed, with the intent to continue to conclude cases promptly			Mar-20			
WAO 18	1391A2019-20	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R5	**5: some of the related party declarations require more detail** The Health Board should review its guidance to IMs and SOs to ensure that it is clear on the level of detail required in their annual related party declarations. The Health Board's Finance Team should promptly return any inadequate information to the relevant IM / SO, and request their prompt clarification.		Agreed and in future we will ensure that there is clarity in relation to the detail provided so checks can be made			Mar-20			
WAO 18	1391A2019-20	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R6	**6: some of the arrangements around the year-end stocktake require improving** The Health Board should ensure that all officers who undertake and record stock counts are regularly trained so that they fully understand the procedures and key requirements that are in in place.		Your findings will sent out with the annual stock taking instructions at the end of January 2020, with clear instructions that all Clinical Boards comply with your recommendation.			Mar-20			

WAO 18	1391A2019-20	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R7	**7: there is no contract for the GHX electronic invoicing system** The Health Board should confirm with NWSSP whether a contract with the supplier is now in place. If there is still no contract with the supplier, the Health Board should evaluate any associated risks and if necessary consider suspending its use of the portal until a suitable contract is in place.		The GHX system was developed by the Main Medical Consumable Suppliers and NWSSP pay an annual fee to use the system on behalf of NHS Wales. It is a system that is used widely throughout the NHS and represents the only mechanism which NHS Wales can pay a number of the major NHS Suppliers. GHX are based on the G cloud framework and NWSSP will look to enter into a more formal arrangement for the service in the future			31-Dec-19			
WAO 18	1391A2019-20	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R8	8: there is an absence of classifying prepayments between short term and long term The Health Board should remind all relevant officers of the importance of considering the classification of prepayments, in terms of the period that they cover and whether any of the year-end prepayments extend beyond two months after 31 March year-end. The Health Board should ensure that its review of the draft financial statements is sufficiently robust in this area, prior to the submission of the statements for our audit.		The Head of Financial Accounting will request an amendment to the All Wales Coding Structure to set up a new code for prepayments due > 1 year. Your recommendation will then be shared with all finance staff with a clear instruction to use the new code as appropriate.			01-Sep-19			
WAO 18	1391A2019-20	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R9	9: the accounting for purchase-order accruals requires improvement The Health Board should review its arrangements for the identification and assessment of the year-end purchase order accruals. The review should consider the adequacy of the accruals process in place, and whether the relevant staff receive adequate training each year.		The Health Board will provide additional guidance to staff and implement additional training and review processes to ensure that the accuracy of the accrual in 2019-20.			Mar-20			
WAO 19	1604A2019-20	2019-20	Nov-19	Structured Assessment	Chief Executive	2	R1	**Committee meeting frequency and timing** R1 We found scope to review the timings and frequency of some committee meetings to support members to scrutinise current information more often. Reviewing timings will also allow maximum attendance at meetings. The Health Board should: a) Review the frequency of Audit Committee meetings to close the gap between the May and September meeting. b) Review independent member's capacity and timings of committee meetings where there is infrequent independent member attendance		Agree this can be achieved an additional meeting will be added in for July which will also coincide with other meetings taking place in July 2020. This is already under review with the change in Chair and Vice Chair. Current proposals include increasing the membership of each Committee to ensure the meetings are quorate.		Director of Corporate Governance Director of Corporate Governance / Interim Chair of the UHB	Dec 19 Dec 19			
WAO 19	1604A2019-20	2019-20	Nov-19	Structured Assessment	Chief Executive	2	R2	**Performance Management Framework** R2 We found that performance monitoring at an operational level is sound, but some information received by the Board and its committees need to be improved. When the Health Board restarts its performance framework review it should be extended to include: • Monitoring IMTP delivery on a quarterly basis and reporting the wholescale position to the Strategy and Delivery Committee and Board. We have previously suggested presenting the committee with a summarised version of the IMTP progress reports available at clinical board performance reviews. • Ensuring that the Strategy and Delivery Committee receives, the same or more, detailed performance information than that received by the Board.		Agree to recommendation. The flash report which is used for Performance Reviews will be sent to Strategy and Delivery of a quarterly basis. December 2019 we will start from the beginning of the New Year and send to the S&D Committee in January 2020 Agree to the recommendation. The performance information is currently under review alongside other performance information to the Committees to ensure a consistent approach and that assurance can then be appropriately provided to the Board from each Committee.		Director of Planning Director of Digital and Health Intelligence	January 2020 January 2020			
WAO 20	1509A2019-20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R1	**Long-term** Further enhance the profile of primary care by building upon the successes of existing promotional campaigns.		We will continue to build on the Primary Choice campaign to promote Primary Care.		Director of Operations, PCIC	Ongoing			
WAO 20	1509A2019-20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R2	2 Develop a campaign to educate the public about what types of services will be available at each of the centres and hubs.		We have an active engagement programme for each of the Wellbeing Hubs and Health and Wellbeing Centres, we will continue to evolve our engagement working with local organisations, public health colleagues and community groups to promote the services in each centre.	Director Planning		Dec-21			
WAO 20	1509A2019-20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R3	3 Use examples of successfully moving services from secondary to community and primary care to promote and sustain a shift in resources from other services that could be provided closer to home.		Supporting services to move to community delivery is a core element of the Health Board's Integrated Medium Term plan. Through this process we are celebrating and promoting examples of good practice.	Director Planning		Ongoing			
WAO 20	1509A2019-20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R4	4 Develop a model to monitor and review the impact and benefits of the centres and hubs. Use a blended approach that includes outcome measures, data, exemplar projects and patient stories to show not only cost effectiveness but also the positive impact on patient experience.		The Regional Partnership Board is developing an Outcomes Framework which will provide a tool to support the evaluation of the impact of Health and Wellbeing Centres and Wellbeing Hubs.	Director Planning		Jul-20			

WAO 20	1509A2019-20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R5	**Prevention** 5 Undertake needs assessments on an ongoing basis and continually review services to ensure that centres and hubs remain current and fit for purpose.		Primary Care Clusters are required to produce plans to meet the needs of their populations, this will include considerations of Wellbeing Hub services once established. These plans will take into account evidence from wider needs assessments including future updates to the population assessment required under the Social Services and Wellbeing Act and the Wellbeing Assessment required under the WFG Act		Director of Operations, PCIC	Annually			
WAO 20	1509A2019-20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R6	6 Develop a clear plan to agree finances prior to centre and hub services commencing to prevent duplication of resources.		This will form part of the operating model of the Wellbeing Hubs.	Director of Public Health		Nov-21			
WAO 20	1509A2019-20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R7	**Integration** 7 Undertake a community services mapping exercise for each of the localities to identify services it could signpost patients to if they fall		We will be undertaking this mapping on a locality and cluster basis in partnership with existing tools and services such as Dewis Cymru.	Director of Planning		Oct-21			
WAO 20	1509A2019-20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R8	**Collaboration** 8 Develop some overarching principles for the centres and hubs operating model which allow for some local variation based on community need.		We will establish an overarching operating model for the Health and Wellbeing Centre and Wellbeing Hubs focussed on operating as single assets and supporting community ownership.	Director of Planning		Oct-21			
WAO 20	1509A2019-20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R9	**Involvement** 9 Explore the best vehicles to engage marginalised citizens both in terms of planning future centres and hubs and in ensuring they are accessible to all when in operation. For example, by finding community leaders to help roll out key messages and engage with these groups on an ongoing basis.		We will ensure this forms part of the engagement plan for each project.	Director of Planning		Oct-21			
WAO 20	1509A2019-20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Public Health	10	R10	10 Include a question in the IMTP template which asks how clinical boards will reach marginalised groups.		Considerations of service developments and engagement with marginalised groups already form part of the development of IMTPs.	Director of Planning		Oct-21			

Report Title:	Timetable For the Production of the 2019-20 Annual Report							
Meeting:	Audit Committee					Meeting Date:	03/03/2020	
Status:	For Discussion	x	For Assurance		For Approval	x	For Information	
Lead Executive:	Director of Corporate Governance							
Report Author (Title):	Interim Head of Corporate Governance							

Background and current situation:

The Welsh Government has issued, as in previous years, guidance for the preparation of annual reports and accounts. This guidance is based on HM Treasury's Government Financial Reporting Manual (FReM)1 and is intended to simplify and streamline the presentation of the annual reports and accounts so that they better meet the needs of those who read and use them.

NHS bodies are required to publish, as a single document, a three part annual report and accounts document, which must include:

Part 1 The Performance Report, which must include:
• An overview
• A Performance analysis

Part 2 The Accountability Report, which must include:
• A Corporate Governance Report
• A Remuneration and Staff Report
• A Parliamentary Accountability and Audit Report

Part 3 The Financial Statements

The Draft Annual Report including the Performance Report, Accountability Report and Financial Statements (Accounts) must be completed and submitted to Welsh Audit Office by the 6th May 2020.Therafter the final document must be submitted to Welsh Government by 29th May 2020.

Further detail on the content and format of the Annual Report and who is responsible for each aspect can be found at Appendix 2

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

The purpose of this report is to provide the Audit Committee with the opportunity to discuss and comment on the draft timetable for the production of the 2019 - 20 Annual Report (see *Appendix 1*).

The timetable highlights proposed amendments and/or requirements for additional 'out of committee' action that will be required to in order to accommodate the reporting timeframes set by Welsh Government.

The timetable has been considered by the Management Executive whose teams will be completing the various elements of the report.

Following consideration by the Audit Committee, a copy of the timetable will be shared with Wales Audit Office (WAO) and Internal Audit to ensure that they are aware of the points at which draft and final documents will be made available to them for audit and scrutiny.

The suite of documents that make up the 2019-20 Annual Report will be presented at the Annual General Meeting scheduled for 30 July 2020.

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

Given the tight timescales involved in the preparation of the Annual Report it is important that the timetable and the summary document at Appendix 2 are noted and approved so that work can begin urgently.

Recommendation:

The Audit Committee is asked to:

REVIEW and APPROVE the proposed timetable and approach for the Annual Report 2019-20;

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	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	
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.*

Appendix 1

ANNUAL REPORT AND ACCOUNTS TIMETABLE 2019/20

Date	Meeting	Required	Completed
3rd February	Nicola Foreman, Aaron Fowler, Ceri Knight	Initial briefing meeting	✓
10th February	Management Executives	Annual Report Contents and Format List and timetable to be approved.	✓
18th February	Nicola Foreman, Aaron Fowler, Mark Jones (WAO) and Rhodri Davies (WAO)	Meeting to discuss Performance Report and Accountability Report	
3rd March	Audit Committee	Annual Report Contents and Format List and timetable to be approved	
16th March	Nicola Foreman, Aaron Fowler and Ceri Knight	Review progress of Review Draft Annual Report (including performance Report and Accountability Report)	
13th April	Management Executives	Review Draft Annual Report (including performance Report and Accountability Report) and Financial Statements	
21st April	Audit Committee	Review Draft Annual Report (including performance Report and Accountability Report) and Financial Statements	
6th May 2020	WAO	Submission of Draft Annual Report Review Draft Annual Report (including performance Report and Accountability Report)	
TBC following meeting with WAO	WAO	Submission of Draft Financial Statements	

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on 18th February			
TBC following meeting with WAO on 18th February	WAO Meeting and Cardiff and Vale Officer	Discuss Draft Audit Report	
TBC following meeting with WAO on 18th February	WAO	Final Audit Report Issued	
28th May (AM)	Audit Committee	Review Annual Report and Financial Statements and recommend approval to the Board Receive WAO on Financial Statements	
28th May (PM)	Board Meeting	Approve Annual Report and Financial Statement and recommend and consider WAO on Financial Statements	
30th May	Welsh Government	Submission of Whole of Government Accounts Return to Welsh Government	
30th July	AGM	Presentation of Annual Report and Financial Statement and Quality Account.	

Appendix 2

Annual Report and Accounts 2019/20

Contents / format

The Annual Report & Account comprises three main elements: **A. The Performance Report (including an overview and a performance analysis)** **B. The Accountability Report (including a corporate governance report, a remuneration and staff report, a National Assembly for Wales Accountability and Audit Report)** **C. The Financial Statements (include the Audited Annual Accounts 2019/20)** All three sections are signed by the Accountable Officer in addition to the Annual Governance Statement	**Executive**	**Who provides the information/where can it be sourced**
A. Performance Report		
(1) Overview		
A joint statement from the CEO and Chair providing their perspective on performance of the organisation during 2019/20 – need to document IMTP status and include financial duties.	**Len /Jan**	Ceri Knight to meet with LR and CJ to prepare statement.
A statement of the purpose and activities of the organisation – summary of diagnostic phase of plan, duties against delivery framework and wider duties – Human rights, CHC and welsh language.	**Len/ Abi/Martin**	
The key issues and risks that could affect the entity in delivering its objectives – also include where not going to deliver against national targets, reasons why and what we are doing to improve.	**Nikki**	**B.A.F Document**
An explanation of the adoption of the going concern basis.	**Bob**	
Performance on other matters promoted by HM Treasury.	**Bob**	
Performance Summary – summary of achievements against plan and areas improvements required should be high level and cover each part of performance section.	**Jonathon/ Steve**	

(2) Performance Analysis Report / summary on delivery against performance measures: - Each delivery framework domain - Delivery against finance and workforce plans - Wider performance matters inc partnership working - Main achievement against service specific delivery plans and delivery against local requirements	**Jonathon/ Martin/Steve**	
Information on how we measure performance – What are our KPI's, how we check performance against measures and a narrative to explain the link between KPIs, risk and uncertainty	**Martin/Steve**	
Detailed analysis and explanation of the development and performance of the entity during the year and an explanation of the relationships and linkages between different pieces of info. Use a wide range of data including key financial information from financial statements.	**Martin/Steve/Bob**	
Non-financial information including social matters, respect for human, rights anti-corruption and anti-bribery matters.	**Nikki**	
Environmental matters including the impact of the UHB on the environment. - Mandatory sustainability Reporting.	**Abi**	**PES Guidance available.**
A page or two on each domain and where delivery is against plan/national target and reasons for none delivery. - Trend analysis where delivery not met demonstrating where/when delivery will be met	**Steve**	
Locally developed measures we have used in our local reporting. - Key financial and workforce information from the financial statements to be included to demonstrate the integrated nature of plans.	**Bob**	
Information on investments and disinvestments and why and what it has achieved.	**Bob/Abi**	
Performance of other matters raised during the year – such as specific issues raised in the public domain e.g. HIW and WAO reports.	**ALL**	
(3) Well-being of Future Generations (Wales) Act 2015 – Well-being Statement of Annual Reporting		
Publish a statement explaining our Well-being objectives and explain why the objectives will help the UHB achieve its goals and how the sustainable development principle has been or will be applied – Must reflect	**Abi?**	

diversity of UHB area.		
Must publish Annual Report showing progress in meeting objectives –The UHB can provide a link to a published statement which the UHB may have made regarding its well-being objectives and ensure that these objectives are reflected in the Performance Report.	**Abi?**	
(4) Annual Quality Statement		
Requirement to produce an Annual Quality Statement by 29th May 2020. This is made available separately to the Annual Report and Accounts but Annual Report and Accounts must include a reference on how AQS can be accessed.	**Ruth**	
(5) Sustainability Report – See annex 5 of Chapter 2 guidance – copy attached	**Abi**	
(6) Other Mandatory items		
Patterns of primary and secondary care expenditure over the last 5 years should be disclosed with performance against Resource Limits included.	**Bob**	
B. Accountability Report (reviewed by auditors for consistency with financial statements)		
Introduction to Accountability Report to mirror 2018/2019 version.		**Ceri Knight**
(1) Corporate Governance Report To explain the composition of the organisation and the entity's governance structures and how they support the achievement of objectives. Comprises three elements:	**Nikki**	
(i) The Directors report – to include the following:	**Nikki**	
Names of Chairman and Chief Executive and Directors during the financial year up to the point the ARA is approved		
Composition of the management Board (including advisory and non-executive members)		
Names of Directors forming an Audit Committee		**Glynis Mulford**
Details of company directorships of other significant interests held by members of the Board		**Laura Tolley – DOI database.**
Information of personal data related incidents where these have been reported to the information commissioners office. This should be referred to the AGS and a reference to the comments in the AGS should be included within the Directors Report.	**Jonathon**	**James Webb**

Information on environmental, social and community issues	**Abi**	
Statement for public sector information holders confirming they have complied with the cost allocation and charging requirements set by HM Treasury – To be signed by LR.	**Bob**	
(ii) Statement of Accountable Officers Responsibilities		
Accountable Officer to explain responsibility for preparing the financial statements	**Nikki/Len**	
Accountable Officer to confirm that as far as he or she is aware there is no relevant audit information of which the entities auditors are unaware and as Accountable Officer has taken all the steps necessary to make himself aware of any audit information.	**Nikki/Len**	
Accountable Officer to confirm that the annual report and accounts as a whole is fair and balanced.	**Len**	
(iii) Statement of Directors' responsibilities in respect of the accounts		
Previously included in the Annual Accounts – It should be signed by the Chair, CEO and FD	**Jan, Len, Bob**	
(iv) Annual Governance Statement	**Nikki**	
Key feature of annual report and accounts and demonstrates publicly the management and control of resources and extent the UHB complies with its own governance requirements		
Brings together annual report and disclosures relating to governance, risk and control		
Should add value to the effectiveness of corporate governance and internal control		
Optional - Modern Slavery Act 2015 statement.		
(2) Remuneration and staff Report Sets out organisations remuneration policy for directors and senior managers and how the policy has been implemented. Sets out amounts awarded to directors and senior managers and where relevant the link between performance and remuneration. Should include Executive Members and Board Secretaries as well as non-Executive Members and associate members.	**Bob/Martin**	
Disclosure Information about named individuals will be given in all circumstances		
Remuneration Relationship Details of remuneration relationship are reported in the Annual Accounts and a reference should be made to note where this is included within the accounts.		

(i) **Remuneration Report** – to include the following information where relevant: • Details of the Remuneration Committee and ToR • Statement on policy of remuneration of senior managers for current and future financial years • Explanation of methods used to assess whether performance conditions were met • Explanation of remuneration subject to performance • Summary and explanation of duration of contracts, notice periods and termination arrangements • Details of service contracts for each senior manager who has served during the year • Details of significant awards made to past managers • Salaries and other remuneration (Pensionable and Non – Pensionable). • Other remuneration (e.g. Golden Hellos or compensation for loss of office). • Name and title of any senior manager that has been appointed or resigned during the year. • Performance related bonuses. • Benefit in Kind.		

(ii) Staff report Must include the following information:	**Martin**
Staff numbers	
• Staff numbers - analysed in the groupings within the accounts (staff on outward secondment should not be included). - Average number of employees is calculated as the WTE number of employees under contract of service each week in the financial	

year, divided by the number of weeks in the financial year. - The "contracted hours" method of calculating whole time equivalent numbers should be used.	
•	
• Staff composition – number of employees of each sex who were directors, senior managers and employees	
• Sickness absence data	
• Staff policies applied during the year:	
- For giving full and fair consideration to applications for employment made by disabled persons, having regard to aptitudes and abilities	
- For continuing the employment of, and for arranging appropriate training for, employees who became disabled during the period they were employed.	
- For training, career development and promotion of disabled employees.	
- Diversity issues and equal treatment in employment and occupation	
- For other employee matters such as diversity issues, equal treatment, health and safety, pay policy etc.	
• Expenditure on consultancy	
• Off payroll engagements	
(3) National Assembly for Wales Accountability and Audit Report Should contain disclosure on the following:	**Bob**
(i) Regularity of Expenditure	
(ii) Fees and charges	

(iii) A Statement if the entity has not complied with cost allocation and charging requirements set out by HM Treasury	
(iv) Statement of material remote contingent liabilities	
(4) Audit Certificate and AGW Report Report from Auditor	**Auditor**
C. The Financial Statement 2018/19	

Report Title:	Audit and Assurance Committee – Terms of Reference							
Meeting:	Audit and Assurance Committee				Meeting Date:		3rd March 2020	
Status:	For Discussion	x	For Assurance		For Approval	x	For Information	
Lead Executive:	Director of Corporate Services							
Report Author (Title):	Director of Corporate Services							

Background and current situation:

In line with the UHB's Standing Orders, Terms of Reference for Committees of the Board, should be reviewed on an annual basis.

This report provides Members of the Audit and Assurance Committee with the opportunity to review the Terms of Reference prior to submission to the Board for approval.

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

The Terms of Reference for the Audit and Assurance Committee were last reviewed in February 2019 and approved by the Board in March 2019 therefore, only a few changes have been recommended.

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

The Terms of Reference for the Audit and Assurance Committee have been reviewed by the Director of Corporate Governance. There are a limited number of changes to the document, these have been tracked and left in the draft so Committee Members can identify the changes that have been made since approval by the Board in March 2019.

Recommendation:

The Audit and Assurance Committee is asked to:

APPROVE the changes to the Terms of Reference for the Audit and Assurance Committee and **RECOMMEND** the changes to the Board for approval.

Shaping our Future Wellbeing Strategic Objectives

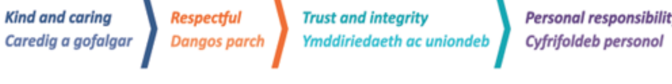
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	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	
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	x	Long term		Integration		Collaboration		Involvement	

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



Audit and ~~Risk~~ Assurance Committee

Terms of Reference

~~Updated November 2018~~Reviewed by Audit and Assurance Committee: 3rd March 2020
Approved by the Board: 27th March 2020

AUDIT AND ~~RISK~~ ASSURANCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The UHB Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the LHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In line with Standing Orders (3.4.1) and the UHB Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Audit and ~~Risk~~ Assurance Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

2. PURPOSE

2.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the UHB's assurance framework - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the UHB's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its assurance framework may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- the adequacy of the UHB strategic governance and assurance framework and processes for risk management and internal control designed to support the Accountable Officer's statement on internal control, providing reasonable assurance on:

- the organisations ability to achieve its objectives;
- compliance with relevant regulatory requirements, standards and other directions and requirements set by the Welsh Government and others;
- the reliability, integrity, safety and security of the information collected and used by the organisation;
- the efficiency, effectiveness and economic use of resources; and
- the extent to which the organisation safeguards and protects all its assets, including its people
- the adequacy of the arrangements for declaring, registering and handling interests at least annually
- the adequacy of the arrangements for dealing with offers of gifts or hospitality

to ensure the provision of high quality, safe healthcare for its citizens;

- the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;
- the Schedule of Losses and Compensation;
- the planned activity and results of internal audit, external audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);
- the adequacy of executive and managements response to issues identified by audit, inspection and other assurance activity;
- anti-fraud policies, whistle-blowing processes and arrangements for special investigations; and
- any particular matter or issue upon which the Board or the Accountable Officer may seek advice

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by:

- reviewing the ***comprehensiveness*** of assurances in meeting the Board and the Accountable Officers assurance needs across the whole of the UHB's activities, both clinical and non-clinical;

- reviewing the ***reliability and integrity*** of these assurances; and

- considering and approving policies as determined by the Board.

3.3 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- there is an effective Internal Audit function that meets the standards set for the provision of Internal Audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- there is an effective Counter Fraud Service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Quality, Safety and Experience Committee;

- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees

- the work carried out by key sources of external assurance, in particular, but not limited to the UHB External Auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity

- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;.

- the systems for financial reporting to the Board, including those of budgetary control, are effective; and that

- the results of audit and assurance work specific to the UHB, and the implications of the findings of wider audit and assurance activity relevant to the UHB's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations governance arrangements.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- any other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.6 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit Committee.

3.7 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.8 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.9 The Committee may, subject to the approval of the UHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members, comprising:

Chair	Independent member of the Board
Vice Chair	Chosen from amongst the Independent members on the Committee
Members	At least one other independent members of the Board *[one of which should be the member of the Quality and Safety Committee (or equivalent)]*

The committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance

Chief Executive
Director of Finance (Lead Executive)
Director of Corporate Governance
Head of Internal Audit
Local Counter Fraud Specialist
Representative of External Auditor
Other Executive Directors will attend as required by the Committee Chair

4.3 By invitation

The Committee Chair may invite:

- any other UHB officials; and/or
- any others from within or outside the organisation
- to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 Secretary - As determined by the Director of Corporate Governance

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair - taking account of the balance of skills and expertise necessary to deliver the committee's remit and subject to any specific requirements or directions made by the Assembly Government.

4.6 Committee members' terms and conditions of appointment, (including any remuneration and reimbursement) are determined by the Board, based upon the recommendation of the UHB Chair {and on the basis of advice from the UHB's Remuneration and Terms of Service Committee}.

Support to Committee Members

4.7 The Director of Corporate Governance , on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of organisational development for committee members as part of the UHB's overall OD programme developed by the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the Committee, one of whom should be the committee Chair or Vice Chair.

Frequency of Meetings

5.2 Meetings shall be held no less than quarterly, and otherwise as the Chair of the Committee deems necessary – consistent with the UHB annual plan of Board Business.

Withdrawal of Individuals in Attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the UHB overall framework of assurance.

6.5 The Committee shall embed the UHB's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of committee minutes and written reports throughout the year;
- bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive (and Accountable Officer) or

Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

7.2 The Committee shall provide a written, annual report to the board and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance framework, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

7.3 The Board may also require the Committee Chair to report upon the committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.4 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the UHB Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- quorum (set within individual Terms of Reference)

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

Report Title:	Audit and Assurance Committee – Annual Workplan 2020-21							
Meeting:	Audit and Assurance Committee				Meeting Date:		3rd March 2020	
Status:	For Discussion		For Assurance		For Approval	x	For Information	
Lead Executive:	Director of Corporate Governance							
Report Author (Title):	Director of Corporate Governance							

Background and current situation:

The purpose of the report is to provide Members of the Audit and Assurance Committee with the opportunity to review the Audit and Assurance Committee Work Plan 2020/21 prior to presentation to the Board for approval.

The work plan for the Committee should be reviewed on an annual basis to ensure that all areas within its Terms of Reference are being delivered.

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

The work plan for the Audit and Assurance Committee has been developed based upon the requirements set out in its Terms of Reference (also on the agenda). It ensures that the Committee will advise and assure the Board and the Accountable Officer on whether effective governance and assurance arrangements are in place. The Terms of Reference are also in line with standards of Good Governance determined by the NHS Wales.

Recommendation:

The Audit and Assurance Committee is asked to:

REVIEW the Work Plan 2020/21;
APPROVE the Work Plan 2020/21;
RECOMMEND approval to the Board of Directors.

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	x

		sectors, making best use of our people and technology	
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	x	Collaboration	x	Involvement	x

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

Audit Committee Work Plan 2020 - 21							
A -Approval D- discussion I - Information	**Exec Lead**	**21-Apr**	**28-May**	**07-Jul**	**08-Sep**	**17-Nov**	**09-Feb**
Agenda Item							
Governance							
Review the system of assurance	NF	D				D	
Review the risk management system	NF		D				D
Note the business of other Committees and review inter-relationships	NF					D	
Review Draft AGS	NF	D	A				
Review Draft Quality Statement	RW	D	A				
Review the UHB Annual Report	NF	D	A				
Review of Standing Orders	NF						D
Report on Declarations of Interest and Gifts and Hospitality	NF	D		D	D	D	D
Receive relevant reports from Regulatory Bodies	NF	D		D	D	D	D
Receive tracking report from recommendations from Regulatory Bodies	NF	D		D	D	D	D
Undertake Annual Review of PAC Report	NF	D					
Financial Focus							
Agree final accounts timetable and plans	RC						A
Review of audited annual accounts and financial statements	RC		A				
Review changes to SFIs and changes to accounting policies	RC/NF	D					
Review losses and special payments	RC	D	A			A	
Single Tender Actions	RC	D		D	D	D	D
Internal Audit							
Review and approve annual internal audit plan	IA	A					
Review and approve internal audit Terms of Reference	IA						A
Review the effectiveness of internal audit	IA					D	
Review of internal audit progress reports	IA	D		D	D	D	D
Receive annual internal audit report and associated opinions (HoIA)	IA		A				
Receive Tracking Report on internal audit recommendations	NF	D		D	D	D	D
External Audit							
Agree Auditor General's Audit Plan	WAO						A
Review the effectiveness of external audit	WAO					D	
Review External Audit Progress Reports	WAO	D		D	D	D	D
Receive the Auditors report to those charged with governance	WAO		A				
Receive the Auditors Annual Audit Report	WAO						A
Receive Annual Structured Assessment Report	WAO					D	
Clinical Audit							
Review annual Clinical Audit Plan	SW					D	
Counter Fraud							
Review and approve annual counter fraud plan	CF	A					
Review counter fraud progress reports	CF	D		D	D	D	D
Review the effectiveness of Counter Fraud Specialist	CF					D	
Receive counter fraud annual report	CF	D	A				
Audit Committee							
Annual Work Plan	NF						A
Self assessment of effectiveness	NF	D					
Induction Support for Committee Members	NF	D					
Review Terms of Reference	NF						A
Produce Audit Committee Annual Report	NF						A
Private discussion with internal and external auditor	NF	D		D	D	D	D
Minutes of Audit Committee Meeting	NF	A	A	A	A	A	A
Action log of Audit Committee Meeting	NF	D	D	D	D	D	D

Report Title:	**Draft Annual Report 2019/20 – Audit and Assurance Committee**						
Meeting:	**Audit and Assurance Committee**				**Meeting Date:**	**03/03/2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**X**	**For Information**	
Lead Executive:	**Director of Corporate Governance**						
Report Author (Title):	**Corporate Governance Officer**						

Background and current situation:

An Annual Report from the Committee is produced to demonstrate that it has undertaken the duties set out in its Terms of Reference and to provide assurance to the Board that this is the case.

The purpose of the report is to provide Members of the Audit and Assurance Committee with the opportunity to discuss the attached Annual Report before being submitted to the Board for approval by the end of March 2020.

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

The Committee has achieved an overall attendance rate of 92% and has met on six occassions during the year.

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

The attached Annual Report 2019/20 of the Audit and Assurance Committee demonstrates that the Committee has undertaken the duties as set out in its Terms of Reference.

Recommendation:

The Audit and Assurance Committee is asked to:

- **REVIEW** the draft Annual Report 2019/20 of the Audit and Assurance Committee
- **RECOMMEND** the Annual Report to the Board for approval.

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	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	
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	X	Long term		Integration		Collaboration		Involvement	

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

Annual Report of Audit and Assurance Committee 2019/20

DRAFT

1.0 INTRODUCTION

In accordance with best practice and good governance, the Audit Committee produces an Annual Report to the Board setting out how the Committee has met its Terms of Reference during the financial year.

2.0 MEMBERSHIP

The Committee membership is a minimum of three Independent Members one of which must have financial experience and one whom must be a member of the Quality, Safety and Experience Committee. During the financial year 2019/20 the Committee comprised four Independent Members. In addition to the Membership, the meetings are also attended by the Director of Finance (Executive Lead for the Committee), Director of Corporate Governance, Internal Audit and Wales Audit Office. The Chair of the Board is not a Member of the Committee but attends at least annually after agreement with the Committee Chair. Other Executive Directors are required to attend on an ad hoc basis.

3.0 MEETINGS AND ATTENDANCE

The Committee met six times during the period 1 April 2019 to 31 March 2020. This is in line with its Terms of Reference. The Audit Committee achieved an attendance rate of 92% (80% is considered to be an acceptable attendance rate) during the period 1st April 2019 to 31st March 2020 as set out below:

	23.04.19	23.05.19	30.05.19	30.09.19	3.12.19	3.03.20	Attendance
John Union	✓	✓	✓	✓	✓	✓	**100%**
John Antoniazzi	✓	✓	✓	n/a	n/a	n/a	**100%**
Eileen Brandreth	✓	✓	X	X	✓	✓	**67%**
Charles Janczewski	✓	✓	✓	n/a	n/a	n/a	**100%**
Dawn Ward	✓	✓	✓	✓	✓	✓	**100%**
Total	**100%**	**100%**	**83%**	**67%**	**100%**	**100%**	**92%**

4.0 TERMS OF REFERENCE AND WORKPLAN

The Terms of Reference and work plan were reviewed and approved by the Committee on 3 March 2020 and were approved by the Board on 27 March 2019.

5.0 WORK UNDERTAKEN

During the financial year 2019/20 the Audit and Assurance Committee reviewed the following key items at its meetings:

PRIVATE AUDIT AND ASSURANCE COMMITTEE

APRIL, MAY, SEPTEMBER, DECEMBER 2019 AND MARCH 2020

Papers presented to the private session of the Audit and Assurance Committee are as follows:

- Counterfraud Progress Report
- Procurement Compliance Report
- Workforce and Organisational Development Compliance Report

DRAFT

- Draft Letter of Representation
- Corporate Risk Register

PUBLIC AUDIT AND ASSURANCE COMMITTEE – SET AGENDA ITEMS

April 2019 - March 2020

- **Internal Audit Plan 2019/2020**

Internal Audit Reports were submitted to each of the Audit and Assurance Committee meetings with the exception of 30 May 2019 (which related to the Health Board accounts). The reports presented provided details relating to outcomes, key findings and conclusions from the finalised internal Audit assignments and specific detail relating to progress against the audit plan and any updates that occurred within the plan.

Eighteen reports presented during the year were from the 2018/19 Internal Audit Plan; three of which received a substantial rating, 15 a reasonable rating and three received a Limited rating. (A table at the end of the report shows a list of internal audit reports presented to the Committee.)

- **Wales Audit Office Progress Reports**

The Wales Audit Office provided updated reports to the Audit and Assurance Committee on current and planned Wales Audit Office work. It covered financial audit, performance audit and the Auditor General's programme of national value-for-money examinations.

The Committee was informed that there would be increased testing on fixed assets this year. The Wales Audit Office had undertaken work on a project with the Executive Director of Public Health on the Future Generations Wellbeing Act to ensure the principles of the Act were embedded in the organisation. The report is currently on the Wales Audit Office website with the final recommendations.

The Structured Assessment 2019 (thematic review) highlighted that the Health Board was strengthening processes that supported Board business, risk management and arrangements for tracking recommendations. It also highlighted that the Health Board had an approved IMTP, forecasted a breakeven position and had made progress in tackling workforce issues.

- **Declarations of Interest**

Following a 'Limited Assurance' rating for Internal Audit, the Governance team had 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. A number of recommendations were followed through to include implementation of a monthly Declaration of Interest alert on the ESR system which will be rolled out in April 2020; revised the Standards of Behaviour Policy which was approved at the Board meeting in November 2019 and arranged an awareness campaign to be rolled out across the UHB with guidance directed towards staff and service users on information screens, through social media campaigns and on an updated intranet page. Also, developed was a comprehensive DOI register with a RAG rating system and amalgamated the Gifts, Hospitality & Sponsorship register so there is one, single register held centrally. A follow-up internal audit increased the rating to Substantial.

- **Legislative and Regulatory Tracker**

The Audit and Assurance Committee also received an Internal Audit report on the Legislative and Regulatory Tracker with a 'Limited Assurance' rating where seven recommendations were made. Good progress was made with redesigning a detailed tracker and a follow-up Internal Audit report improved the rating to Reasonable. The Committee was informed that the department will continue to develop and improve the tracker 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 which was submitted for approval by HSMB at the beginning of October. The tracker will be updated on a quarterly basis throughout the organisation and also reported to the Audit and Assurance Committee on a quarterly basis.

- **Internal Trackers and External Trackers**

The reports and trackers provided Members of the Audit and Assurance Committee with assurance on the implementation of recommendations which have been made by Internal Audit or the Wales Audit Office by means of an internal / external audit recommendation tracking report and were able to view progress and improvements made from the Limited Assurance rating to Reasonable Assurance rating.

- **Post Payment Verification Report**

The Post Payment Verification Manager presented the Committee with reports which summarised the work undertaken by the Post Payment Verification (PPV) department in accordance to the Welsh Assembly Government (WG) directions in respect of General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS). The purpose of a PPV visit to the above contractors is to ensure that claims submitted by contractors are correct and in accordance with the Statement of Financial Entitlement (SFE) and service specifications set by WG and LHBs, regulations, and related procedures.

The aim of the PPV process is to ensure propriety of payments of public monies by the LHBs. The probity checks conducted during a PPV visit will provide reasonable assurance to LHBs that public money has been spent appropriately by contractors making accurate claim submissions, contractors internal protocols are clinically sound and services are being claimed for in accordance to clinical specifications.

- **The Annual Progress Report**

The Director of Corporate Governance presented an update on the progress being made with the drafting of the 2018-19 Annual Report which included the Governance Statement.

- **Internal Audit Annual Report 2017/2018**

The Head of Internal Audit set out his opinion together with the summarised results of the internal audit work performed during the year. The report also included a summary of audit performance in comparison to the plan and an assessment of conformance with the Public Sector Internal Audit Standards.

- **Audit Enquiries to those charged with Governance and Management**

A formal letter from the Wales Audit Office sought for documented consideration and understanding on a number of governance areas that had an impact on the audit of the Health Board's financial statements. These considerations were relevant to both the management of the Cardiff and Vale University Local Health Board (the UHB) and 'those charged with governance' (the Board).

- **Report on Annual Accounts of the UHB 2018/2019 and Workshop**

The Committee was presented with a report that introduced the Annual Accounts which are included within the Annual Accountability Report and the associated documents. It also set out the key changes made to the draft accounts and outlined the financial performance of the UHB. A workshop was also held prior to the Board meeting to review all the draft papers.

- **WAO ISA 260 Report**

The International Standard on Auditing (ISA) 260 requires the Wales Audit Office to report certain matters arising from the audit of the financial statements to those charged with governance of a body in sufficient time to enable appropriate action. A report was presented which set out the relevant matters for consideration by the Audit and Assurance Committee and the Board.

- **WAO Financial Statement Report – Recommendations Addendum**

Wales Audit Office presented a report which was an addendum to the WAO Audit of the Financial Statements Report 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 2019-2020 financial statements; and an update on the Health Board's progress with last year's recommendations.

- **Losses and Special Payments**

As defined in the Standing Financial Instructions, the Audit and Assurance Committee is required to approve the write off of all losses and special payments within the delegated limits determined by the Welsh Government. To assist the Audit and Assurance Committee with this task, the UHB has established a losses and special payments panel, under the chairmanship of the Director of Finance (delegated to The Deputy Director of Finance). This panel meets twice yearly and is tasked with considering the circumstances around all such cases and to make appropriate recommendations to the Committee.

6.0 REPORTING RESPONSIBILITIES

The Committee has reported to the Board after each of the Audit and Assurance Committee meetings by presenting a summary report (introduced from November 2018) of the key discussion items at the Audit Committee. The report is presented by the Chair of the Audit Committee.

7.0 OPINION

The Committee is of the opinion that the draft Audit and Assurance Committee Report 2019/20 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

John Union

Committee Chair

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Internal Audit Reports submitted at each meeting

RATING	23.04.19 (from 2018/19 plan)	23.05.19 (from 2018/19 plan)	30.09.19 (2019/20 plan)	3.12.19	3.03.20
SUBSTANTIAL	• Delayed Transfers of Care • Ward Nurse Staffing Levels	• Strategic Planning and IMTP	• Standards of behaviour Follow-up • Annual Quality Statement • Carbon Reduction Commitment	• Mental Health CB 3rd Sector Contracts • Claims Reimbursement Final Report	•
REASONABLE	• Capital Project – Rookwood Relocation • PCIC CB Interface Incidents • Medicines CB– Sickness Absence Management Report • Capital – CRI Safeguarding Works • Commissioning Report • E-IT Learning Report	• Core Financial Systems • Estates Statutory Compliance – Water • E-Advice • UHB Transformation Process • MHRA Compliance • Health and Care Standards	• MHRA Compliance • E-Advice Project • UHB Transformation Process *(The three reports above are from the 2018/19 plan)* • MH CB Sickness Management Follow-up • Sustainability Reporting • Specialist CB Rosterpro • Legislative / Regulatory Compliance Follow-up	• Surgery CB Medical Finance Governance Follow-up Final • Deprivation of Liberty Safeguards Final Report • Charitable Fund Final Report • PCIC Business Continuity Final Report • Maelfa Wellbeing Hub • PCIC CB: CHC Adults Follow-up • Children and Women CB: CHC Child Follow-up	•

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LIMITED	• Surgery CB – Medical Finance Governance • Medicine CB – Internal Medicine Follow-up	• Cyber Security		•	•

Cardiff & Vale University Health Board

Safeguarding Adults & Children

Final Internal Audit Report

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

Review reference:	C&V-1920-22
Report status:	Final Internal Audit Report
Fieldwork commencement:	28th June 2019
Fieldwork completion:	25th November 2019
Draft report issued:	2nd December 2019
Management response received:	6th February 2020
Final report issued:	18th February 2020
Auditor/s:	Jayne Gibbon, Audit Manager Ian Virgil, Head of Internal Audit
Executive sign off:	Ruth Walker, Executive Nurse Director
Distribution:	Jason Roberts, Deputy Executive Nurse Director Linda Hughes-Jones, Head of Safeguarding
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 review of safeguarding arrangements for adults and children was completed in line with the 2019/20 Internal Audit Plan for Cardiff & Vale University Health Board.

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

Safeguarding is considered in Part 7 of the Social Services & Wellbeing (Wales) Act 2014. The Health Board is required to comply with Standard 2.7 of the Health and Care Standards, which relates to the safeguarding of children and adults at risk to include Violence Against Women, Domestic Abuse and Sexual Violence (2015).

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place in relation to safeguarding, in order to provide assurance to the Health Board's Audit Committee that risks material to the system objectives are managed appropriately.

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

- Safeguarding policies and procedures are in place and reflecting the UHB's responsibility to safeguard and promote the wellbeing of children and adults at risk.
- There is evidence of clear lines of accountability for safeguarding from Board to frontline staff within the UHB.
- Clarity in respect of roles and responsibilities for all staff in relation to child protection and protection of adults at risk.
- Arrangements to manage allegations of abuse against professionals or staff members, complaints/concerns relating to children, young people and adults at risk across the Clinical Boards.
- Identification and acting upon safeguarding issues and review of practice and performance in these areas.
- Effective multi-agency working relationships exist.
- Staff training, whereby applicable staff have received training regarding child protection; protection of adults at risk; children's rights and domestic abuse. Understanding the action required when issues and concerns arise.

- Adequate governance arrangements exist, with clear strategy and leadership in place.
- The Health Board takes appropriate action to ensure compliance with Standard 2.7 of the Health and Care Standards.
- Arrangements are in place to identify domestic abuse and the action required by staff (Ask & Act).

3. Associated Risks

The potential risks considered in this review were:

- Non compliance with Standard 2.7, Safeguarding Children and Safeguarding Adults at risk and applicable legislation, guidance and policy.
- Insufficient communication and cooperation with interested parties and organisations.
- A lack of training and development of staff to ensure effective working.
- A lack of clear lines of accountability for safeguarding from the Board to front line staff.
- Risk of injury and death to vulnerable patients due to insufficient procedures, resources and training.
- A duty of care to children and adults at risk not being implemented.

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 the arrangements in place for Safeguarding Adults & Children 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.

The review found that the systems and processes in place for the management and oversight of safeguarding within the Health Board are of a reasonable standard.

There are dedicated Safeguarding pages on the Intranet that provide information on all relevant guidance and processes to follow for safeguarding issues as well as details of key contacts.

There is a clear structure in place and the reporting arrangements are well defined. The Safeguarding Steering Group meets on a bi-monthly basis to oversee Safeguarding issues and regular updates are then provided to the Health Board's Quality, Safety & Experience Committee.

The Audit found that arrangements in place to allow for multi-agency working were appropriate also noting that the Health Board is a member of the Cardiff & Vale Regional Safeguarding Board.

There were a few minor issues raised regarding the updating of terms of reference and also the absence of evidence to support several of the processes in place.

However the audit did identify two high priority issues during the audit. These related to the poor compliance rate for the statutory & mandatory training modules for safeguarding and also poor attendance of some of the Clinical Boards at the Safeguarding Steering meetings.

5. Assurance Summary

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

Assurance Summary					
1	Code of Ethics Safeguarding policies and procedures are in place and reflecting the UHB responsibility to safeguard and promote the wellbeing of children and adults at risk.				✓
2	There is evidence of clear lines of accountability for safeguarding from the Board to front line staff within the UHB.				✓
3	Clarity in respect of roles and responsibilities of all staff in relation to child protection and protection of adults at risk.				✓
4	Arrangements to manage allegations of abuse against professionals or staff members, complaints/concerns relating to children, young people and adults at risk across the Clinical Boards.				✓
5	Identification and acting upon safeguarding issues and review of practice and performance in these areas.				✓
6	Effective multi-agency working relationships exist.				✓

Assurance Summary					
7	Staff training, whereby applicable staff have received training regarding child protection; protection of adults at risk; children's rights and abuse.		✓		
8	Adequate governance arrangements exist, with clear strategy and leadership in place.		✓		
9	The Health Board takes appropriate action to ensure compliance with Standard 2.7 of the Health and Care Standards.				✓
10	Arrangements are in place to identify domestic abuse and the action required by staff (Ask & Act).				✓

** 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 arrangements for Safeguarding Adults & Children.

Operation of System/Controls

The findings from the review have highlighted 4 issues that are classified as weaknesses in the operation of the designed system/control for arrangements for Safeguarding Adults & Children.

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: Safeguarding policies and procedures are in place and reflecting the UHB responsibility to safeguard and promote the wellbeing of children and adults at risk.

The following areas of good practice was noted:

- There is a dedicated page on the Health Board's intranet for Safeguarding which is accessible to all staff. The Home page then provides further links / signposts to additional pages where guidance/procedures can be found for the following areas:
  - Safeguarding Children
  - Safeguarding Adults
  - Domestic Abuse & Sexual Violence
  - Female Genital Mutilation
  - Modern Slavery
- A review of a sample of procedures in place found that they were current and in accordance with statutory requirements.

We did not identify any findings under this objective.

Objective 2: There is evidence of clear lines of accountability for safeguarding from the Board to front line staff within the UHB.

The following areas of good practice were noted:

- Ultimate responsibility lies with the Chief Executive which has then been delegated to the Executive Nurse Director.
- There is a central Integrated Safeguarding Team in place that provides support and assistance on safeguarding issues to all staff within the Health Board.
- The safeguarding structure is formally documented in the Safeguarding Annual Report.
- There is a Safeguarding Steering group in place to provide assurance on all Safeguarding matters. Membership includes representatives from Clinical Boards as well as multi agency partners.
- The Safeguarding Steering Group is accountable to the Health Board's Quality, Safety & Experience Committee where Safeguarding is a Standing Agenda Item.

- Information /actions regarding Safeguarding issues are cascaded to the Clinical Boards via the Clinical Boards Quality Safety & Experience meetings.

There were no significant findings for this objective.

Objective 3: Clarity in respect of roles and responsibilities of all staff in relation to child protection and protection of adults at risk.

The following areas of good practice were noted:

- The roles and responsibilities for the safeguarding function are clearly defined on the Safeguarding Intranet Pages.
- Further information is also detailed within the Annual Safeguarding report.

We did not identify any findings under this objective.

Objective 4: Arrangements to manage allegations of abuse against professionals or staff members, complaints/concerns relating to children, young people and adults at risk across the Clinical Health Boards

The following areas of good practice were noted:

- Guidance on the process to follow on any suspected cases of abuse can be found on the Safeguarding pages on the Intranet.
- As well as the Safeguarding Team each Clinical Board will have a Designated Lead for Safeguarding.
- There is a central database in place that records all documentation concerning all safeguarding cases.
- Regular meetings take place to review all cases concerning safeguarding issues against professionals.
- Meetings with the Directors of Nursing for two of the Clinical Boards found that staff are fully aware of actions to be taken should any safeguarding issues arise.
- Testing undertaken on a sample of safeguarding cases found that cases were being appropriately managed.

We did not identify any findings under this objective.

Objective 5: Identification and acting upon safeguarding issues and review of practice and performance in these areas

The following areas of good practice were noted:

- The Safeguarding Steering group meeting is the forum where feedback on lessons learned from cases is reported and also any recommendation for changes in practice to be adopted.

- A review of a sample of agendas for the Safeguarding Steering Group noted the following agenda items:
    - Presentations from Clinical Boards on safeguarding issues
    - Domestic Homicide Review
    - NHS Wales Learning from Safeguarding Events
    - Child Sexual Exploitation Update
- A review of the Safeguarding Update Reports submitted to the Quality, Safety & Experience Committee noted that the following information is included:
    - Updates on All Wales Policies
    - Updates on reviews
    - Details of safeguarding activity within the Health Board
    - Details of any Shared Learning
- The Safeguarding Annual Report also details examples of changes in practice as a result of reviews that have taken place.
- The All Wales NHS Safeguarding Maturity Matrix (SMM) has been completed for 2018/19 and an improvement plan drawn up. This is reviewed periodically at the Safeguarding Steering Group.

We did not identify any issues for this objective.

Objective 6: Effective Multi-Agency working relationships exist.

We identified the following areas of good practice:

- The intranet safeguarding pages sets out the policies and procedures for multi-agency working arrangements.
- The Annual Safeguarding Report provides details on multi agency working arrangements.
- The Health Board is also a member of the Regional Safeguarding Board.

We did not identify any findings for this objective.

Objective 7: Staff training, whereby applicable staff have received training regarding child protection; protection of adults at risk; children's rights and domestic abuse. Understanding the action required when issues and concerns arise.

The following areas of good practice were noted:

- The Integrated Safeguarding Team provides classroom training for the statutory & mandatory level 2 modules for Safeguarding Adults & Safeguarding Children.
- Responsibility for identifying those staff that require Level 2 training lies with individual Clinical Boards with the training then provided by the Integrated Safeguarding Team.
- As part of her supervision responsibilities the Head of Safeguarding will have regular 1:1 meetings with her staff where any training requirements will be identified.
- Compliance rates for the safeguarding statutory & training modules is a standing agenda item of the Safeguarding Steering Group within the Organisational and Performance Section.
- Discussions with the Directors of Nursing for 2 Clinical Boards noted that Statutory & Mandatory Training compliance is discussed at the Clinical Board's monthly performance meetings.

The following significant finding was identified:

- A review of the current compliance rates for the Level 2 Statutory & Mandatory Training Modules for Adults and Children noted that the compliance rate was well below the 85% target set by Welsh Government.

Objective 8: Adequate governance arrangements exist, with clear strategy and leadership in place

The following areas of good practice were noted:

- The Health Board is a member of the Cardiff & Vale Regional Safeguarding Board.
- There is a Safeguarding Steering Group in place which is chaired by the Deputy Nurse Director and meets on a bi-monthly basis. Membership includes representatives from Corporate, Clinical Boards, and other public bodies.
- A review of agendas for the Safeguarding Steering Group found that business discussed was appropriate with the meeting split into the following sections:
  - Strategic Direction and Service Improvement
  - Organisational Performance and Effectiveness
  - Governance
  - Reports/Minutes from other Groups Committees
- An update report concerning Safeguarding is also submitted to each meeting of the Health Board's Quality, Safety and Experience Committee and bi-monthly to the Health Board's Executive Team.

The following significant finding was noted:

- A review of attendance of a sample of Safeguarding Steering Group meetings noted an issue with representation from the Clinical Boards.

Objective 9: The Health Board takes appropriate action to ensure compliance with Standard 2.7 of the Health and Care Standards

The following area of good practice was noted:

- Responsibility for ensuring compliance with the requirements of the Standard 2.7 Safeguarding of the NHS Wales Health and Care Standards has been delegated to the Safeguarding Steering Group.
- A review of the minutes of the group noted that progress on the improvement plan drawn up from the 2018/19 self-assessment is reviewed.

We did not identify any findings for this objective

Objective 10: Arrangements are in place to identify domestic abuse and the action required by staff (Ask & Act)

The following areas of good practice were noted:

- There is a specific page within the Safeguarding pages on the intranet for Domestic Abuse; the page details the following information:
    - Information on signs and examples of domestic abuse
    - Links to the Health Board's Policy
    - Details of the Pathway in place and referral form.
- The Health Board has established the post of Independent Domestic Violence Advisor within the Safeguarding Team. Information on the role is detailed on the intranet page.

We did not identify any findings for 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	**2**	**0**	**2**	**4**

Finding 1 Statutory & Mandatory Training Compliance (Operating effectiveness)	Risk
The Welsh Government has set a compliance target of 85% for Statutory & Mandatory Training Compliance. A review of the compliance rates as at 31/10/19 for the Statutory and Mandatory Level 2 Safeguarding Modules noted the following: • Safeguarding Adults - The compliance rate for all Clinical Boards was below the 85% target set by Welsh Government • Safeguarding Children - The compliance rate for all Clinical Boards was below the 85% target set by Welsh Government • Violence Against Women, Domestic Abuse and Sexual Violence - 4 of the Clinical Boards compliance level was below the 85% Target The overall Health Board compliance rates for Level 2 Safeguarding Adults and Children were only 43.61% and 44.22% respectively. It is noted that whilst compliance rates for Level 2 Statutory & Mandatory Training is an agenda item at the Safeguarding Steering group it is more for information purposes.	Risk of injury and death to vulnerable patients due to insufficient procedures, resources and training.

Recommendation	Priority level
Management should ensure that Clinical Boards put the appropriate actions in place with a view to ensuring compliance rates are improved to meet the 85% compliance rate that has been set by Welsh Government. Management should also ensure that actions taken are reported back to the Safeguarding Steering Group and appropriately recorded.	**High**
Management Response	**Responsible Officer/ Deadline**
Safeguarding Training is a standard item on the agenda at the Safeguarding Steering Group Meeting (SSG). Training figures are circulated with the agenda prior to the meeting and discussed at the meeting. Poor Clinical Board representation at the meeting may account for the lack of improvement in the overall figures for each Clinical Board, this will be addressed by the Deputy Executive Nurse Director at a meeting with the Clinical Board Directors of Nursing in January. Furthermore the implementation of the Value Based Appraisal from April 2020 should ensure that staff are compliant with their Mandatory Training to receive any pay awards through annual increments. Compliance will continued to be monitored within the SSG meeting with an expectation that improvements will be made. Ownership of the Mandatory Training must be the responsibility of Clinical Boards to ensure compliance. Head of Safeguarding to monitor through SSG. This will be on-going and escalated to the Executive Team if no improvement is evident.	Deputy Executive Nurse Director January 2020 Head of Safeguarding Ongoing 2020/21

It is noted that the compliance to all Statutory and Mandatory training is a will documented risk to the UHB due to the challenge of releasing clinical staff.	

Finding 2 Safeguarding Strategic Group Attendance (Operating effectiveness)	Risk
Testing was undertaken on the attendance of 4 Safeguarding Steering Group meetings to ensure that all Clinical Boards were represented. The following issue was noted: • The PCIC Clinical Board was only represented at 1 of the 4 meetings reviewed • The Mental Health Board was only represented at 1 of the 4 meetings reviewed • The Specialist Services Clinical Board was only represented at 2 of the meetings reviewed The current low levels of attendance could present a risk that key safeguarding issues and / or lessons learned from incidents may not be effectively communicated back to the Clinical Boards. It is acknowledged that at the July 2019 meeting of the Steering Group the issue had been noted and an action was agreed for the Deputy Executive Nurse Director to contact all Clinical Boards about the declining attendance.	Insufficient communication and cooperation with interested parties and organisations
Recommendation	**Priority level**
Management should ensure that all Clinical Boards are reminded of the requirement to provide appropriate representation at Safeguarding Steering	**High**

Group Meetings. On-going attendance should then continue to be monitored to ensure appropriate attendance is maintained.	
Management Response	**Responsible Officer/ Deadline**
The Deputy Executive Nurse Director will address this with Directors of Nursing (DON) in January 2020. DON's will be reminded that safeguarding should be a standard item at Quality & Safety meetings to ensure information is shared and disseminated within each directorate of the Clinical Board. Clinical Boards will be asked to provide evidence of a sample agenda from their Q & S meeting to share at the SSG. Improved attendance noted at January 2020 meeting. All but one Clinical Board represented. Deputy Executive Nurse Director to re contact Clinical Board representation.	Head of Safeguarding will ensure that this is implemented and reported by the Clinical Boards through the SSG from January 2020.

Finding 3 Roles & Responsibilities Evidence (Operating effectiveness)	Risk
As part of the fieldwork reviewing roles and responsibilities in respect of Safeguarding, Internal Audit met with staff for two Clinical Boards to ensure that key staff are aware of their responsibilities and that this is reflected in their job descriptions. At the time of the completion of the audit fieldwork no evidence had been provided by one of the Clinical Boards (Children & Women).	A lack of clear lines of accountability for safeguarding from the Board to front line staff.
Recommendation	**Priority level**
Management should ensure that evidence to support safeguarding responsibilities is readily accessible should it be required at a future point in time.	**Low**
Management Response	**Responsible Officer/ Deadline**
Each Clinical Board is responsible for ensuring that safeguarding information is available to staff employed within their area. Staff should have access to a computer to access UHB safeguarding pages and training resources on the intranet, where this is not available other arrangements should be made by departments within the Clinical Board. The UHB Safeguarding Team has shared an information poster with Clinical Boards in the last two years and undertaken a small audit of staff and student awareness of their understanding of safeguarding themes, UHB responsibilities and awareness of the Regional Safeguarding Board previously. This audit will be repeated during 2020 to ensure	Clinical Boards Directors of Nursing June 2020

awareness is maintained. However the Safeguarding Team cannot take responsibility for information included in practitioner roles and responsibilities identified in individual job descriptions. Safeguarding is everybody's responsibility. Directors of Nursing for each Clinical Board and HR representatives ensure that individual job descriptions have safeguarding included as part of roles and responsibilities for all staff.	

Finding 4 SSG Terms of Reference (Operating effectiveness)	Risk
A review of the Terms of Reference for the Safeguarding Steering Group found that there was no evidence that the current Terms of Reference had been reviewed and approved at the December 2018 meeting. Audit were advised that the Terms of Reference would be submitted to the January 2020 Meeting of the Safeguarding Steering Group for review and approval.	Non Compliance with Standard 2.7 Safeguarding Children and Safeguarding Adults at risk and applicable legislation, guidance and policy.
Recommendation	**Priority level**
Management should ensure that the Terms of Reference for the Safeguarding Steering Group are reviewed and approved on an annual basis and appropriately evidenced.	**Low**
Management Response	**Responsible Officer/ Deadline**
The Head of Safeguarding acknowledges that there was no evidence in the minutes to support that the ToR had been discussed at the January 2019 SSG meeting, although a copy was available along with other papers to be discussed at the meeting. It is also acknowledged that the footnote for the ToR had not been updated to evidence that the copy held in the folder was a new copy. This will be addressed at the January 2020 meeting. Head of Safeguarding will ensure that the ToR are signed off for 2020 at the SSG meeting in January 2020 and evidenced in the minutes.	Head of Safeguarding January 2020

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

Freedom of Information (FOI)

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Appendix A Management Action Plan
Appendix B Management opinion and action plan risk rating

Review reference:	CUHB1920.23
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Auditors:	John Cundy
Executive sign off:	Jonathon Gray, Executive Director of Transformation and Informatics
Distribution:	David Thomas, Director of Digital & Health Intelligence James Webb, Information Governance 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 review of the arrangements in place to ensure compliance with the Freedom of Information Act (FOI) within Cardiff & Vale University Health Board (the UHB) has been completed in line with the 2019/20 Internal Audit Plan.

The Freedom of Information Act came into effect on 1 January 2005. They affect all public sector organisations including Cardiff & Vale University Health Board.

It is intended to ensure openness, transparency and accountability of all public organisations. Under the Act, all public bodies have a legal duty to ensure that the public, staff and other organisations are able to access information about how they operate and make decisions about their performance.

The Health Board has a statutory responsibility to respond to these requests initially to acknowledge the request and later to provide that information.

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

2. Scope and Objectives

The audit seeks to provide assurance to the Health Board that arrangements are in place to ensure compliance with the requirements of the FoI.

The objectives of the review are:

- to consider if there is a governance framework to support compliance with FoI responsibilities;
- to consider if there are policies and procedures in place which explain the organisation's approach to, and responsibilities for FoI, and that these are complied with;
- to establish whether there are procedures in place to deal with requests for information which ensure that information is provided in compliance with FoI, and that these are complied with; and
- to establish whether there are procedures in place for the provision and monitoring of staff training in relation to FoI and the awareness of associated requirements relating to their roles and responsibilities.

3. Associated Risks

The potential risks considered in the review are as follows:

- controls not operating resulting in non-compliance with FoI.

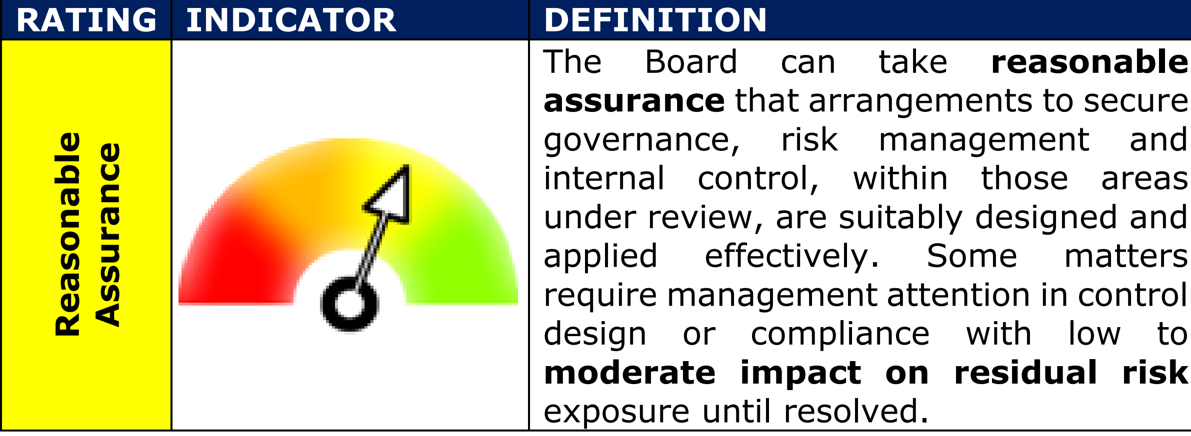
OPINION AND KEY FINDINGS

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 FoI 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.

We note that at present the UHB is partway through a significant, wholesale Digital Strategy transformation programme covering all aspects of UHB digital integration. This includes information governance, of which FoI is one small part.

We found that the UHB was not complaint with FoI requirements throughout 2018; however we note that this was recognised and steps were taken to address the deficiencies. Staffing changes were made and the current team and structure has been in place since November 2018. We also note that this is part of the ongoing digital transformation and may not yet be fully complete or permanent.

FoI compliance has improved significantly over the previous year with an

overall compliance rate for January to September 2019 of 85.22% and the assurance rating reflects the current situation.

Although there has been a significant improvement over 2018 there are still opportunities for further process improvements, and to further embed FoI compliance requirements throughout the entire area of board operations.

The key issues identified in the report are the lack of permanent staffing in place to cover FoI, which leads to an underlying risk of the Health Board being unable to maintain compliance with the FoI Act in the event of key staff leaving and the lack of any formal quality assurance process or approval of responses prior to release.

5. Assurance Summary

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

Assurance Summary					
1	Governance		✓		
2	Policies and Procedures		✓		
3	Provision of Information			✓	
4	Training and Awareness			✓	

** 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 **3** issues that are classified as weakness in the system control/design FoI.

Operation of System/Controls

The findings from the review have highlighted **4** issues that are classified as weakness in the operation of the designed system/control for FoI.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: There is a governance framework to support compliance with FoI responsibilities.

The following areas of good practice were noted:

- overall responsibility for FoI sits with the Chief Executive. The FoI procedure document confirms that lead responsibility for FoI is delegated to the chair of the Digital Health Intelligence Committee (DHIC);
- the FoI function is appropriately located within the DHIC structure. It is adequately resourced at present;
- the FoI report is a standing item on the DHIC meeting agenda. The report states requests received and the rate of compliance with the 20 day response target. This is sufficient to inform board management of FoI compliance;
- requests for review / complaints about FoI responses are considered independently by the head of Corporate Governance. Requestors then have a further opportunity to complain directly to the ICO if still not satisfied; and
- the Health Board website has a defined page for FoI and this includes a link to information on the publication scheme.

The following significant finding was identified:

- The current FoI lead and manager are employed on an interim basis on fixed term contracts. People employed on this basis can leave with minimum notice and/or at the end of their contract.

Objective 2: There are policies and procedures which explain the organisation's approach to, and responsibilities for FoI.

The following area of good practice was noted:

- the FoI web page on the Health Board website contains all necessary information to assist and support a member of the public in the completion of a FoI request.

The following significant finding was identified:

- Both the FoI policy and procedure documents were due for review 31/03/2018. At the time of the audit there was no evidence that the review had been completed and that updated documents had been ratified and accepted.

Objective 3: There are procedures in place to deal with requests for information, which ensure that information is provided in compliance with FoI.

- there is one control document (spreadsheet) for the whole FoI request receipt and response process;
- there is a publication template for responses which helps ensure that no personal data is disclosed;
- the use of templates for commonly used text e.g. Section 16 or 21 helps support response quality and consistency;
- FoI requests are acknowledged within two days;
- requests are responded to within 20 working days; and
- testing showed that exemptions and redactions were correctly and appropriately applied in all cases reviewed.

The following significant finding was identified:

- There are weaknesses in the collation and release of responses, with no formal approval to release the response by a senior officer and no formally described quality assurance (QA) process operating.
- The current process for monitoring and tracking requests does not allow for easy tracking of all the stages of the process.
- The main barrier to complying with FoI request timescales is receiving information from service departments. The extant SOP sets out a clear mechanism for escalation, should information not be received on time however this is not happening.

Objective 4: There are procedures in place for the provision and monitoring of staff training in relation to FoI and the awareness of associated requirements relating to their roles and responsibilities.

The following area of good practice was noted:

- FoI is included in the Information Governance mandatory training and in the GDPR awareness sessions being presented to all staff across the UHB.

There were no significant findings identified in this area.

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	**2**	**3**	**2**	**7**

Finding 1–Resourcing (Operation of system/controls)	**Risk**
The current FoI lead and manager are employed on an interim basis on fixed term contracts. People employed on this basis can leave with minimum notice and/or at the end of their contract. Having recently recovered from a period of staffing instability which contributed to the Health Boards previous non-compliance with FoI legislation, this presents a risk to the continued effectiveness of the FoI function and therefore compliance with the 2000 FoI act.	Non-compliance with FoI
Recommendation	**Priority level**
The Health Board should take steps to ensure the continuity of the FoI management function, and that all necessary knowledge and expertise currently being utilised is able to be retained, especially if/when personnel changes occur.	**High**
Management Response	**Responsible Officer/ Deadline**
Both of the fixed term contracts are being addressed and are being made permanent in the new Digital structures.	Director of Digital & Health Intelligence/ By March 2020

Finding 2–Quality Control (Control design)	Risk
There are weaknesses in the collation and release of responses • there is no formal approval to release the response by a senior officer as set out in the SOP; and • there is no formally described quality assurance process operating that includes a review of response prior to approval and ensures the completion of all necessary records. This increases the risk that inaccurate, incomplete, or inappropriate responses are issued to the public.	Non-compliance with FoI
Recommendation	**Priority level**
A simple, reviewable QA process should be adopted such as a checklist created from template and included in the S:Drive folder. It should cover the basic process steps and at a minimum confirm that: • The S:drive folder is complete, copies of all documentation included, (including the QA sign-off); • The reply has been subject to QA; • Any escalation process has been applied as designed so that FoI time – limit compliance is achieved; • The main controlling spreadsheet has been completed accurately;	**High**

• The disclosure log is fully complete; and • The QA is digitally signed and dated. All responses should be formally approved prior to release.	
Management Response	**Responsible Officer/ Deadline**
QA process has now been created by the UHB's FOI lead and is in use, with all the noted bullet points incorporated into the QA process.	Complete

Finding 3–Policy and Written Procedure Documents (Operation of system/controls)	**Risk**
Both the FoI policy and procedure documents were due for review 31/03/2018. At the time of the audit there was no evidence that the review had been completed and that updated documents had been ratified and accepted. Neither document refers to or fully considers the GDPR act. This could mean that at least theoretically Health Board policy and procedure documents contain statements and practices that are contrary to extant enforceable legislation.	Non-compliance with FoI
Recommendation	**Priority level**
The FoI Policy and Written Procedures documents should be reviewed and updated as necessary to fully comply with current legislation, and ratified and accepted by the Board.	**Medium**
Management Response	**Responsible Officer/ Deadline**
FOI Procedure approved and uploaded to both internet and intranet. IG Policy submitted for ratification at DHIC.	Complete

Finding 4 – Process Improvement (Operation of system/controls)	Risk
The current process for monitoring and tracking requests does not allow for easy tracking of all the stages of the process.	Non-compliance with FoI
Recommendation	**Priority level**
The tracking and monitoring process should be improved by the addition of: • a 'triage' process for all requests, initial consideration of likely exemptions, redactions, and time and cost; • categorisation of requests by main topic areas; • record of time taken to complete for each stage of the request; • recording names of internal staff contacted, dates of contact, response, 'chase up'; and • clear identification and 'linking' of linked or follow up requests on the control sheet.	**Medium**

Management Response	Responsible Officer/ Deadline
• Incorporated into QA process created for 2b. • FOI Log lists the relevant department and a brief description of topic. • The IG team catalogues all correspondence relating to FOI requests. • The IG team catalogues all emails relating each FOI, using a convention that enables the team to pick up where others have left off. • Incorporated into QA process created	Complete

Finding 5–Information Asset Owners (Operation of system/controls)	**Risk**
The main barrier to complying with FoI request timescales is receiving information from service departments. The extant SOP sets out a clear mechanism for escalation, should information not be received on time however this is not happening. Without the full support of all staff, and particularly the IAO network FoI responses may miss the statutory target.	Non-compliance with FoI
Recommendation	**Priority level**
Service departments / Clinical Boards should be reminded of the legal obligation to provide information. The timescales for providing information should be monitored by the FoI lead and should responses not be received this should be escalated promptly. Where departments are consistently delaying the process this should be reported to the DHIC.	**Medium**
Management Response	**Responsible Officer/ Deadline**
FOI lead has an email drafted to go to HODs, DMs and frequent info providers stating the ICO's intent to use enforcement to implement Openness by Design. Compliance is monitored by the FOI lead and discussed in weekly IG meeting (along with problematic requests). Escalation is incorporated into the QA process.	Complete

Finding 6 – Disclosure log numbering (Control design)	**Risk**
Where the request response requires more than one document there is no numbering convention followed when the responses are published on the disclosure log. This leads to a risk of a loss of response documents from the log in the event of IT issues	Non-compliance with FoI
Recommendation	**Priority level**
A simple numbering scheme should be applied where multiple documents are posted in response to a request. E.G. FoI/19/174-1 FoI/19/174-2 FoI/19/174-3	**Low**
Management Response	**Responsible Officer/ Deadline**
The IG team has adopted a numbering convention as suggested.	Complete

Finding 7– Training (Control design)	**Risk**
At present there is no formal specific FoI training available to staff. Lack of formal training and certification can result in • Unqualified staff • Low morale • Poor performance • Higher rates of staff turnover All of which contribute significantly to failure to achieve organisational objectives and targets. For FoI specifically those failures can lead to ICO criticism and sanction. We note however that training options are currently under consideration by the FoI lead.	Non-compliance with FoI
Recommendation	**Priority level**
FoI certification or additional FoI training should be available for team members whose role involves processing and answering FoI requests.	**Low**
Management Response	**Responsible Officer/ Deadline**
FOI lead in discussion with NWIS re national approach to training.	Information Governance Manager/ Q1 2020/21

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

C&W CB – Consultant Annual Leave

Final Internal Audit Report

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

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Auditor/s: Ian Virgil / Adam Davies

Executive sign off: Steve Curry – Chief Operating Officer

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Hilary Sharpe – Human Resources Manager

Melanie Cotter – Medical Education Manager

Committee: Audit Committee

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1. Introduction and Background

The review of the management of Consultant Annual Leave within the Children and Women Clinical Board was completed in line with the 2019/20 Internal Audit plan for Cardiff and Vale University Health Board (the UHB).

The UHB is committed to developing and maintaining arrangements which make it an excellent employer. Annual leave is a statutory right but must be appropriately organised and arranged so that consistent service cover is provided in order to be able to deliver an effective and safe service to patients.

The UHB seeks to ensure that members of staff are able to take the Annual Leave to which they are entitled, the purpose of which is to provide a break from work.

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

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 Consultant Annual Leave within the Children & Women Clinical Board, 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 is to establish if consultant annual leave is being planned and effectively managed so that all leave is taken whilst maintaining adequate service provision.

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

- Appropriate and up to date Policy and procedures are in place for the management of consultant annual leave;
- All consultant annual leave is formally requested in compliance with the minimum required notice period and effective arrangements are made to cover duties;
- All consultant annual leave is subject to formal approval by the relevant Clinical Director;
- Accurate records of all consultant annual leave are securely retained within the relevant Directorate offices; and
- Effective monitoring arrangements are in place to ensure consultants annual leave is taken within the relevant leave year and any carried over leave is appropriate, within allowed levels and subject to formal authorisation by the relevant Clinical Director.

As part of the audit, review and testing of local processes was undertaken within the Acute Child Health and Obstetrics & Gynaecology Directorates.

3. Associated Risks

The potential risks considered in this review are as follows:

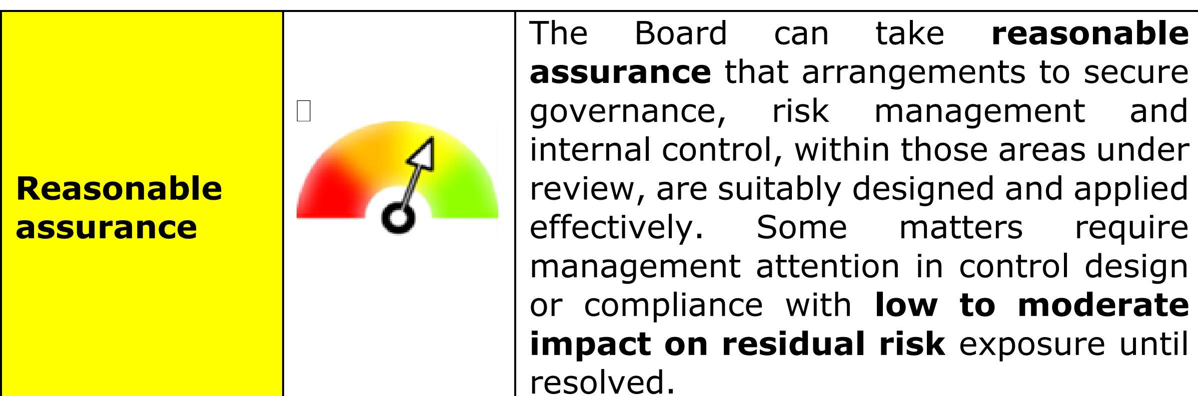
- Disruption to service provision due to lack of cover for consultant leave; and
- Consultants over or undertake leave against their annual entitlement.

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 Children & Women's Clinical Board – Consultant Annual Leave is **Reasonable Assurance.**



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.

Consultants' annual leave is administered through Intrepid which has many in-built controls and so is a good basic, fail-safe platform for such purposes. Additionally, many consultants will be familiar with the system from their junior doctor training. Aspects of the overall control framework can be strengthened by developing the policy and ensuring that it is underpinned at Directorate level by localised procedures, thereby promoting more consistent administrative functions.

The review identified seven medium priority recommendations for management consideration.

A separate review of Medical Staff Study Leave, also administered through Intrepid, was completed in conjunction with this work. Those

recommendations that relate primarily to Intrepid but are reported in that report are the need to:

- assess and review the use of Intrepid as a tool for recording activities other than those of junior doctors and formulate a plan going forward; and
- develop the Intrepid User Group to coincide with the introduction of the updated Policy and procedures.

These findings have been taken into account in arriving at the assurance ratings for 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.

5. Assurance Summary

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

Assurance Summary					
1	Appropriate and up to date Policy and procedures are in place for the management of consultant annual leave			✓	
2	All consultant annual leave is formally requested in compliance with the minimum required notice period and effective arrangements are made to cover duties				✓
3	All consultant annual leave is subject to formal approval by the relevant Clinical Director				✓
4	Accurate records of all consultant annual leave are securely retained within the relevant Directorate offices			✓	

Assurance Summary					
5	Effective monitoring arrangements are in place to ensure consultants annual leave is taken within the relevant leave year and any carried over leave is appropriate, within allowed levels and subject to formal authorisation by the relevant Clinical Director			✓	

** 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 4 issues that are classified as weaknesses in the system control/design for the Children & Women's' Clinical Board – Consultant Annual Leave. Additionally, I design issue classified has been raised that does not apply directly to this review but requires attention by management.

Operation of System/Controls

The findings from the review have highlighted 1 issue that is classified as weakness in the operation of the designed system/control for the Children & Women's Clinical Board – Consultant Annual Leave.

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 - Appropriate and up to date Policy and procedures are in place for the management of consultant annual leave

We note the following finding that forms the basis of the assurance rating and/or good practice:

- the Policy is subject to a formal review and update process; and
- the Policy is administered through the Deanery Intrepid System which has in-built controls to enhance compliance and consistency.

The following significant findings were identified for this objective:

- strengthen the Policy by defining a more comprehensive control framework from the Directorate through to the Consultants. At the same time incorporating additional elements of operational activity such as treatment of leavers, sickness; and
- ensure Directorates have desk notes in place to address local practices and to complement the revised Policy.

Objective 2 - All consultant annual leave is formally requested in compliance with the minimum required notice period and effective arrangements are made to cover duties

We note the following finding that forms the basis of the assurance rating and/or good practice:

- the Deanery Intrepid System used to administer the annual leave process has in-built controls over the application process.
- testing identified effective compliance with the required 6 week notice period and cover provisions required by the policy. One Directorate administered rota setting alongside the leave application process thereby improving the robustness of the monitoring function.

We are pleased to report that there were no significant findings identified for this objective.

Objective 3 - All consultant annual leave is subject to formal approval by the relevant Clinical Director

We note the following findings that form the basis of the assurance rating and/or good practice:

- the Deanery Intrepid System used to administer the annual leave process has in-built controls over the application process.
- testing confirmed that all requests were suitable authorised.

We are pleased to report that there were no significant findings identified for this objective.

Objective 4 - Accurate records of all consultant annual leave are securely retained within the relevant Directorate offices

We note the following findings that form the basis of the assurance rating and/or good practice:

- the Deanery Intrepid System used to administer the annual leave process has in-built controls over parts of the monitoring process.
- testing identified that records were held appropriately within the Directorates.

The following significant findings were identified for this objective:

- review and assess the impact of introducing annual leave calculations that reflect consultants different working practices; and
- assess the use of Intrepid as a function administration tool.

Objective 5 - Effective monitoring arrangements are in place to ensure consultants' annual leave is taken within the relevant leave year and any carried over leave is appropriate, within allowed levels and subject to formal authorisation by the relevant Clinical Director

We note the following finding that forms the basis of the assurance rating and/or good practice:

- the Deanery Intrepid System used to administer the annual leave process has in-built controls that facilitate the monitoring process.

The significant findings that apply to this Objective are those that have been reported as part of Objective 4 and have been taken in to consideration for the assurance grading.

The review identified the following improvement action that does not directly apply to the objectives of this review:

- local spreadsheets that are maintained as part of the overall administration of clinical services should be accessible by relevant users.

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**	**5**	**0**	**5**

Finding 1 – Policy Review and Update (Control design)	Risk
The UHB Annual Leave Policy for Career Grade Medical & Dental Staff was due for update on 6/9/2019 and at the time of this review was with the BMA for comment. Assessing the policy details against both BMA guidance and a selection of current policies for other Trusts, identified that there are additional areas where the policy could be strengthened, for example including detail on:- • roles and responsibilities – of Directorates, Managers, Consultants; • compressed working practices (see Recommendation 3); • monitoring and reporting; • leavers, sickness, bank holidays and including example calculations for clarity; and • details of the annual entitlement and leave taken in year to date on the manual leave form appended to the policy. The areas outlined above do not necessarily constitute all the activities that are not in the policy statement.	Control framework is not fully defined. The lack of guidance in some areas could lead to inconsistencies in applying the Policy at Directorate level.

Recommendation	Priority level
The UHB Annual Leave Policy for Career Grade Medical & Dental Staff should be reviewed and revised. The policy should more clearly specify: • roles and responsibilities; • treatment of consultants different working practices (see Recommendation 3); • monitoring and reporting arrangements • extending detail on leavers, sickness, bank holidays etc. • update the manual leave form to include entitlement and days taken to date.	**Medium**
Management Response	**Responsible Officer/ Deadline**
UHB Annual Leave Policy will be reviewed in light of these comments and taken back to LNC for agreement	Senior Medical Workforce Manager and Assistant Medical Director July 2020

Finding 2 - Procedures (Control design)	Risk
The two Directorates visited did not have any standard documented procedures or desk notes in place to detail the various localised processes around the administration of Consultants Annual Leave or Study Leave. In rolling out the use of Intrepid, Medical Education do provide a range of training and support the detail of which would form the basis of such operating procedures. A feature of the system is that it contains some in-built controls, most noticeably around authorisation. Whilst this does provide a sound control framework, supplementary procedures would ensure consistency of approach and assist staff taking on the function in event of absence of key personnel or where authorisation processes change.	Control framework is not defined leading to a disparity of working practices.
Recommendation	**Priority level**
Pro-forma procedures for administering annual leave and study leave should be drawn up and shared with Directorates for them to customise to their particular circumstances. Such procedures could also include good practice, dos & donts and other useful advice as well as designate an administrative back-up.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Further guidance to ensure consistency will be agreed with Directorates and overseen by the Intrepid User Group and overseen by the Medical Workforce Advisory Group	Senior Medical Workforce Manager and Assistant Medical Director July 2020

Finding 3 - Consultants 'Compressed' Working Practices (Control design)	Risk
Full time consultants are entitled to 33 days leave per annum. However, one consultant may deliver their work programme over 5 days whilst another over 4 days. If both have the same number of days leave, to get a full week off they take a different number of days leave. In this case one consultant 5 days the other 4 days. The BMA refer to this as 'compressed leave'. At the start of each financial year full time consultants are credited with an entitlement of 33 days on Intrepid. Consequently those that have 'compressed working weeks' will benefit. Testing of consultants leave taken identified several instances where this arose. Whilst the impact of different working arrangements can vary greatly depending on the specialty the BMA states: - 'there should be no advantage or disadvantage in terms of leave as a result of adopting different working patterns.'	Discrepancies arise between consultants in taking annual leave days depending on the working schedules.
Recommendation	**Priority level**
Review and evaluate the impact of compressed annual leave. If arrangements are changed build in to Policy	**Medium**
Management Response	**Responsible Officer/ Deadline**
Discuss with LNC and build guidance in to the policy to reflect best practice around compressed leave and entitlement within intrepid	Executive Medical Director July 2020

Finding 4 - Administrative Practices (Operating effectiveness)	Risk
Discussion and testing identified that administrative practices vary across Directorates. For example: • leave balances at the year-end were not always carried forward and there was not always an obvious reason as to why not. It might be that the Intrepid system is not always used; • manual calculations of entitlements were not always checked independently; • system generated e-mail notifications of consultants authorised leave were not set-up to send the relevant clinic or rota leads; • instances of negative year end leave, where presumably earned days in lieu had not been entered on Intrepid; • honorary staff were not always on Intrepid; • balances of annual leave are sometimes carried forward and 'authorised' as part of the next application; and • formal substitution arrangements are not in place should the main administrative staff be unavailable. Specific queries arising from testing were shared with the Directorates in order for them to debrief. We also recognise that all consultants have access to Intrepid and that it is incumbent on them to ensure that the record is accurate.	Disparate and inconsistent working practices occur across and within Directorates.

Recommendation	**Priority level**
Directorate administrative arrangements should be reviewed and strengthened in line with the revised Policy and as a part of producing operational procedures. Procedures should include the checking of core data on an annual or rolling basis.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Intrepid User Group will oversee implementation of revised guidelines in the Areas highlighted in this report	Senior Medical Workforce Manage and Assistant Medical Director September 2020

Finding 5 - Associated Arrangements (Control design)	Risk
In applying for annual leave consultants must confirm on Intrepid that suitable cover for the leave dates is in place. As part of our testing, for some consultants, we did follow through to confirm to the actual staff rota's and patient booking systems. In some cases, managers had designed and kept local spreadsheets to assist them in managing activity. However, access to some of these was not always shared.	Operational processes are disrupted if local spreadsheets cannot be accessed.
Recommendation	**Priority level**
Directorates should identify and assess the use of all local spreadsheets of operational services making sure access is available via shared drives.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Clinical board Head of Operations will ensure Directorates utilise appropriate ancillary spreadsheets if Intrepid does not align with local requirement and ensure Shared drive access is appropriately implemented.	Clinical Board Head of Operations July 2020

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

Medical Staff Study Leave

Final Internal Audit Report

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Appendix A Management Action Plan
Appendix B Assurance opinion and action plan risk rating

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Executive sign off: Martin Driscoll – Executive Director of Workforce

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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 review of the management of Medical Staff Study Leave was completed in line with the 2019/20 Internal Audit plan for Cardiff and Vale University Health Board (the UHB).

Study leave for medical and dental staff is determined in the Terms and Conditions of Service as leave granted for postgraduate purposes and approved by the employer and includes study (usually but not exclusively or necessarily on a course) research, teaching or taking examinations, visiting clinics and attending professional conferences.

The UHB is committed to supporting activities that are aligned to the needs of the individual and the organisation in delivering the health outcomes and healthcare priorities of NHS Wales in line with the principles of Continuing Professional Development (CPD). Study leave aims to satisfy the needs of not only the individual doctor but also those of the Health Board in improving patient care.

The Health Board introduced an updated 'Study Leave Procedure for Medical and Dental Staff' in July 2018. The procedure describes the study leave process for all medical and dental staff other than those in training programmes.

The relevant lead for this review is Executive Director of Workforce.

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 Medical Staff Study Leave, 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 is to establish if study leave provided to Medical Staff is being managed in accordance with the Health Board procedure and complies with BMA guidance, is of value to the professional and the UHB and is accounted for appropriately

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

- The Health Board Procedure is appropriate, complies with relevant BMA guidance, has been subject to formal approval and is appropriately published and made available to all relevant staff;
- All episodes of study leave are appropriately applied for and are subject to appropriate approval in accordance with the Procedure;
- All Medical staff undertake study / professional leave in accordance with the recommended standards for study leave in the UK; and
- The costs associated with study leave are identified and accounted for appropriately.

As part of the audit, review and testing of local processes was undertaken

within the Acute Child Health, Gastroenterology, Cardiothoracic Directorates and the Dental Hospital.

3. Associated Risks

The potential risks considered in this review are as follows:

- Provision of lower quality patient care;
- Unnecessary / inappropriate expenditure; and
- Medical staff do not stay up to date with developments within their field.

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 management of Medical Staff Study Leave is **Reasonable Assurance.**

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

Overall the Health Board Medical Staff Study Leave Procedure provides a sound administrative control framework and testing confirmed that the Procedure is being properly applied at Directorate level.

However, elements of the control framework can be strengthened. Developing the HB Procedure. to incorporate direction on areas such as budgeting, and ensuring that it is underpinned at Directorate level by localised procedures will promote more consistent administrative functions.

Study leave is administered through Intrepid which has many in-built controls and so is a good basic, fail-safe platform for administration purposes. Intrepid was initially designed to be a junior doctor administration tool but over time its use has been extended. It would therefore be opportune to assess and review its fitness of purpose for its current uses as well as develop the role of the Intrepid User Group.

The review identified six medium priority recommendations for management consideration.

The overall level of assurance assigned to this review is a reflection of the priority of findings and recommendations attributable to each specific review objective and of their combined impact on the overall control framework.

5. Assurance Summary

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

Assurance Summary					
1	The Health Board Procedure is appropriate, complies with relevant BMA guidance, has been subject to formal approval and is appropriately published and made available to all relevant staff			✓	
2	All episodes of study leave are appropriately applied for and are subject to appropriate approval in accordance with the Procedure			✓	
3	All Medical staff undertake study / professional leave in accordance with the recommended				✓

Assurance Summary					
	standards for study leave in the UK				
4	The costs associated with study leave are identified and accounted for appropriately			✓	

** 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 four issues that are classified as weaknesses in the system control/design for the Medical Staff Study leave processes reviewed.

Operation of System/Controls

The findings from the review have highlighted two issue that are classified as weaknesses in the operation of the designed system/control for the Medical Staff study Leave processes reviewed.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that were 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 - The Health Board Procedure is appropriate, complies with relevant BMA guidance, has been subject to formal approval and is appropriately published and made available to all relevant staff.

We note the following findings that form the basis of the assurance rating and/or good practice:

- the Procedure is subject to a formal review and update process; and
- the Procedure is administered through the Deanery Intrepid System which has in-built controls to enhance compliance and consistency.

The following significant findings were identified for this objective:

- strengthen the Procedure by defining a more comprehensive control framework of responsibilities from the Directorate through to the

Consultants. At the same time incorporating additional elements of direction on operational activity such as budgeting and reporting; and

- ensure Directorates have procedures in place to address local practices and to complement the revised Health Board Procedure.

Objective 2 - All episodes of study leave are appropriately applied for and are subject to appropriate approval in accordance with the Procedure.

We note the following findings that form the basis of the assurance rating and/or good practice:

- the Deanery Intrepid System used to administer the annual leave process has in-built controls over the application process.
- testing identified effective compliance with the required 6 week notice period and cover provisions required by the policy.

The following significant finding was identified for this objective:

- ensure that administrative functions are strengthened, especially that normal clinical authorisation is evidenced on Intrepid when agreeing leave applications.

Objective 3 - All Medical staff undertake study / professional leave in accordance with the recommended standards for study leave in the UK

We note the following findings that form the basis of the assurance rating and/or good practice:

- the Deanery Intrepid System used to administer the annual leave process has in-built controls over the application process.
- testing identified that all study leave applied for fitted the categories of study leave contained in the Procedure.

We are pleased to report that there were no significant findings identified for this objective.

Objective 4 - The costs associated with study leave are identified and accounted for appropriately

We note the following findings that form the basis of the assurance rating and/or good practice:

- the Deanery Intrepid System used to administer the annual leave process has in-built controls over parts of the monitoring process.
- testing identified that expenses were well controlled.

The following significant findings were identified for this objective:

- review and strengthen the Directorate budgetary control arrangements.

During the course of the review the following findings in relation to the use of Intrepid were identified:-

- need to assess the use of Intrepid as a functional tool for administering activity other than junior doctors; and
- develop the Intrepid User Group network.

Whilst these findings do not strictly specific apply to any of the audit objectives, they relate to assessing the suitability of purpose of the present administrative arrangements around the study leave and consultants leave processes.

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**	**6**	**0**	**6**

Finding 1 – Corporate Procedure Review and Update (Control design)	**Risk**
Assessing the UHB Study Leave Procedure for Medical & Dental Staff details against a selection of current policies for other Trusts, identified that there are additional areas that the policy could be strengthened. For example including detail on:- • roles and responsibilities – of Directorates, Managers, Consultants; • funding and budget guidance. • monitoring and compliance arrangements including KPIs; and • reporting arrangements. The areas outlined above do not necessarily constitute all the activities that are not in the Procedure statement.	Control framework is not full defined. The lack of guidance in some areas could lead to inconsistencies in applying the Procedure at Directorate level.
Recommendation	**Priority level**
The UHB Study Leave Procedure for Medical & Dental Staff should be reviewed and revised. The policy should more clearly specify: • roles and responsibilities – of Directorates, Managers, Consultants; • funding and budget guidance. • monitoring and compliance arrangements including KPIs; and • reporting arrangements. Once updated, the procedure flow chart that is appended should also be updated accordingly.	**Medium**

Management Response	Responsible Officer/ Deadline
UHB Study Leave procedure document will be reviewed and strengthened in the areas outlined in the report. This will require agreement with the Local Negotiating Committee (LNC) of the UHB.	Executive Director of Workforce and OD & Medical Director. July 2020

Finding 2 – Directorate Procedures (Control design)	Risk
The four Directorates visited did not have any standard documented procedures or desk notes in place to detail the various localised processes around the administration of Consultants Study Leave or Annual Leave. In rolling out the use of Intrepid, Medical Education do provide a range of training and support the detail of which would form the basis of such operating procedures. A feature of the system is that it contains some in-built controls, most noticeably around authorisation. Whilst this does provide a sound control framework, supplementary procedures would ensure consistency of approach and assist staff taking on the function in event of absence of key personnel or where authorisation processes change.	Control framework is not defined leading to a disparity of working practices.
Recommendation	**Priority level**
Pro-forma procedures for administering consultants study leave and annual leave should be drawn up and shared with Directorates for them to customise to their particular circumstances. Such procedures could also include good practice, dos & don'ts and other useful advice as well as designate an administrative back-up.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Enhanced Guidance will be provided for Directorates on interpretation of types of leave and their level and status of approval. This can then be consistently applied and adapted to local circumstances and will need to be agreed with the LNC.	Executive Director of Workforce and OD & Medical Director. July 2020

<table>
<tr><th>Finding 3 - Administrative Practices (Operating effectiveness)</th><th>Risk</th></tr>
<tr><td>Discussion and testing identified that administrative practices vary across Directorates. For example:

for one Directorate, study leave was not formally authorised on the Intrepid system. We are satisfied that the study leave is reviewed and agreed informally and evidenced on the outlook system as part of managing the clinic rotas.
manual calculations of study leave were not always checked independently. Instances were noted where staff reduced hours but the study leave was not accordingly amended, although the study leave was not over-claimed;
one case of retrospective study leave being authorised;
one case where leaver had full year of study leave allocated but the leave taken was less than the revised allowance;
system generated e-mail notifications of consultants authorised study leave were not always set-up to send to the relevant clinic or rota leads;
honorary staff were not always included on Intrepid; and
formal substitution arrangements are not in place should the main administrative staff be unavailable.

Some of these issues are historic and well recognised. Specific queries arising from testing were shared with the Directorates in order for them to debrief. We also recognise that all consultants have access to Intrepid and that it is incumbent on them to ensure that the record is accurate.</td><td>Disparate and inconsistent working practices occur across and within Directorates leading to lack of efficiency, effectiveness and economy.</td></tr>
</table>

Recommendation	**Priority level**
Directorate administrative arrangements should be reviewed and strengthened in line with the revised Health Board Procedure and as a part of producing local operational procedures, particularly the recording of clinical authorisation on Intrepid. Procedures should include the checking of core data on an annual or rolling basis.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Comprehensive Review of local processes Directorate by Directorate will take place to ensure consistency of process with UHB Procedures and guidance	Executive Director of Workforce and OD & Medical Director. Complete by September 2020

Finding 4 – Budget, costs and reporting (Control design)	Risk
As it stands, UHB Study Leave Procedure for Medical & Dental Staff does not contain any direction on funding and budgetary control. Accordingly, practices across Directorates varied greatly. Some Directorates allow study leave costs without any discrete budget funding being allocated and informed to the administrator. We believe that overall the sums involved were not significant. The reporting of the study leave costs by Medical Education to Directorates has recently been introduced. The report shows estimated against the actual costs on a case by case basis. We are aware that the format of the report is to be further developed and considered its utility could be improved through including budget details, variances and projected outcomes. Discussion also identified that:- • recently 60% of honorary consultants' expenses were being treated as eligible for payment whilst the policy stipulates that expenses should be proportional to the number of contractual sessions; and • one of the directorates had the opportunity to fund study leave from Trust Funds.	Incomplete control framework leading to poor budgetary control.
Recommendation	**Priority level**
The following arrangements are reviewed and strengthened:- • budget setting, monitoring and reporting; • payment of honorary staff expenses; and	**Medium**

• ability to access Trust funds to support study leave budgets.	
Management Response	**Responsible Officer/ Deadline**
Capped annual or triannual budget allocations are to be introduced after discussion with the LNC. Honorary Academic Consultants are contractually entitled to 0.6 of this annual or triannual allocation as per contract terms and conditions. Once capped allocation agreed consistent budget line allocation will be anticipated against which spend can be measured.	Executive Director of Workforce and OD & Medical Director. September 2020

Finding 5 - Intrepid plan (Control design)	Risk
Intrepid is a Deanery system designed for junior doctors that has been used to administer consultants study and annual leave. Discussion indicated that the use of Intrepid for these additional purposes within the Health Board has been on an informal basis and that various development initiatives are on-going, for example linking through to consultant rotas using Rosterpro. From an administrative perspective Intrepid provides a sound control framework. However, discussion indicated that there had been no overall assessment of its suitability for these other purposes.	Intrepid developments provide sub-optimal solutions over time.
Recommendation	**Priority level**
Assess and review the use of Intrepid as a tool for managing activities other than junior doctors and formulate a plan going forward.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Intrepid approval system enables approver to view a 'team' leave view that facilitates approval only where cover for clinical services can be managed and Intrepid will not allow leave application unless cover has been agreed by a named colleague. The UHB is currently considering options for e rostering of Medical Staff etc within the Medical Productivity Project alongside e job planning.	Executive Director of Workforce and OD & Medical Director. December 2020

Finding 6 - Intrepid User Group (Control design & Control effectiveness)	Risk
The Intrepid system was installed across the Health Board through a roll out programme that commenced in 2010. Support for Intrepid is provided by the Medical Education Department, both in a formal and informal capacity. Besides being the main point of contact with The Deanery, the Department also liaise with Directorates and Administrators through training, meetings and responding to ad hoc queries. We note that at present the administrative authorisations are gradually being reviewed, previously there was no regular process. An Intrepid User Group is in place but its meetings and attendance have recently been of a more informal basis. As the use of Intrepid varies between Directorates' there is the opportunity to identify issues and good practice. One theme that emerged from discussions with user staff was the limited ability to access 'team views' from intrepid or to generate reports. We are not fully aware of the technical options available but from the user perspective these limitations lessen the use of the system as an active staff management tool.	Intrepid is not used optimally, leading to lack of efficiency. effectiveness. and effectiveness.
Recommendation	**Priority level**
Develop the Intrepid User Group to co-incide with the introduction of the updated Health Board Procedure and local operational procedures. Besides regularising practices, the group could be a forum to identify development opportunities and good practice. The ability of the system to generate 'team views' and reports should be considered as well. Once updated, the authorisations should be checked annually.	**Medium**

A Terms of Reference should be put in place and all meetings should have minutes and action plans.	
Management Response	**Responsible Officer/ Deadline**
Intrepid User Group will be refreshed with revised TOR and membership. Minutes of meetings and associated Action plans will be reviewed by the Medical Workforce Advisory Group	Assistant Medical Director (Workforce and Revalidation), Medical Workforce Manager and Medical Education Lead. July 2020

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.

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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*
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* Unless a more appropriate timescale is identified/agreed at the assignment.

Control of Contractors

Final Internal Audit Report 2019/20

Cardiff & Vale University Health Board

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance

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Appendix A Management Action Plan
Appendix B Appointment of Contractors: results of testing
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Appendix D Audit Assurance Ratings

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Distribution	Geoff Walsh, Director of Capital, Estates and Facilities Tony Ward, Head of Discretionary Capital & Compliance Phil Mackie, Health & Safety and Asbestos Manager
Committee	Audit Committee

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1. Introduction and Background

The Control of Contractors audit was commissioned as a part of the approved 2019/20 internal audit plan, in order to evaluate the processes and procedures that support the management and control of contractors working for the Capital, Estates & Facilities (CEF) function of the University Health Board ('the UHB').

Both the UHB and its appointed contractors have responsibilities under Health and Safety law, to ensure appropriate precautions are taken to reduce the risks of dangers to patients, employees, visitors and contractors themselves. Applicable legislation includes the Health and Safety at Work etc. Act 1974, Management of Health and Safety at Work Regulations 1999, Control of Substances Hazardous to Health Regulations 2002 and the Control of Asbestos Regulations 2012, amongst others.

The Health & Safety Executive (HSE) has produced a range of guidance on the safe management of contractors, including "Managing Contractors" (HSG 159), and the "Using Contractors – a Brief Guide." The audit assessed compliance with the requirements of this guidance.

Note: the assessment of compliance with the Construction (Design and Management) Regulations 2007 was outside the scope of this current review.

2. Scope and Objectives

The review was undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of the UHB for the management of capital projects, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

The audit focussed on the management of contractors within the responsibility of the CEF function only. This review did not consider the management of other contractors such as IT or Medical Equipment, which will be considered at future audit plans.

Accordingly, the focus of the current audit was directed to the following areas:

- **Governance -** assurance that the UHB had adequate arrangements in place to support the control of CEF contractors and compliance with regulations and guidance. Further, assurance that appropriate policy and procedural documents were in place to manage the control of contractors, in line with HSE guidance.
- **Appointment of contractors –** assurance that potential CEF contractors were appropriately checked to establish compliance with

HSE requirements and the UHB's required standards for health & safety, including confirmation that contractors had:

  - sufficient skills, knowledge, experience and the ability to implement appropriate health & safety systems;
  - undertaken an appropriate risk assessment in relation to the specific work they were to undertake; and
  - a reasonable track record of occupational health & safety performance at work of a similar nature.

- **Management of work on site –** assurance that appropriate arrangements were in place to manage CEF contractors working on the UHB's premises including:
  - control over access to site;
  - appropriate site induction arrangements;
  - risk assessments, safe systems of work etc. were in place;
  - operation of Permits to Work where appropriate; and
  - regular monitoring of contractors on site to ensure compliance with required practices.
- **Monitoring and reporting –** assurance that ongoing monitoring and review of CEF contractors / contractor related incidents was employed in order to maintain the required standards of health & safety and to improve existing processes, including:
  - monitoring, review and reporting (both internal and external e.g. RIDDOR requirements) of any contractor-related incidents including the feedback of lessons learnt to contractors and to inform the UHB procedures; and
  - monitoring of compliance with the UHB's requirements.
- **Other –** review of any other issues relevant to the general objectives above which arose during the review.

3. Associated Risks

The potential risks considered in the review were as follows:

- Patient, staff, contractor & public safety;
- Damage to the UHB property;
- Adverse publicity/reputational damage;
- Breach of HSE regulations and potential financial penalties; and
- Prosecution/criminal negligence

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.

Being cognisant of the work that has been invested by the UHB over recent years, general compliance was noted with the established control frameworks including:

- Governance;
- Vetting of contractors, for compliance to HSE requirements, prior to commencement of work; and
- Monitoring and reporting of contractors (and related incidents where applicable).

However, application of the expected standards was reduced in the following areas:

- Risk Assessment and Method Statements (RAMS) need to be received prior to commencement of work and retained;
- A data cleansing exercise of the Backtraq system needs to be undertaken to ensure only current, verified contractors are recorded;
- The induction process needs to be updated to reflect consistency with UHB policies;
- The sign in/out reporting functionalities of Backtraq require improvement;
- The formality of the sign in/out process of contractors on community sites requires addressing;
- A review on the use (and retention) of Job Evaluation Forms (JRFs) is required to ensure consistency of application;
- The formality of monitoring of contractors on site, and reporting post completion, needs to be enhanced;
- The Permit to Work procedure needs to be finalised and ratified; and
- The requirement for reporting of UHB compliance to the Control of Contractors policy, on an annual basis, needs to be addressed.

It is acknowledged that some of the above will be addressed through contractor review meetings, which will be scheduled through the newly

established contractor frameworks; in addition to the implementation of a JRF database for use by Supervising Officers.

Accordingly, against this context, the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with control of contractors 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.

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	Governance				✓
2	Appointment of contractors			✓	
3	Management of work on-site			✓	
4	Monitoring & reporting			✓	

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

Design of Systems/Controls

The findings from the review highlighted **three** issues that are classified as a weakness in the system control/design for the management of contractors within the responsibility of the Capital, Estates & Facilities function.

Operation of System/Controls

The findings from the review highlighted **eight** issues that are classified as weaknesses in the operation of the designed system/control for the management of contractors within the responsibility of the Capital, Estates & Facilities function.

6. Summary of Audit Findings

Governance

We sought assurance that there were adequate arrangements, including policies and procedures, in place to support the control of Capital & Estates contractors and compliance with regulations and guidance.

The Health & Safety Committee, chaired by an independent member, has responsibility for the control of contractors,

The UHB has produced a corporate-wide 'Control of Contractors' policy. The policy has recently been reviewed (October 2019) and the update was ratified for issue by the Health & Safety Committee.

The policy provides extensive guidance to ensure robust controls and processes are in place to manage the risks to patient, staff and contractor safety in line with HSE guidance.

Local contractor control procedures ('Contractor's General Code of Safe Practice') were in place, which were issued through the contractor appointment process.

Noting the defined governance arrangements currently operating, **substantial assurance** has been determined in this area.

Appointment of contractors

We sought assurance that Capital & Estates contractors were appropriately checked to establish compliance with HSE requirements and the University Health Board's required standards for health & safety.

The defined appointment process requires the Health & Safety team [within the Discretionary Capital team] to ensure potential contractors are either:

1. Registered with Safety Schemes in Procurement (SSIP); or
2. Issued with an appropriate internal pre-qualification questionnaire (CCHSQ1 as per the Control of Contractors policy)

All appointed contractors were also provided with a copy of the UHB's Contractors General Code of Safe Practice (last reviewed January 2019).

Compliance with this process was reviewed for appointments at a sample of six Discretionary Capital Projects (DCPs) and 16 Estates Maintenance jobs.

Appointment controls were found to be robust for all the DCPs with the provision of required information as part of the tender submission. Current SSIP documentation, or equivalent, was evidenced for all of the 16 jobs reviewed (refer to **Appendix B** for full audit findings). It is noted that whilst not all valid evidence was available at the date of the audit fieldwork, it was provided retrospectively thus reducing the exposure of the UHB to the risk of non-compliance.

Upon appointment, there is an expectation that Risk Assessments and Method Statements (RAMS) are provided by the contractor. This was evidence for all the DCPs reviewed. Fourteen of the Estates Maintenance jobs sampled required a RAM; of which 11 were evident (refer to **Appendix B**) **(recommendation 1)**

Management advised that a number of Contractor Frameworks[1] are currently being finalised which would ensure management of current certifications therefore mitigating the risk that contractors were working at UHB sites without due compliance with HSE requirements. It is acknowledged that whilst the frameworks will be managed by the Discretionary Capital team, Estates will be able to make use of them to assist in appointment of contractors.

Management recognised that there were a significant number of contractors classed as 'approved' on the Backtraq software; of which only a small percentage are currently used. The introduction of the frameworks should enable a data cleansing exercise to be undertaken to allow only current, verified, contractors (Capital & Estates appointed) to be recorded **(recommendation 2)**.

Noting the level of compliance observed, and the benefit the proposed implementation of contractor frameworks will bring to managing compliance with HSE requirements, **reasonable assurance** has been determined in this area.

[1] *Frameworks for Mechanical, Electrical and Asbestos Removal will be operational from the beginning of February 2020. Framework for Building will be operational from the end of February 2020. Framework for Asbestos Removal anticipated to be operational by the end of March 2020.*

Management of work on-site

We sought assurance that appropriate arrangements were in place to manage Capital & Estates contractors working on the University Health Board's premises.

The HSE sets out clear guidance for managing contractors on site, including the requirement for all contractors to sign in/out, a clear site contact to be established, information and rules to be reinforced and job checks to be undertaken prior to any work commencing.

The UHB policy specifies processes in place to address the HSE guidance (including an induction session and completion of Job Registration Forms [JRFs]) i.e.:

- All contractors appointed to work at UHB sites must complete an induction session, which is provided by the Health & Safety and Asbestos Manager. A review of the session content noted coverage of areas including site safety rules, fire safety, the issue/return of access cards, keys and ID badges. All inductions are valid for a period of two years; and must be evidenced as complete, or the contractor cannot be signed on-site through the 'Contractor Control' element of the Backtraq software.

  It was noted through discussion that the content of the induction presentation provided to the contractors requires updating as it currently does not reflect working practices **(recommendation 3)**.

- JRFs were introduced as a consequence of a serious incident at the UHW site in 2016, to provide a robust checklist ensuring adequate health & safety checks are made prior to commencement of work. The JRFs were trialled across the Capital, Estates & Facilities function during 2017 with formal implementation in December 2017. The review of completed JRFs for our selected sample (refer to **Appendix C**) noted an inconsistency in their application arising from a variance in understanding by Supervising Officers as to when they are required **(recommendation 4)**.

  There were also issues noted regarding the retention of completed JRFs **(recommendation 5).**

  Management advised of the recent implementation of a database through which JRFs could be completed as well as allowing attachments such as permits to work and RAMS (applicable to the individual job); reducing the risk of lost paperwork. At the date of the audit, this had been rolled out on a trial basis with proposed full implementation with effect from January 2020.

- The UHB uses Backtraq and Contractor Control software to manage the information records of contractors and the sign in/out process. The Contractor Control functionality allows Supervising Officers to

sign in individuals for the estimated period of time that the work is expected to take.

It is required by HSE guidance and the UHB's Contractor's General Code of Safe Practice that individual contractors sign in/out on a daily basis. Across the UHW and UHL sites, this is managed through the use of scanners which are linked to the Backtraq system; through which management information is provided to the nominated Supervising Officer (i.e. the officer who signed the contractor personnel into the system) to confirm contractor attendance at a point in time.

It is noted the management information is a high-level summary; issued to only the nominated officer; and further interrogation of the system is required to confirm the exact dates and times to which the management information is related. This reporting output is deficient to the needs of the UHB **(recommendation 6)**

- Monitoring of daily sign in/out of contractors at the community sites is more difficult as scanners are not installed at every site. Discussions held with management highlighted the potential for the use of the site asbestos registers as a way to bridge the gap. Contractors are expected to review the register prior to commencement of work; this review could be extended to a sign in/out sheet to provide confirmation of attendance at site **(recommendation 7)**
- In practice, Permits to Work were completed across the discretionary capital projects and Estates maintenance schemes examined. Noting the same, at the time of the review, there was no supporting guidance in place to assist staff; we acknowledge that management were in the process of developing appropriate guidance **(recommendation 8).**
- The Asbestos Management Plan (approved November 2019) sets out appropriate measures undertaken before work commences i.e. the checking of the Asbestos register; completion of appropriate surveys.

It was observed that the Health & Safety and Asbestos Manager selectively undertakes visits and spot checks to engage with contractors working on-site. These visits covered a sample of current work (specifically in relation to the DCPs) with findings regularly reported. There was no evidence of monitoring of a similar nature undertaken by Estates officers however it is acknowledged that the Health & Safety and Asbestos Manager will review all contractors, even if employed by another department. The Health & Safety and Asbestos Manager has recently introduced a monitoring initiative to improve consistency in monitoring undertaken for work managed by Estates Maintenance **(recommendation 9).**

Noting the issues highlighted above, and the changes to working practices being addressed by the UHB, **reasonable assurance** has been determined.

Monitoring and reporting

We sought assurance that appropriate ongoing monitoring and review of contractors / contractor related incidents was employed in order to maintain the required standards of health & safety and to improve existing processes.

Monthly Health & Safety group meetings were held within the Capital, Estates and Facilities Directorate. Information was reported regarding current works, number of contractors on site, completed inductions, completed JRFs and reported contractor incidents (if applicable).

A summary of the above was reported to the Capital, Estates & Facilities Service Board and to the corporate Health & Safety Committee.

Aside from the RIDDOR reportable incident in 2016, there have been no significant contractor related incidents at the UHB in the last three years. Appropriate action was taken post incident with the immediate development of an action plan to address issues specific to the incident as well as general measures such as the introduction of the JRF and a revised permit for working at height.

The Control of Contractors policy, and HSE issued guidance, suggests a review of contractor-led work upon completion. However, there was no evidence of a formal review process for completed DCPs or Estates Maintenance jobs; **(recommendation 10),** or evidence of an annual review of key performance indicators as stated within the policy **(recommendation 11)**. Management advised that these areas will be addressed as part of the Contractor Framework management process**.**

Noting the requirements for improvement to the formality of monitoring and reporting procedures, **reasonable assurance** has been determined.

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 raised	1	8	2	**11**
Actioned since fieldwork	1	2	-	**3**
Number of recommendations to address	-	6	2	**8**

Appointment of Contractors – Risk Assessment & Method Statements	**Risk**
Section 1.3 of the UHB's Contractors General Code of Safe Practice states that: *"Before work commences on each contract…so that the appropriate arrangements for health and safety can be made….Risk Assessments and Method Statements must be produced for the activity to be undertaken"* Completed Risk Assessments and Method Statements (RAMS) were evidenced for all of the DCP's reviewed. Fourteen of the Estates Maintenance jobs sampled required RAMS; of which 11 were evident [*refer to Appendix B for full audit findings*].	Contractors may not hold appropriate competencies to undertake the work; or to adequately protect the UHB and patients/ visitors. Non-compliance with HSE requirements.
Recommendation 1	**Priority level**
RAMS (where applicable) should be requested and retained prior to the contractor commencing the relevant activity on site **(O)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
Accepted. RAMS will now be incorporated within the database implemented in January 2020. It will be the Engineering Manager's responsibility to review the database on a weekly basis to ensure the required suite of RAMS is evident. A sample check of the database will be undertaken on a monthly basis by the Health & Safety and Asbestos Manager, to ensure compliance and reported to the Capital, Estates & Facilities Department Health & Safety Meeting. The first compliance check will be reported to the March 2020 meeting.	Health & Safety and Asbestos Manager March 2020

Appointment of Contractors – Data Cleansing Exercise	Risk
A number of Contractor Frameworks are currently being finalised which would ensure management of current certifications; therefore mitigating the risk that contractors were working at UHB sites without due compliance with HSE requirements. Noting the introduction of these frameworks, and the refined number of contractors that would ensue, it would present an opportunity to undertake a data cleansing exercise of Backtraq for those contractors that are rarely used or not used at all; to minimise the risk of any officers using legacy appointments for which no valid documentation is held.	Failure to maintain adequate records.
Recommendation 2	**Priority level**
Management should undertake a data cleansing exercise of the Backtraq system **(O)**	**Low**
Management Response	**Responsible Officer/ Deadline**
Accepted. An initial review of the database, in consultation with the relevant officers within the Capital, Estates & Facilities department, will be undertaken to remove any contractors that have not been used in the past three years. The remaining contractors will then be reviewed accordingly.	Health& Safety and Asbestos Manager October 2020

Induction sessions (content)	**Risk**
A review of the presentation used for the induction sessions offered to contractors noted inconsistencies in actual practices observed i.e.: • Sign in/out process • Return of ID badges upon completion of work It was also noted that the presentation did not make explicit reference to the requirements of reporting of any contractor-related incidents sustained by personnel. However, it is acknowledged that this was addressed with the Contractors General Code of Safe Practice [section 2.24].	Inconsistent advice given to contractors regarding UHB best practice
Recommendation 3	**Priority level**
Induction content should be reviewed and updated to reflect current practice **(O)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
Accepted. The presentation will be updated to reflect current practice. The audit-visual presentation will be audible version of the induction will be removed from use until any ambiguities in the narrative have been addressed. In the interim, physical presentations by UHB staff will be undertaken.	Health & Safety and Asbestos Manager March 2020

Job Registration Form (JRF)	Risk
JRFs were introduced as a consequence of a serious incident at the UHW site in 2016. The forms aim to provide a robust contractor checklist to ensure adequate health & safety checks are made prior to the commencement of work. Guidance issued by the UHB, in 2017, for the use of JRFs states: *a) A JRF must now be completed for all contractor activities on any UHB site (outside of work in F10 [2] areas) and emergency work.* *b) For pre-planned maintenance (PPM) contractors, on a term contract, the requirement is to complete one JRF at the start of the contract only.* *DCPs* All of the six DCPs sampled had completed JRFs retained on file. *Estates Maintenance* In accordance with the JRF guidance, 11 of the Estates jobs sampled would have required a JRF. There was no evidence of such for eight of these jobs (refer to Appendix C); and for two, a further explanation was provided by the Supervising Officer: • Boiler Maintenance: UHL - recorded as completed as per the JRF register maintained, but no completed form was evident.	Non-compliance with HSE guidance. Reduced control in managing contractors on-site.

[2] F10 projects are in relation to work areas that are not under the direct control of the UHB.

• Street Lighting Column Replacement: UHL - the Supervising Officer was on a course at the date of appointment. Non-completion of the JRF was attributed to lack of appropriate delegation of responsibilities. An alternative approach to completion was applied to term contractors (who are appointed for a defined time period). These were required to complete a single generic JRF dated for the duration of the term. There were four 'term' contractors included within our sample, and there was evidence of JRF's completed for three. Management advised of the recent implementation of a database through which JRFs could be completed as well as allowing attachments such as permits to work and RAMS (applicable to the individual job).	
Recommendations 4 & 5	**Priority level**
4. Management should formally implement the database, across Capital, Estates & Facilities, as the main control for completion and retention of JRFs **(D)**	**Medium**
5. Management should roll-out appropriate training on JRF guidance including requirements for delegation of responsibility during periods of absence **(O)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
4. Accepted. The database was formally implemented in January 2020	Actioned since fieldwork
5. Accepted. All relevant Supervising Officers within the Capital, Estates & Facilities department have been trained on the usage of the database.	Actioned since fieldwork

Management of work on site - Backtraq	Risk
The Control of Contractors policy (section 5.4) states that Supervising Officers are responsible for '*ensuring when the contractor is on site, they sign in and out and wear appropriate identification*'. The UHB utilises Backtraq and Contractor Control software to manage the information records of contractors and the sign in/out processes. The Contractor Control functionality allows Supervising Officers to sign in individuals for the estimated period of time that the work is expected to date. Scanners had been installed (UHW and UHL only) to be used with the barcode on the ID badges to facilitate daily sign in/out; for which management information is provided to the nominated Supervising Officers upon completion of the work. It was noted the management information is a high-level summary; issued to only the nominated officer; and further interrogation of the system is required to confirm the exact dates and times to which the management information is related. The information provided includes: • Visit reference • Contractor • Personnel • Assigned site • Work type	Non-compliance with HSE guidance. Lack of control in managing contractors on-site. The UHB does not know which contractors are on site on any given day.

Unless the name of the contractor personnel is known by an officer interrogating the system, it is difficult to ascertain attendance on a contractor job basis. Furthermore, there were no formal mechanisms for sign in/out evidenced at the UHB's community sites.	
Recommendations 6 & 7	**Priority level**
6. The functionality of the Backtraq system should be reviewed for the timeliness and detail of the management information provided. **(D)**.	**Medium**
7. A sign in/out system should be in place at each community site, using measures appropriate to the site, with ALL contractors required to action daily **(O)**.	**High**
Management Response	**Responsible Officer/ Deadline**
6. Accepted. Initial discussions have been held with the software provider re: potential enhancements to the existing system. However, it is accepted that a standalone system for sign in/out would be more effective. Different options will need to be reviewed to determine an appropriate direction of travel.	Head of Discretionary Capital & Compliance Health & Safety and Asbestos Manager September 2020
7. Accepted. As asbestos registers are maintained at each community site, these have been updated to include a requirement to evidence the date/time all contractor's sign in and out of the respective site.	Actioned since fieldwork

Permit to work-procedure	**Risk**
Whilst a permit to work system was in operation at the UHB initiated either from: a) Receipt of the RAMS; or b) Completion of the JRF There was no formal documented procedure in place as is outlined in HSE guidance.	Potential inconsistent/inappropriate processes applied due to lack of formal guidance. Potential non-compliance with HSE requirements.
Recommendation 8	**Priority level**
A Permit to Work procedure should be developed, ratified and communicated to all relevant officers **(D)**	**Low**
Management Response	**Responsible Officer/ Deadline**
Accepted. The procedure is currently out for consultation and will be presented to the Capital, Estates & Facilities department Health & Safety meeting for ratification at the March 2020 meeting.	Head of Discretionary Capital & Compliance Health & Safety and Asbestos Manager March 2020

Contractor monitoring/progress meetings	Risk
Whilst noting the substantial level of monitoring, supervision and reporting of findings by the Health & Safety Support Officer and progress meetings for DCPs, there was no evidence of replication of this level of monitoring by Estates Supervising Officers. Management advised that discretion was exercised in such instances i.e. determined by the time duration of the job, the level of risk assigned to the job etc. Discussions held with management noted that whilst Supervising Officers were aware of issues as they arise, if applicable, and contractor performance, no formal recording process was applied. The Health & Safety Support Officer has since introduced a monitoring initiative whereby Supervising Officers must complete one monitoring form per week for contractor-related works. Checks to be undertaken included: • Ensuring all personnel on site had been signed in; • Checking the job was adequately supervised; • Appropriate Personal Protective Equipment (PPE) was worn; and • Checking appropriate permits to work were in place. There were also monthly meetings undertaken by CEF staff, with contractors appointed to undertake statutory compliance work. However, these were not formally documented.	Non-compliance with HSE guidance Reduced control in managing contractors on-site.

Management advised that the introduction of contractor frameworks will assist in making the required review process more manageable with formal reporting timetables to adhere to.	
Recommendation 9	**Priority level**
Management should collate the output of the contractor monitoring forms for reporting to an appropriate forum; for actions to be taken where required. **(O)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
Accepted. In the role of Framework Manager, the Head of Discretionary Capital & Compliance, will initially hold six-monthly review meetings with all contractors addressing the recommendation requirements; and subsequent frequency will be dependent on how often the contractor is used by the UHB. However, all will have an annual review meeting.	Head of Discretionary Capital & Compliance September 2020

Review of projects/jobs post completion	Risk
The majority of Capital, Estates & Facilities works are considered high risk and therefore should follow the high risk work flow chart as per the UHB's Control of Contractors Policy. This states that the Supervising Officer should review performance with the contractor on completion of the works and agree with the works requester that all duties were completed to the agreed scope and quality. Furthermore, HSE guidance states that after the job is finished, it should be reviewed to: • Evaluate quality; • Ensure lessons (positive and negative issues) are learnt and are applied at future works/jobs etc. There was no evidence of feedback meetings post completion at any of the DCPs and Estates Maintenance jobs sampled. Management advised that discussions were held, to raise issues where applicable, but not formally documented. The absence of such information prevents the UHB from making suitably informed appointment decisions at future projects. Management also advised that the introduction of contractor frameworks will assist in making the required review process more manageable with formal reporting timetables to adhere to.	Absence of a review/feedback loop could result in the future use of subpar contractors.

Recommendation 10	Priority level
Formal post completion review meetings of contractor performance should be undertaken in accordance with HSE guidance **(O)**	**Medium**
Management Response	**Responsible Officer/ Deadline**
Accepted, as per the response to recommendation 9.	Head of Discretionary Capital & Compliance September 2020

Monitoring & reporting – annual audit	Risk
Section 12 of the Control of Contractors policy states that the policy will be audited annually. It further provides details of the key performance indicators, including: - Evidence of contractor compliance with pre-tender selection process- - Valid Health & Safety Policy - Incidents being reported - Risk assessments - Method statements - Evidence of contractors being provided with health & safety information - Evidence of pre-site checklist being completed (i.e. JRF) There was no evidence of annual audits being completed during the past two years. It is acknowledged that a summary of monthly performance is reported to the Health & Safety Group, with further reporting to Service Board; however, the detail does not currently cover the aforementioned indicators.	Non-compliance with UHB policy and subsequent lack of assurance that the process and policy is being followed
Recommendation 11	**Priority level**
An annual audit of compliance with the policy should be completed and reported to an appropriate forum. **(O)**	**Medium**

Management Response	Responsible Officer/ Deadline
Accepted. Discussions will be held with the Head of Health & Safety with a view to enhance the data that is reported to the Health & Safety Committee within the Annual Report.	Health & Safety and Asbestos Manager June 2020

Appendix B: Appointment of Contractors – results of testing

Project/Job	Location	UHB's H&S standards conveyed	Pre-qualification questionnaire completed (CCHSQ1)	Current SSIP Accredited[1]	Evidence of current insurances	Risk assessment/Method statement
Discretionary Capital projects						
Academic Building	UHL	Y	Y	Y	Y	Y
Black & Grey Theatres	UHL	Y	Y	Y	Y	Y
Barracc Ward - Barry	Barry	Y	Y	Y	Y	Y
Panel Pumping Station 2	UHW	Y	Y	Y	Y	Y
Renal Ward	UHW	Y	Y	Y	Y	Y
Woodlands House	Woodlands House	Y	Y	Y	Y	Y
Compliance		**100%**	**100%**	**100%**	**100%**	**100%**
Estates Maintenance						
Roof repairs/leak	Community site	Y	Pre-approved	Y	Y	Y
Repair leaking medical air pipe	UHL	Y	Pre-approved	Y	Y	Y
Replace compressor motor	UHL	Y	Pre-approved	Y	Y	Y
Street lighting column replacement	UHL	Y	Y	Y	Y	Y
Boiler maintenance	UHL	Y	Pre-approved	Y	Y	Y
Noise from roof space investigation	UHL	Y	Pre-approved	Y	Y	N/A (inspection only)
Fire alarm maintenance	UHW	Y	Pre-approved	Y	Y	Y
Renewal of Boiler no.2	UHW	Y	Pre-approved	Y	Y	N

Project/Job	Location	UHB's H&S standards conveyed	Pre-qualification questionnaire completed (CCHSQ1)	Current SSIP Accredited[1]	Evidence of current insurances	Risk assessment/Method statement
Inspect and test electrical infrastructure after fire	UHW	Y	Pre-approved	Y	Y	Y
Repairs to chiller	UHW	Y	Pre-approved	Y	Y	Y
Aviation lighting maintenance	UHW	Y	On hold	On hold	On hold	On hold as submitted RAMS deemed insufficient
Roof repair/leaks	UHW	Y	Pre-approved	Y	Y	N/A (not started)
Fault with operating light – after hours	UHW	Y	Pre-approved	Y	Y	N
Install and commission inverters in cardiac day centre	UHW	Y	Pre-approved	Y	Y	Y
Supply & fit thermal insulation to boiler	UHW	Y	Pre-approved	Y	Y	N
Install flood lights and sockets	UHW	Y	Pre-approved	Y	Y	Y
Compliance		**100%**	**100%**	**100%**	**100%**	**77%**

[1]SSIP (Safety Schemes in Procurement) is an accreditation scheme supported by the HSE for occupational health and safety standards. It is used by the UHB as a control to assess contractors' accreditations including health and safety measures and insurance coverage. Contractors are expected to maintain up-to-date information regarding competencies and insurance coverage.

Appendix C: Management of work on-site – results of testing

Audit Ref	Location	JRF completed [3]	Induction completed [4]	Knowledge of on-site contact [5]	ID Badge issued	Sign in/out records [6]
Academic Building	UHL	Y	Y	Y	Y	Y
Black & Grey Theatres	UHL	Y	Y	Y	Y	Y
Barracc Ward	Barry	Y	Y	Y	Y	Y
Panel Pumping Station 2	UHW	Y	Y	Y	Y	Y
Renal Ward	UHW	Y	Y	Y	Y	Y
Woodlands House	Woodlands House	Y	Y	Y	Y	Y
Compliance		**100%**	**100%**	**100%**	**100%**	**100%**
Roof repairs/leak	Community site	Y	Y	Y	Y	Y
Repair leaking medical air pipe	UHL	Y	Y	Y	Y	Personnel details provided
Replace compressor motor	UHL	Y	Y	Y	Y	Y
Street lighting column replacement	UHL	N	Y	Y	Y	N

[3] JRFs were requested from Estates staff and/or the Health & Safety Support Officer for each specific job with the expectation of being provided with a duly completed JRF for the job/project or a generic JRF dated for the term for term-contractors.
[4] Induction testing: this was reliant on the ability to interrogate Backtraq effectively by approximating the dates of the jobs/projects. This was not always feasible unless the names of the individuals were known by CEF staff. However, it is acknowledged that a contractor can't be issued with a badge or be signed in on-site unless evidenced as inducted on the system.
[5] Knowledge of on-site contact was verified by checking JRFs and/or Backtraq sign-in records.
[6] Sign in/out records: verified via Contractor Control. The scope of the information reviewed in testing does not provide the names of individual contractor personnel used for the work sampled. As such, a high-level review was been undertaken to confirm attendance by the contractor at the approximate time-period of the work sampled [noting some dates reviewed were invoice dates rather than date of actual attendance on site]. The number of individuals assigned to the work has been determined but sign in/out records not evidenced for all.

Audit Ref	Location	JRF completed [3]	Induction completed [4]	Knowledge of on-site contact [5]	ID Badge issued	Sign in/out records [6]
Boiler maintenance	UHL	N	Y	Y	Y	Personnel details provided
Noise from roof space investigation	UHL	Not needed	Y	Y	Y	Personnel details provided
Fire alarm maintenance	UHW	N	Y	Y	Y	Personnel details provided
Renewal of Boiler no.2	UHW	N	Y	Y	Y	Personnel details provided
Inspect and test electrical infrastructure after fire	UHW	Emergency – not needed	Under supervision	Under supervision	Under supervision	Under supervision
Repairs to chiller	UHW	N	Y	Y	Y	Y
Aviation lighting maintenance	UHW	On hold	On hold	On hold	On hold	On hold
Roof repair/leaks	UHW	Not started	Not started	Not started	Not started	Not started
Fault with operating light – after hours	UHW	Emergency – not needed	Under supervision	Under supervision	Under supervision	Under supervision
Install and commission inverters in cardiac day centre	UHW	Y	Y	Y	Y	Personnel details provided
Supply & fit thermal insulation to boiler	UHW	N	Y	Y	Y	Personnel details provided
Install flood lights and sockets	UHW	N	Y	Y	Y	Personnel details provided
Compliance		**27%**	**100%**	**100%**	**100%**	

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 & Vale University Health Board

Digital Readiness

Final Internal Audit Report

2019/20

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Appendix A Management Action Plan
Appendix B Staff Survey

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Distribution: David Thomas, Director of Digital & Health Intelligence
Committee: Audit Committee

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

Please note:

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1. Introduction and Background

The review of the readiness of the UHB to move to a digitally enabled organisation has been completed in line with the 2019/2020 Internal Audit Plan.

Digital transformation is a process of using technology to radically change service delivery. This transformation includes changing how the organisation works at every level and technology underpins all digital transformation projects. The technology changes as time goes on, but organisations need to adopt technologies that help them harness and make sense of the vast quantities of data they are sitting on, as well as preparing for trends like the Internet of Things (IoT) and mobile.

These technologies have the potential to to transform health care and organisational service delivery. In a digital world the patient or service user is the centre, surrounded by the patient-facing technologies providing them with opportunities to manage their health and engage with health care providers. Technologies that provide tools for health care professionals are embedded within the organisation, such as decision support, the capacity to access other professionals' expertise, tools to prioritise and manage their clinical workload and tools to identify the patients at greatest risk.

The move to a digitally enabled organisation should be part of an IM&T Strategy which should support the organisational strategy and provide a holistic view of the current business and IT environment, the future direction, and the initiatives required to migrate to the desired future environment.

The UHB is currently in the process of redefining its IM&T Strategy with a view to enabling it to capitalise on new, digital technologies.

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

2. Scope and Objectives

The objective of the audit is to evaluate and determine the processes in place within the development of the digital strategy to allow the UHB to move to a digitally enabled organisation and ensure that it drives value from investment in new technology.

The main areas that the review will seek to provide assurance on are below and map to themes that act as signifiers for organisational readiness for digital:

- The strategy development process has appropriate mechanisms for re-imagining service delivery and business processes.

- The strategy development process is engaging the service users and seeking to redefine the relationship.
- The strategy development process is leveraging the wider ecosystem in Health and Social Care.
- There are processes in place to ensure UHB staff have the right technology skill-set and mind-set to make use of digital technologies.
- The leadership of the UHB understands the value of digital technology and is involved in defining the digital strategy.
- There are appropriate mechanisms in place for prioritising digital transformation initiatives.

In particular, the review will review the following areas to identify any improvements to processes that will further enable digital transformation:

- decision making process within the UHB;
- business case development and assessment process, including a consideration of "digital first";
- ownership of services / systems / changes;
- project control and resources / skills for digital technologies; and
- barriers to digital within the UHB.

3. Conclusion

Cardiff & Vale UHB is not well advanced in the use of digital technologies, and this is due to a variety of reasons, including the low expenditure on IT, the historically fractured nature of the management of IM&T across the organisation and the and lack of formalised ADI role. This position is changing with the structures within the UHB being revised. The ADI role has been formalised, as has the CCIO and the reporting and management Committee has been elevated to a formal Board Sub-committee. The Health Board is developing a digital strategy and continuing to revise structures to allow a vision for how technology will enable service delivery to take shape. These changes, along with other intended changes will better position the health board to take advantage of digital technology.

The development process for the Digital Strategy acknowledges that is needs to be led by users and Clinical Boards are being asked to consider their functional requirements. The development process also includes a focus on user needs and the Health Board has a framework for engaging with users with a Clinical Informatics Group in existence.

Although there is no articulated vision for the use of digital technologies, staff across the Health Board are generally positive about the potential benefits of technology and there is an appetite for increased use of this.

There are also structures in place to facilitate the generation of ideas for new ways of working and taking these forward.

There are a number of barriers which will impact the delivery of a digital strategy, and we note that the draft Strategy acknowledges and proposes mechanisms to minimise these. The chief of these is the lack of funding as this is sought on a case by case basis. The required level of resource in ICT has not been fully defined, however it is likely is not fully sufficient to allow for full collaborative working with users. In particular, there is a lack of analysts to work with Clinical Boards. This issue is exacerbated by the legacy systems position and the nature of the NHS in Wales with systems and services being provided by a mixture of local ICT and national systems provided by NWIS.

4. Summary of Audit Findings

Objective 1: The strategy development process has appropriate mechanisms for re-imagining service delivery and business processes.

The UHB is giving consideration to re-imagining service delivery within the Clinical Boards and there are areas of good practice where digital technology is enabling differing methods of service delivery. However, in many cases this work is in pockets and reliant on individuals rather than a holistic organisational structure. This is partly due to the lack of a formal overarching organisational strategy for how it wants to use digital technology and a roadmap to achieve this.

The Patient Knows Best initiative is being used within the UHB, and this is an initiative for redesigning services around patients, using aps and information to let patients monitor and manage their own care. This is used in areas across the UHB, however the lack of a Strategy means that there is a risk that this becomes the de-facto strategic position rather than a considered choice.

The current state of the Digital Strategy is that it is work in progress. There is an acknowledgement that the Strategy needs to be led by users and not Informatics. As such the Clinical Boards are being asked to consider their functional requirement for IT moving forwards. The development of the Strategy does consider the re-imagining of service delivery by noting the requirement to focus on functionality and the consideration of different ways of working and the use of data.

There is a potential risk for the future development of digital service delivery in that as service staff are not fully aware of what IT can do they may not maximise the possibilities of digital technology. Conversely they may place

over reliance on technology and assume or request a technically infeasible or prohibitively expensive solution.

Recommendation 1: The Health Board should seek to increase the level of participation of technical staff / analysts in the requirements definition and service redesign work within Clinical Boards.

Objective 2: The strategy development process is engaging the service users and seeking to redefine the relationship.

The development of the Digital Strategy does consider the relationship with the user as it explicitly notes that functionality should be focussed on user needs. The draft strategy further considers needs from both the clinician and patient perspective.

The Health Board has a framework for improving engagement with ICT users, in particular there is a Clinical Information Management Team (CIMaT) for engagement with medical and nursing staff. There are also pockets, and groups of staff who can be termed enthusiasts who could act as champions and trailblazers for driving forward the digital agenda.

Although this framework is in place it is not functioning to its full potential as the impact of the CIMaT is reduced by a lack of attendance from the clinical staff group, with not all consultants aware of its existence. This is exacerbated by lack of linkage between CIMaT and decision making for ICT which further decreases its impact. In addition many of the IT enthusiasts are within the junior doctor group who cannot commit to ICT developments due to the nature of their work load.

Recommendation 2: The Health Board should seek to encourage and facilitate participation at CIMaT by providing protected time for medical and nursing staff to attend and by ensuring it has a say in the use of digital technology.

In terms of engaging with service users, this is at an early stage with only isolated examples provided within Clinical Boards, however the Patient Knows Best work does provide a mechanism for improving patient engagement. There is a framework is in place for engagement as there is a Stakeholder Reference Group extant. However, at present this has not fully covered the wants and needs of service users in terms of ICT.

Recommendation 3: The Health Board should improve its assessment of service user wants and needs for digital technology. The Stakeholder Reference Group should feed into this process and consult with service users.

Objective 3: The strategy development process is leveraging the wider ecosystem in Health and Social Care.

The development of the Digital Strategy does consider the wide Health and Social care ecosystem. As part of the context setting it notes the national architecture review. It also notes the need to remove boundaries and includes collaboration with neighbours within the information platform. The intent is to include Welsh Government / NWIS representation on the Digital Review Group.

The Health Board can show areas where it is starting to leverage the wider health and care information ecosystem, in particular the WCCIS project involves closer working and information sharing with local authorities and some third sector organisations. There has also been work undertaken on shared information flows within PCIC and work with GPs in Dermatology.

There are structures in place to enable the move towards more integrated working in that there is a monthly regional digital group which is attended by the Director of Digital & Health Intelligence along with counterparts from Cardiff and the Vale Councils. This allows the organisations to be aware of each others plans and actions and lays the basis for a better collaborative structure. In addition there are regular meetings of CCIOs and ADIs at which collaboration and sharing issues are discussed.

The ICT ecosystem within the Health Board does continue to have silos, with a large number of small, departmental systems. Services are able to procure their own ICT without a formal requirement to liaise with the ICT department. Whilst this does allow services to prioritise and fund their own developments, this leads to the risks that inconsistent data sets are collected, increased difficulties to integrate and unexpected increases in support requests to ICT. There is also a risk of "digital fragmentation" whereby a large number of inconsistent or competing processes are piloted within the Health Board.

Recommendation 4: The Health Board should ensure that all purchases or commissioning of ICT services and equipment are at least notified to the ICT department. This will ensure that ICT can act as a gatekeeper or coordinator and ensure a consistent approach is taken.

The current position regarding ICT is that each Clinical Board is able to move forward with their own projects, within their resource constraints. This means that there are currently 8 separate mechanisms for decision making for ICT and no holistic decision making route. This leads to a risk fragmentation and of competing or non-interoperable choices being made. The development of the Digital Strategy has considered this and there is an intent to establish a new group (Digital Review Group) with representation from all Clinical Boards in order to act as a coordinating, prioritisation and review process for all ICT projects and systems.

Recommendation 5: ICT should gain oversight over all ICT projects in order to ensure that they fit within the Health Boards overall strategy and there is no fragmentation of its ICT estate.

The role of NWIS as national provider causes some tension within the system. There is a risk to the Health Board's delivery of new digital services related to the requirement for NWIS to provide connectivity and support. In addition NWIS do not always progress national developments at a sufficient pace to meet the needs of the Health Board. This is also compounded by a lack of clarity / agreement over the meaning of "Once for Wales" and the future use of digital technologies. At present information is not being fully shared across Wales between organisations with boundaries being maintained in the digital sphere, as the nature of IT is still individual "system" focussed and not integrated.

Recommendation 6: The Health Board should continue to work with NWIS and ensure the dependencies are escalated and commitment to delivery is received.

Objective 4: There are processes in place to ensure UHB staff have the right technology skill-set and mind-set to make use of digital technologies.

The development process for the Digital Strategy considers staff skillsets, both in terms of staff users where it notes the need for clinical engagement and informaticians, and also for ICT staff as it notes that staff need to have the skills to implement the strategy.

There has been work within the ICT department to quantify the numbers and skills of staff needed and there has been a restructure of the department to better fit the needs of the organisation. However, although it is felt that there is a skills gap there has been no assessment of what skills and volumes are required, compared to the current capacity. This is compounded as even when posts are funded recruitment can be difficult, particularly due to the requirement to fit within the Agenda for Change pay structure.

Recommendation 7: The Health Board should undertake a full assessment of the future need for ICT staff, this should include the number of staff required for ongoing support and also the numbers and skill types needed to increased use of new technology and the development of this.

Accordingly, a formal workforce plan should be developed for ICT to ensure that the establishment matches the aims of the organisation. This should consider recruitment issues and the possibility of improving and enhancing current staff skills.

In the past the Health Board has a silod IT approach with the service provided by the IT department being tightly defined. As such there are ICT skills within the Health Board that sit outside the ICT department, in particular there has been commitment from some Clinical Boards to develop IT functions with PCIC and CD&T funding their own posts for developments.

Recommendation 8: The Health Board should consider developing a mechanism for engaging and utilising IM&T skills of staff outside the ICT department. This should link with the processes in place for developing ideas and should allow for staff to have dedicated time to work on IM&T developments and projects.

From the staff perspective, there are pockets of very good technological skills within the Health Board, in particular in areas where departments have been providing their own IT systems and in general the results of a survey (Appendix B) show that staff across the Health Board have a positive outlook on digital, recognise the benefits and have an appetite to move forward. In addition, staff are generally confident in their skills for working with technology, particularly within the current paradigm.

However, the user survey we undertook identified a tranche of staff who don’t fully understand the benefits of digital technologies and who have concerns over the impact of increasing use of technology on face to face care time and the risks of confidentiality together with a lack of understanding of how choice can be improved using digital technologies. This staff group also self identified as not being fully confident in working in new ways. If this significant minority staff group are not fully engaged and upskilled the Health Board will encounter resistance to implanting new technology solutions and will not gain the benefits of these.

Recommendation 9: The organisation should increase the communication of the benefits of digital technologies and how care can be improved without increased risk to confidentiality.

Related to this work, a series of training sessions should be offered to staff to ensure they are comfortable in working with technology.

As digital projects are rolled out, the organisation should consider the use of change managers / agents to ensure all users are engaged.

Objective 5: The leadership of the UHB understands the value of digital technology and is involved in defining the digital strategy.

The Health Board does not contain a member with detailed technical knowledge and background apart from the lead non officer member for ICT. However the board does not need to be full of technical wizards, but it should understand what can be accomplished at the intersection of business and technology and must be prepared to help shape how technology can transform the organisation. As such the board should sufficiently understand emerging technology and the business well enough to see opportunities for a better operating model.

Recommendation 10: Work should be undertaken with Board members to ensure they understand the possibilities of digital technologies and have the appropriate knowledge and skills to take their priority areas forward.

The key senior level staff within the Health Board have a consistent overall vision of how the Health Board should move forward with digital technology. This includes the Director of Digital & Health Intelligence, Non Officer Board Lead and CCIO.

Currently however, the articulation of the Health Board vision / Strategy for development of IT services and use of digital technology is incomplete. There is no final ICT Strategy in place and although the updated IMTP includes a core objective of “Digitally enabling the organisation” the underpinning SOP has not been updated. Consequently the vision has not been fully communicated to the Health Board as a whole and staff cannot therefore fully engage to move the digital agenda forward. The results of the staff survey support this as they show that the message regarding digital and the Health Board’s vision and aims are not being properly communicated and staff do not feel the Health Board is pushing or using digital fully yet. This implies that there is a greater appetite for digital than is being exploited within the Health Board.

Recommendation 11: The vision for digital technologies should be fully articulated within the strategy and communicated to all staff across the Health Board.

The strategy development process includes a consideration of leadership, and there is strong executive support for the development of the Digital Strategy and the CCIO post has been formalised. Changes have been made to how the governance of ICT sits within the Health Board. The previous IT&G Sub Committee has been replaced by the Digital Health Intelligence Committee, which is now a formal Board Sub-committee. This better reflected the importance of ICT to the delivery of the Health Boards objectives and has led to an increased profile of ICT and better representation by Board members.

Objective 6: There are appropriate mechanisms in place for prioritising digital transformation initiatives.

The lack of an articulated Strategy means that the Health Board cannot easily prioritise ICT initiatives from a holistic perspective and as noted above the lack of a single forum for approving digital initiatives leads to a risk that individual projects may be approved that are not holistically aligned and not prioritised in the best interests of the Health Board. The development of the Health Boards Digital Strategy considers this and proposed the establishment of a single prioritisation forum for all ICT projects with the additional creation of "Digital Change Coordinator" posts to act as gatekeepers within the Clinical Boards. The concept of digital fragmentation is also considered with a focus on function and not vendor specific solutions.

There are mechanisms for idea generation and experimentation within the Health Board, specifically the CDT innovates group within CD&T and the process within Clinical Innovation. These processes allow a mechanism for any member of staff to propose new ideas and ways of working and provide a mechanism for resource for developing these as proof of concept and thus allow experimentation. These structures are not fully linked however and there is no inclusion within the Digital Strategy. In addition not every Clinical Board is aware or involved and so in many cases staff with ideas do not have a route to take forward.

Recommendation 12: The current innovation groups should be explicitly linked into the Digital Strategy and the prioritisation forum. Similar groups should be established within each Clinical Board.

Barriers

This section discusses the current status of the Health Board against identified barriers to adoption of digital technology.

Lack of a corporate vision for digital

As noted above, although a vision is taking place, and there is a draft Digital Strategy, this has not been completed, communicated to staff and publicised.

Inability to experiment quickly

The Health Board has structures in place to facilitate experimentation and development of ideas, and these allow for staff to feed improvements into the process. As noted above these should be strengthened and widened to take in the whole of the Health Board.

Legacy systems

Given the nature of the Health Board, and of the NHS in Wales, legacy systems are inevitably going to be an issue, and will likely remain so for some time. There are a large number of multivariate systems in place, with control of these being spread across clinical Boards, ICT and NWIS. These systems are older, often using inflexible technologies that were emplaced to meet the previous demands. They often have long lifespans and can be difficult to integrate with new cloud and web-based services. One major impact of the legacy systems, particularly when there are multiple systems providing a similar core functionality is that they require resource for just keeping the lights on. The Digital Strategy development process does consider this, with an intent to match the functionality of legacy systems with the functionality required by the service in order to identify those that are no longer suitable.

Recommendation 13: The prioritisation group should include a consideration of legacy systems. The functionality provided by these should be evaluated and rationalisation occur in order to seek to free up resource.

Lack of talent/skills required

The exact requirement for ICT skills has not been established, however it is accepted that there is a shortage of ICT staff with the right skills, however there has been some restructuring to try and mitigate this. This issue is compounded by the lack of ability to successfully recruit and previous attempts have not always been successful.

In terms of user skills, staff in general feel confident in taking up digital technologies and there appears to be a large appetite for increasing the use of technology within the Health Board. There is a subset of staff who, as previously noted are not so supportive and these should be addressed as per the previous recommendation.

Insufficient budget

The Health Board spends a relatively low amount on IM&T, with a value equating to approximately 1% of the budget, this compares unfavourably with average spend of approximately 3% for companies and is also a low value for the NHS in Wales. As the Health Board does not have sufficient allocated budget to progress all of its identified IM&T projects it operates on a case by case basis with funding obtained from various sources such as Welsh Government monies, Efficiency Through Technology Funding, Transformation monies, discretionary capital etc. The Welsh Government has recently allocated £50m for digital healthcare, although it is noted that this value is for the whole of NHS Wales.

The move to digital technologies will need increased funding, and this is a key barrier to moving forward with digital technologies. The draft Digital Strategy acknowledges this and notes the low expenditure it also notes the potential to partner with SMEs in order to alleviate some of the funding pressures. However the funding position is unlikely to change and the Health Board will have to continue to seek funding for its future developments.

Recommendation 14: The Health Board should consider increasing the proportion of its expenditure on IM&T to a value more in line with good practice / NHS Wales.

Cybersecurity

It is vital to ensure that the move towards digital technologies is accompanied by appropriate security. The draft Digital Strategy notes this in the context of how cyber security fits within the proposed open platform model. There is a general skills shortage in cyber security and the pay offer from the NHS in Wales may not be sufficient to attract interest from this limited pool. For this reason the Health Board should look to develop an IT Workforce plan which should include upskilling staff already in place. (as per recommendation 7).

Inability to work across silos

There are silos in place, both within the Health Board and external to the Health Board. The use of digital technologies will require a greater flow of

information and collaboration across silos. The Health Board is working on breaking down some of these silos and there is a feeling that collaboration between Clinical Boards has improved, however this remains a work in progress. The Digital Strategy development process considers this and the draft Strategy discusses the issue. The proposed Digital Review Group is a significant mechanism for the facilitation for greater collaboration within the Health Board in terms of IM&T and the intent to invite external organisations will also assist in improving working with other organisations.

Inadequate collaboration between IT and lines of business

The general feeling is that in the past ICT have not always been fully collaborative, with the boundary between ICT and Clinical Boards being well defined. The Health Board is showing a move to greater collaboration between ICT and the services and this will improve further following the establishment of the Digital Review Group.

Recommendation 15: The Health Board should consider creating defined links between Clinical Boards and ICT by the use of named Leads.

Risk-averse culture

In order to take advantage of new technology, the Health Board has to have a certain appetite for risk, in particular the risk of project or product failure. Whilst the Health Board is highly risk averse in terms of harm to patients, it can demonstrate an appetite for risk of failure by the establishment of the Clinical Innovation Partnership and CDT Innovates group.

Change management capabilities

The move to new way of working with new technology will by necessity involve change and users can be highly resistant to change. The Strategy development process considers this and explicitly discusses change resistance and the need for staff engagement. There has been the use of a change manager role within some projects in order to overcome resistance however, it should be noted that the resource available is limited.

Recommendation 1	Management Response
The Health Board should seek to increase the level of participation of technical staff / analysts in the requirements definition and service redesign work within Clinical Boards	Agreed. We are seeking to introduce a more formal process via the establishment of the Digital Management Board and its sub-groups, whereby Clinical Boards' requirements will be agreed and prioritised.
Recommendation 2	**Management Response**
The Health Board should seek to encourage and facilitate participation at CIMaT by providing protected time for medical and nursing staff to attend and by ensuring it has a say in the use of digital technology.	Agreed. The new governance arrangements for managing the digital programme will reflect the importance of clinically driven initiatives.
Recommendation 3	**Management Response**
The Health Board should improve its assessment of service user wants and needs for digital technology. The Stakeholder Reference Group should feed into this process and consult with service users.	Agreed. The SRG will feed into the Digital Management Board's work programme, linking to CiMaT too.

Recommendation 4	Management Response
The Health Board should ensure that all purchases or commissioning of ICT services and equipment are at least notified to the ICT department. This will ensure that ICT can act as a gatekeeper or coordinator and ensure a consistent approach is taken.	The establishment of the Digital Management Board will ensure that central decision making on ICT services and equipment is logged. Additionally, Finance have a role in ensuring that procurements are logged and supported by the Digital directorate.
Recommendation 5	**Management Response**
ICT should gain oversight over all ICT projects in order to ensure that they fit within the Health Boards overall strategy and there is no fragmentation of its ICT estate.	The Digital Management Board will assume a strategic oversight role to include strategic fit for all ICT related projects or new development work.
Recommendation 6	**Management Response**
The Health Board should continue to work with NWIS and ensure the dependencies are escalated and commitment to delivery is received.	CAV UHB will ensure representation at all national forums representing the digital agenda; e.g. IpAD, NSMB, NIMB and to hold NWIS to account via SLA monitoring meetings.

Recommendation 7	Management Response
The Health Board should undertake a full assessment of the future need for ICT staff, this should include the number of staff required for ongoing support and also the numbers and skill types needed to increased use of new technology and the development of this. Accordingly, a formal workforce plan should be developed for ICT to ensure that the establishment matches the aims of the organisation. This should consider recruitment issues and the possibility of improving and enhancing current staff skills.	Within the new Digital structures, a small number of posts remain unfilled. Roles are being reviewed to ensure that they match not only current skills and capabilities, but also future skillsets, e.g. moving to more cloud-based solutions.

Recommendation 8	Management Response
The Health Board should consider developing a mechanism for engaging and utilising IM&T skills of staff outside the ICT department. This should link with the processes in place for developing ideas and should allow for staff to have dedicated time to work on IM&T developments and projects.	The developing Digital Strategy will be shared and owned by the UHB; this will address the better alignment of ICT skilled staff who sit outside the Digital directorate structures.

Recommendation 9	Management Response
The organisation should increase the communication of the benefits of digital technologies and how care can be improved without increased risk to confidentiality. Related to this work, a series of training sessions should be offered to staff to ensure they are comfortable in working with technology. As digital projects are rolled out, the organisation should consider the use of change managers / agents to ensure all users are engaged.	It is recognised that the emerging Digital Strategy is more than implementing new ICT solutions and that for it to be successful will require different ways of working. Key to this will be Organisational development and change management processes to deliver the benefits associated with the solutions within the digital strategy.

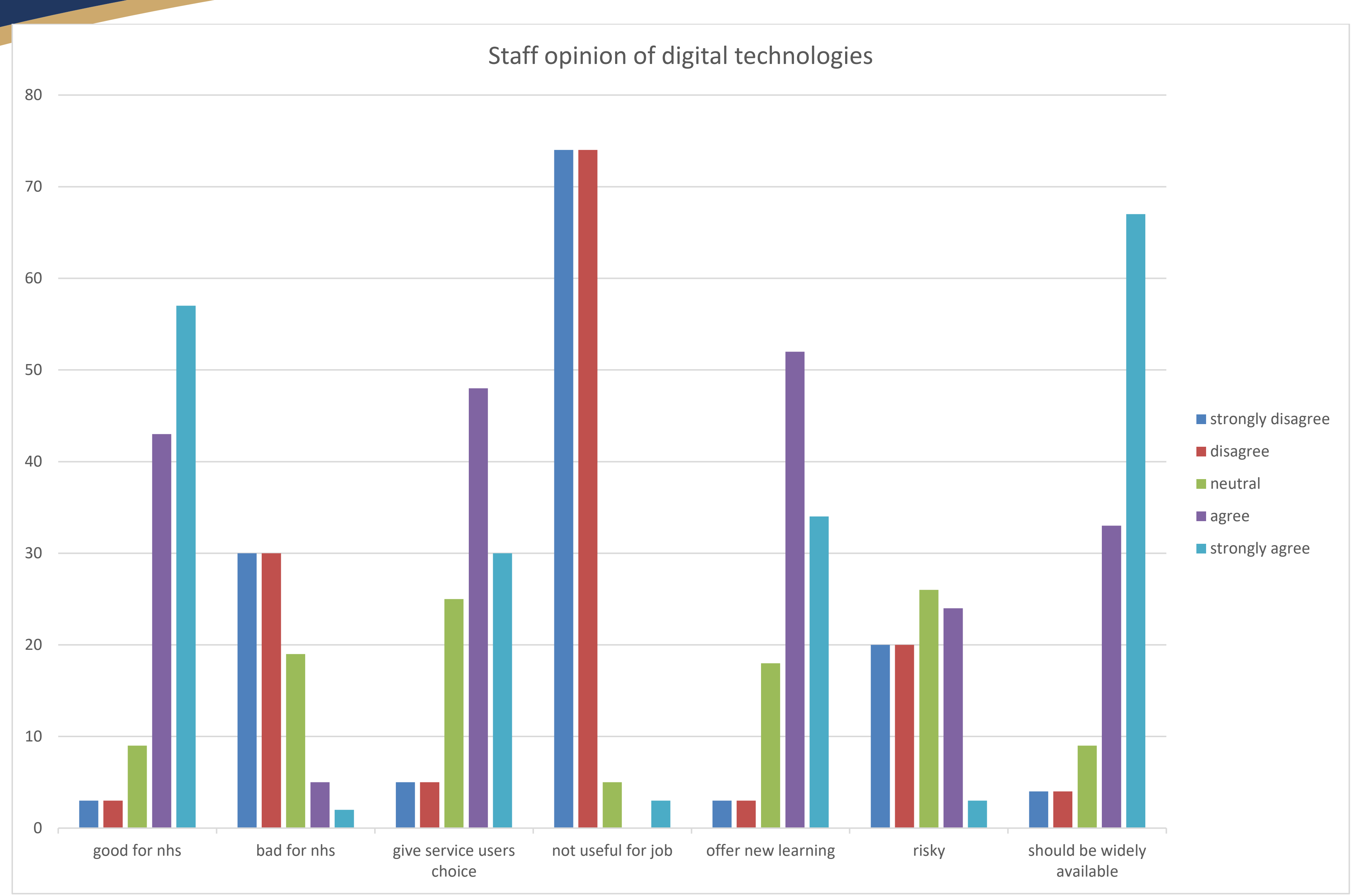
Recommendation 10	Management Response
Work should be undertaken with Board members to ensure they understand the possibilities of digital technologies and have the appropriate knowledge and skills to take their priority areas forward.	Agreed. A number of Independent Members sit on the DHIC committee, which in itself is a committee of the Board. DHIC aims to describe how the organisation will benefit from implementing the digital strategy

Recommendation 11	**Management Response**
The vision for digital technologies should be fully articulated within the strategy and communicated to all staff across the Health Board.	Agreed. The plan is to communicate widely across the organisation what we are planning to do differently and how, via the digital strategy.

Recommendation 12	**Management Response**
The current innovation groups should be explicitly linked into the Digital Strategy and the prioritisation forum. Similar groups should be established within each Clinical Board.	The Digital Management Board will link all clinical boards to the strategic programme of work, ensuring appropriate buy-in to the digital roadmap.

Recommendation 13	**Management Response**
The prioritisation group should include a consideration of legacy systems. The functionality provided by these should be evaluated and rationalisation occur in order to seek to free up resource.	Agreed. This will be addressed by the Digital Management Board.

Recommendation 14	Management Response
The Health Board should consider increasing the proportion of its expenditure on IM&T to a value more in line with good practice / NHS Wales.	The DHIC committee is aware of the level of ICT investment made and the reliance on other sources of income to contribute to the digital spend.
Recommendation 15	**Management Response**
The Health Board should consider creating defined links between Clinical Boards and ICT by the use of named Leads.	This will be addressed via membership and terms of reference for the new Digital Management Board.


Staff opinion of digital technologies
80
70
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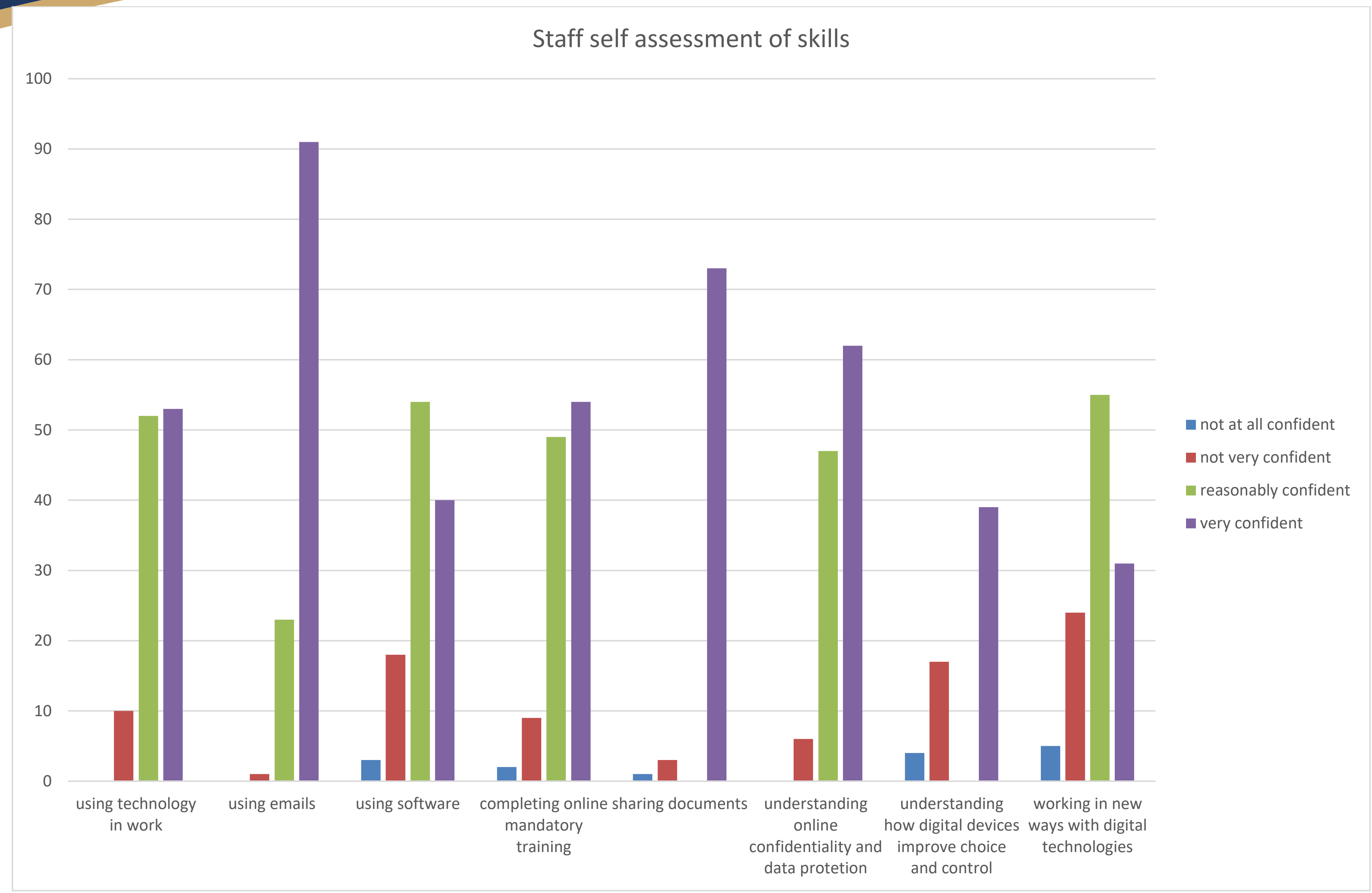
40
30
20
10
0
good for nhs
bad for nhs
give service users choice
not useful for job
offer new learning
risky
should be widely available
strongly disagree
disagree
neutral
agree
strongly agree


Staff self assessment of skills
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using software
completing online mandatory training
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not very confident
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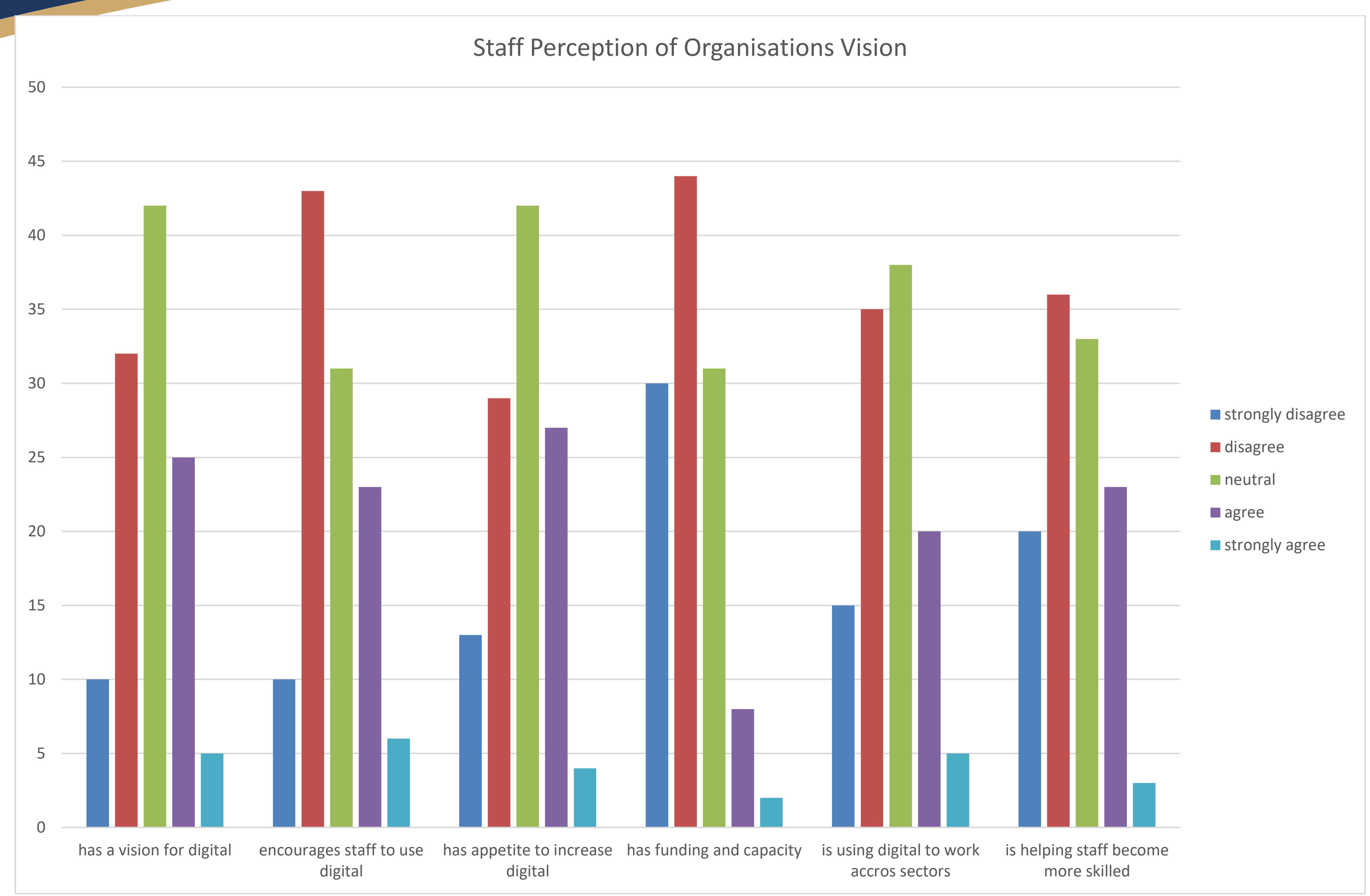
very confident


Staff Perception of Organisations Vision
50
45
40
35
30
25
20
15
10
5
0
has a vision for digital
encourages staff to use digital
has appetite to increase digital
has funding and capacity
is using digital to work accros sectors
is helping staff become more skilled
strongly disagree
disagree
neutral
agree
strongly agree

	Audit & Assurance Committee Meeting - 3rd March 2020						
REPORT TITLE:	**Indemnity clause within Data Processing Contracts**						
STATUS:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**
REPORT AUTHOR (TITLE):	**David Thomas, Director of Digital & Health Intelligence**						

PURPOSE OF REPORT:

SITUATION:

A number of external organisations have refused to sign our Data Processing Contract due to

i) the level of indemnity that currently exists (full indemnity reducing to £5m for lower risk PID) to protect the UHB in the event of a data breach where the processor is responsible.

ii) the level of protection we are asking processors and joint data controllers to provide to us in the event of civil legal action against the UHB where the processor is responsible.

This paper seeks to establish a formal position for the UHB regarding data sharing and mitigating the financial risks to which the UHB is presently exposed.

This paper was initially discussed at the Management Executive meeting on 18th November 2019 before being presented to the Finance committee meeting on 18th December 2019 where it was agreed that the appropriate committee to receive and approve the recommendation to adopt a more flexible approach to applying different indemnity levels should be the Audit and Assurance Committee.

REPORT:

BACKGROUND:

As a consequence of a data breach or when it is determined that the UHB (or it's processor) has failed to process data in line with legislation (eg complete data impact assessments or have a processing contract in place) the UHB is now liable to be fined up to €20 million or 4% of company global annual turnover (whichever is higher). However, regulatory penalties are not the only factor to consider.

In the following case the ICO took no action.

In 2014 an employee of Morrisons Supermarket leaked the payroll details of 100,000 staff. The employee was jailed for 8 years. A group of 5,000 staff, in what is the first data leak class action in the UK, took action against Morrisons in a civil claim. In October 2018 the Court of Appeal upheld a High Court judgement, ruling that the supermarket is vicariously liable for the actions of their former employee. The supermarket now faces paying compensation to all those effected for "upset and distress". Morrisons intend to appeal in the Supreme Court but the impact of this verdict has already seen one claim against the UHB quoting vicarious liability and the Morrisons case.

The concern is this landmark case has been identified by the legal community as a "game changer" for organisations and potentially puts the UHB at greater risk as we embrace big data initiatives.

ASSESSMENT:

As a consequence of not having a negotiating process in place or setting our indemnity requirements at a level which SMEs and charities cannot afford (or will pass on extortionate costs of their own insurance back to us), there is the risk that we are not fully benefitting from the opportunities provided by data sharing, required to deliver Shaping Our Future Wellbeing and operational priorities. These opportunities range from seamless working with the voluntary sector, adoption of technologies or services that are available on the market to other organisations who will accept a lower level of indemnity and our wider research and development programme.

Given our current stance, we also have to consider the possibility that departments may start to enter into agreements with suppliers without signing the required Data Protection Contact in an attempt to alleviate the indemnity issue, but against the legal requirements of GDPR. (A DPC being a legal requirement where information enabling staff and patients to be identified is to be shared).

On the other hand, in the event of a data breach and where we have accepted a lower level of protection, there are real financial risks to the UHB if the fine and compensation exceed the contracted values for indemnity and insurance provided for civil claims. This has been confirmed by Welsh Legal and Risk who advise that the risk pool will not cover either of these claims as they consider the UHB will have undertaken an unlawful act.

It is important that the UHB balances the real financial risks with the strategic and operational benefits of data sharing, recognising that it is not uncommon for the UHB to share data amounting to 100,000s of clinical events.

RECOMMENDATION:

As case law around GDPR is immature, it is recommended that the UHB takes an iterative approach and regularly reviews its adopted position in this area. It is also recommended that national solutions continue to be sought in a co-ordinated fashion which minimise the material risk to the UHB. Steps are already being taken to incorporate these within WG policy considerations around both the GP contract and more directly the IG promise.

In the short term, it is recommended that the following approach to determining indemnity and insurance requirements where the UHB wishes to share patient and staff identifiable information is adopted:

- In the first instance, the UHB should require organisations to fully indemnify the UHB. In scenarios where the supplier is a considered to be a small to medium sized enterprise (SMEs) or a charity and they are unable/unwilling to provide the level of covered require by the UHB, the case should be escalated and presented to the SIRO by a member of the Information Governance Department and a risk-based decision is made to potentially reduce the level of indemnity. Factors for consideration that influence the decision should include, but not be limited to, the number of patients/staff involved in the processing, the nature of processing, the location of processing, steps taken to safeguard the data. This information should be available in the Data Protection Impact Assessment.
- If resisted by the organisation then the UHB should negotiate to a minimum level as suggested within the table below:

	Data sharing is of low value	Data sharing is of medium value (Important but not essential)	Critical to business need
Low risk & volumes of individuals affected is < 1000	Indemnity: £1m Insurance: £500k	Indemnity: £500k Insurance: £25k	Indemnity: £500k Insurance: £25k
Low risk & volumes of individuals affected >1000 patients	Indemnity: £5m Insurance: £1000 per patient	Indemnity: £1m Insurance: £1000 per patient	Indemnity: £1m Insurance: £500k
High risk & volumes of individuals affected < 1000	Indemnity: £5m Insurance: £1m	Indemnity: £5m Insurance: £1m	Indemnity: £5m Insurance: £1m
High risk & volumes of individuals affected >1000	Indemnity: Unlimited Insurance £1000 per patient	Indemnity :Unlimited Insurance £1000 per patient	Indemnity :£20m Insurance: £5m

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	x	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	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		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

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		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.									

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