Audit and Assurance Meeting 21 April 2020

21 April 2020, 09:00 to 12:30

Agenda

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Welcome and Introductions

John Union

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Apologies for Absence

John Union

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Declarations of Interest

John Union

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Minutes of the Meeting held on 3 March 2020

John Union

4 - Audit Com Mins 03.03.20 - AF.pdf (11 pages)

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Action Log - 3 March 2020

John Union

5 - Action Log March 2020.pdf (2 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 April 2020.pdf (3 pages)

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7.2
Declarations of Interest and Gifts and Hospitality Tracking Report

Nicola Foreman

7.2 - DOI report for Audit - April 2020.pdf (3 pages)

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7.3
Regulatory Compliance Tracking Report

Nicola Foreman

7.3.1 - Regulatory Heat Map - April Audit.pdf (7 pages)

7.3 - Regulatory Compliance Covering Report.pdf (3 pages)

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Internal Audit Tracking Report

Nicola Foreman

- 7.4 - Internal Audit Tracker Covering Report.pdf (3 pages)
- 7.4.1 - Internal Audit Summary Tables - Appendix 1.pdf (4 pages)
- 7.4.2 - Audit Recommendation Tracker - Internal Audit - April 2020.pdf (17 pages)

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Nicola Foreman

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Nicola Foreman

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Ian Virgill

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- 9.1.1 - CUHB1920.33 CDT CB Lab TATs Final Report.pdf (10 pages)

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- 9.2 - WAO - Letter.pdf (5 pages)

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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 Workshop:

12.1

Tuesday, 19 May 2020, at 9.00am Woodland House

UNCONFIRMED MINUTES OF THE AUDIT COMMITTEE
HELD ON MONDAY, 3 MARCH 2020
CEFN MABLY ROOM, GROUND FLOOR, WOODLAND HOUSE
MAES Y COED ROAD, HEATH, CARDIFF CF14 4HH

Present:

John Union	JU	Chair – Audit
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
Jonathon Gray	JG	Director of Transformation and Implementation
David Thomas	DT	Director of Digital and Health Intelligence
Mike Usher	MU	Wales Audit Office
Ian Virgil	IV	Interim Head of Internal Audit
Stuart Walker	SW	Executive Medical Director
Glynis Mulford	GM	Secretariat

Apologies:

Eileen Brandreth	EB	Independent Member - ICT

		ACTION
AC: 20/03/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	
AC: 20/03/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
AC: 20/03/003	**DECLARATIONS OF INTEREST** The Chair invited Members to declare any interests in the proceedings. None were declared.	
AC: 20/03/004	**MINUTES OF THE AUDIT COMMITTEE HELD ON 3 DECEMBER 2019** The Committee reviewed the minutes of the meeting held on 3 December 2019. **The Committee resolved that:** The Committee received and approved the minutes of the meeting held on 3 December 2019.	

AC: 20/03/005	**ACTION LOG FOLLOWING THE LAST MEETING** The Committee reviewed the Action Log of the meeting held on 3 December 2019, and noted that the following amendments should be made: **AC: 19/12/013 – Declarations of Interest and Gifts and Hospitality Tracking Report:** The Declarations of Interests and Gifts and Hospitality Form will be updated as of 1 April 2020 to ensure definitions were clear. **AC: 19/12/015 - Internal Audit Tracking Report:** To provide robustness to the system a sample of recommendations would be reviewed. **AC: 19/12/017 - Declarations of Interest Report:** In the last report brought to committee non-compliance stood at 75%. The report for this meeting showed a further reduction to 60%. There was a robust escalation system in place for those staff members who were non-compliant, as people had a duty to declare extra work. The Communications Team had publicised and made people aware of the Health Board's policy on receiving gifts and not declaring. **The Committee resolved – that:** a) the action log be amended and noted.
AC: 20/03/006	**CHAIRS ACTION TAKEN SINCE LAST MEETING** No actions have been taken.
AC: 20/03/007	**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: • There were a few reports due to be finalised which remained outstanding as the team had encountered delays due to staffing issues. A contractor had been employed to address the outstanding reports. • The Infection, Prevention and Control Report was in draft. Pieces of work around the Surgery Clinical Board had progressed but there were setbacks in accessing some of the wards. • It was confirmed that 10 audits had been completed. The Digital Readiness Report was not rated as the IT Strategy had not been completed and the IT department was asked to prepare a position report. This would feed into the Audit Plan for 2020/21 and a formal assurance piece of work would be presented at a future meeting. • With regard to the 2019 Audit Plan, 10 pieces of work were in progress that would be reported at April / May committees.

- The forecast for an overall opinion remained positive for 2019/20 and the only foreseen pressure could be the Tentacle IT Limited Assurance audit. In regard to GDPR and cyber security these had been removed from the plan as the Information Commission Officer (ICO) had undertaken an audit and the outcome of this work could provide assurance. Although it was acknowledged that the outcome from the ICOs audit could place pressure on the individual domain it was noted that this would not impact the overall opinion.
- The KPIs had increased with a delay of five reports as management did not respond to the 15 day deadline. The compliance rating had reduced from 80 to 69%.
- Meetings had been undertaken for the development of the Internal Audit Plan for 2020/21 over the past few weeks and the team were in the early stages of putting the plan together for formal sign off in April.
- The adjustments to the plan were explained and the Head of Internal Audit was happy with the deferral of audits and he considered that this would not affect the opinion. In summary, 29 internal audits had been completed and 17 further reports were to come through the system.

The Committee Resolved that:

a) the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports be considered;
b) updates to the Internal Audit Plan were considered and approved; and
c) the adjustments to the Internal Audit Plan be agreed.

AC: 20/03/008 **CONSULTANT JOB PLANNING FOLLOW-UP: LIMITED ASSURANCE REPORT**

The Head of Internal Audit introduced the report. He stated that an audit was completed in 2018 and received a Limited Assurance rating. The purpose of the follow-up was to review progress against the agreed actions. It was agreed that some of the recommendations would be placed on hold so that they could have time to be implemented. A further follow up was carried out over the period October – December 2019. The findings highlighted that the actions completed were on the lower scales. In regard to the fundamental actions of completing job plans and annual reviews this had not progressed and had deteriorated further with the audit providing an additional Limited Assurance rating.

The Executive Medical Director (EMD) commented that the audit would provide the same results if the same tests were undertaken. Many consultants had job plans in place which were recorded in a variety of formats and stored in different places. It was realised that this needed to be centralised and he proposed a fundamental 'root and branch' change in job planning:

- The first component was benchmarking which the audit report provided. The job planning policy had also been revised. It was explained that the Welsh national contract was unclear and open to local interpretation and varied in how it was interpreted. An organisational view was being defined of what the detail was and what needed to be included.
- The policy had been taken to Medical Leadership for comment and subject to this would go forward to Clinical Directors and the Local Medical Committee where a joint meeting would be held with the British Medical Association. Advice would be sought to ensure that the final product was fit for purpose.
- There was a need for a centralised IT solution and training of staff. Licences needed to be in place which were being procured.
- An engagement exercise was needed to get on board with a systematic and uniform approach to job planning. This would follow on from delivery of the policy.
- In terms of managing expectation, it was explained that job planning was an annual process and if done correctly would be completed in December. It was also confirmed that the cycle of job planning took 18 months. This would be delivered in teams and by December 2021 everyone's annualised job plan should be up-to-date. This would take some resource and plans were to be presented at HSMB. This would also be presented to Medical HR for resource assistance.

The Chair asked for comments and questions:

- Independent Member - Trade Union asked if consultants had an opportunity to see the policy. It was confirmed that the Clinical Director Group includes leaders across the organisation and that the policy would be taken through the consultation body.
- Independent Member - Trade Union commented that two years was a long process. The EMD stated he had undertaken this type of change several times and the process had taken two years. In response to how much of a challenge this presented, it was stated that the timescale had been pushed back from the Medical Leadership team and he had experienced the same challenge and comments when the change was being implemented in England. It was commented this did not benefit either side and there was a need to develop sustainable work plans.
- The investment plan would be taken to HSMB and full support had been received from the Executives and CEO who understood that a cultural piece of work needed to be undertaken.
- The Head of Internal Audit confirmed that the follow-up review would be built into the audit plan and would look at achievable milestones to ensure that progress was being made. It was agreed that an update on progress would be provided to the Committee in February 2021 with a projected timeline.
- The Chair confirmed that he fully understood the timescale and had the full support of committee.

SW

The Committee Resolved that:

a) The Limited Internal Audit Report be noted

AC: 20/03/009 **TENTACLE IT SYSTEM: LIMITED ASSURANCE REPORT**

The Head of Internal Audit informed members that the IT system was developed in-house and was a system for reporting on cancer patients. The auditors had considered governance arrangements, system outputs and business continuity. The main reasons for the Limited Assurance were described in the report but specifically because the system was not fully compatible with the single cancer pathway. It was highlighted that system was due to be replaced within the next 18 months.

The Director for Digital and Health Intelligence made reference to the plan to change the system in light of what had been raised and he confirmed that it was being fast tracked. It was emphasised that the bigger plan may negate some of the recommendations. The following comments were made:

- The Tentacle system would be put on the PMS system immediately as the single cancer pathway was driving a number of initiatives and would be implemented within the next 8 weeks. By the first week of May the system would be operational and subjected to rigorous testing and controls.
- Interim steps had been taken to reduce who could access the data by verifying the authenticity of system users and the use of data sharing would be curtailed.
- It was confirmed that there a user acceptance training programme would be rolled out so that users couldoperate and access the system appropriately.
- The use of silo systems, that had been traditionally employed across the Health Board, would be eliminated and this was being addressed through the Digital Strategy.
- The newly formed Digital Management Board (DMB) had been established as a decision making and scrutiny body. Further checks would be made through finance, procurement and the Charitable Funds Committee.
- The Director for Transformation and Implementation (DfTI) confirmed that it had been very helpful to work on this case and he added that the Digital Readiness paper indicated that there were eight different places where decisions were made. Stones had been turned over and the report clarified that many of the issues were being challenged.
- There was a digital voice through the DMB which was engaging with Clinical Boards. There would be a single point where these systems would come together. A huge amount of work had been done and the team had addressed the recommendations as a transformational piece of work.
- The Chair asked how the recommendations would be checked, in response it was confirmed that this would feed into the Internal Audit Tracker and a number of actions would be superseded and

reflected in the tracker. All Limited Assurance reports would be followed up in the new financial year.

- Independent Member – Trade union asked, although the paper explained the position, where the DMB sat alongside the Clinical Boards. The DfTI explained that they were fortunate to work with the Executive Finance Director (EFD). It was acknowledged that there was less funding than was needed for ICT and the DfTI was working closely with the EFD to increase the finance to 1.7% of the budget over time. The challenge this posed was acknowledged but it was realised that it was necessary to build a stable platform going forward.
- The Chair asked whether monies had been received from the Transformation Fund. Members were informed that there were other monies they had been successful in securing in the short term but this type of funding was not recurrent.

The Committee Resolved that:

a) The Limited Internal Audit Report be noted.

AC: 20/03/010 **WELSH AUDIT OFFICE AUDIT PLAN**

Mike Usher and Anne Beegan, Wales Audit Office (WAO) provided an overview of the Wales Audit Office Audit Plan. The following comments were made:

- Exhibit 2 looked at financial audit risks and the key risks to preparation of the financial statements.
- The Statutory Financial Duty was on a three year limit. The Health Board was in a much better financial position but because of the rolling three year period, WAO had to take into account the previous year's accounts which would be breached again. WAO advised Members that there would be another qualification but acknowledged that the Health Board was on course for a break even position this year.
- Reference was made to the Ministerial Direction relating to pension tax. The pay schemes initiative had been implemented in England where it was a required pay scheme for clinicians as they can be held harmless to help address service delivery. These additional costs would be tested to confirm whether the Health Board has disclosed and accounted for them correctly. The Director for NHS Wales would be closely monitoring this.
- This was a work in progress and new for this year. Welsh Government would meet the costs as a one off for this year. In regard to the ISA 260, the Committee may want a paper from the finance team to confirm how the leasing account positions would be addressed. This was significant for next year's accounts and would result in a tax increase.
- The performance audit work to be undertaken was described and would start over the summer months. Two mandatory pieces of work would be undertaken on Unscheduled Care. The full scope on this topic had yet to be determined. There would

also be a governance review of WHSSC arrangements and that report would be published in early spring.
- Due to efficiencies in the audit approach and working with the finance team, the Audit Fee would be reduced by £20k.

The Committee resolved that:

a) The Wales Audit Office Audit Plan be noted.

AC: 20/03/011 **YEAR END POST PAYMENT VERIFICATION REPORT**

Scott Lavendar, Post Payment Verification Manager presented the report and informed Members that there had been restructuring in their service. A big drive had been undertaken to move the operational work forward to be more robust nationally. Practices with amber and red ratings had been discussed with the Counter Fraud Service. Regarding repeat offenders, discussion had taken place with the Counter Fraud Manager with local and national meetings being held. It was confirmed that errors had reduced significantly and with the drive over the past few years indications showed that recoveries were decreasing annually.

Regarding misunderstanding in practices relating to processes and procedures, training sessions had been undertaken with GMS practice managers, with over 30 managers in attendance. The ophthalmic training evening was well attended which triggered training with Specsavers. Relationships with the Primary Care Team were good and the quarterly meetings were very helpful with a robust system in place.

The Committee resolved that:

a) The Post Payment Verification report be noted.

AC: 20/03/012 **DECLARATIONS OF INTEREST AND GIFTS AND HOSPITALITY TRACKING REPORT**

The Director of Corporate Governance provided an overview of the report. The number of declarations received had increased to 983. This was an upturn from 25% last month to 40% this month. Work had been undertaken with the Improvement and Implementation team to look at the gaps in the process. Members were informed that the IT delays encountered were due to the current IT system place. The process would be replaced by using an electronic form which could be populated on ESR. There was a backlog of forms that were proactively being worked on. This work would move across to the newly established Risk and Regulation Team.

Independent Member – Trade Union acknowledged that the declarations of interest work was being embedded across the Health Board and asked how the conflicts of interest were being checked. In response it was stated that 0.2% was R.A.G rated red as those individuals had a higher conflict of interest; the governance arrangements and measures in place were explained.

The Committee resolved that:

a) the ongoing work being undertaken within Standards of Behaviour be noted and
a) the Declarations of Interest, Gifts, Hospitality & Sponsorship Register be noted.

AC: 20/03/013 **REGULATORY COMPLIANCE REPORT**

The Director of Corporate Governance provided an updated report from the last meeting which highlighted and summarised inspection outcomes. Inspections were being tracked and it was acknowledged that further improvements could be made. The tracker provided clarity on the external bodies that inspect the Health Board. The details and results of inspections could be found in the reports from the inspections which had taken place. The Governance team were tracking all the recommendations and other elements were also tracked through other venues, such as the Health and Safety Committee. It was recognised that this was a step forward but it was also noted that the governance team would want to continue to improve.

The DCG explained how the recommendations matched across the Clinical Boards by feeding into the tracker. This highlighted where the CBs were against their compliance requirements and the dashboard signalled where we were with the level of compliance and when an inspection was due.

The Committee resolved that:

a) the inspections which have taken place since the last meeting of the Audit Committee in December 2019 and their respective outcomes be noted.
b) the continuing development of the Legislative and Regulatory Compliance Tracker be noted.

AC: 20/03/014 **INTERNAL AUDIT TRACKING REPORT**

The Director of Corporate Governance presented the Internal Audit tracking report and Members reviewed the completed actions. New reports were added after each Committee meeting and it was confirmed that the 2017-18 and 2018-19 recommendations had decreased significantly.

The Committee resolved that:

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

AC: 20/03/015	**WALES AUDIT OFFICE TRACKING REPORT** The Director of Corporate Governance presented the External Audit tracking report and informed Members that the information presented reflected the position up to 21 February 2020. Any new actions would be added accordingly. **The Committee resolved that:** a) The progress which has been made in relation to the completion of WAO recommendations be noted
AC: 20/03/016	**AGREE ANNUAL REPORT TIMETABLE AND PLANS** The timetable and plans regarding the Annual Report which was taken to the Executive Team was presented to deliver final end of year arrangements. This was the same process as last year but changes to the timescales from Welsh Government meant the Performance Report had to be completed at the same time. **The Committee resolved that:** a) the proposed timetable and approach for the Annual Report 2019-20 be reviewed and approved
AC: 20/03/017	**TERMS OF REFERENCE** The Director of Corporate Governance presented the draft Terms of Reference and end of year arrangements. **The Committee Resolved that:** a) the changes to the Terms of Reference for the Audit and Assurance Committee were approved; and b) changes made to the Terms of Reference be recommended to the Board for approval.
AC: 20/03/018	**COMMITTEE WORKPLAN** The Director of Corporate Governance presented the draft Workplan which was aligned to the Terms of Reference. **The Committee Resolved that:** a) the Work Plan 2020/21 was reviewed; b) the Work Plan 2020/21 was approved; c) the Work Plan 2020/21 be recommended for approval to the Board of Directors.
AC: 20/03/019	**COMMITTEE ANNUAL REPORT**

	The draft Annual Report was presented by the Director of Corporate Governance and it was confirmed that the report provided assurance to the Committee on the work undertaken during the year 2019/20, as required by the Committee's Terms of Reference. **The Committee Resolved that:** a) The draft Annual Report 2019/20 of the Audit and Assurance Committee was reviewed; and b) the Annual Report be recommended to the Board for Approval.
AC: 20/03/020	**ITEMS FOR NOTING AND INFORMATION** The Committee received the following Internal Audit reports for information: 1. Budgetary Control 2. Brexit Planning 3. Safeguarding Adults and Children 4. Freedom of Information Reviews 5. C&W Clinical Board Consultant Annual Leave 6. Medical Staff Study Leave 7. Control of Contractors **8.** Digital Readiness **The Committee resolved that:** a) Items for information were noted
AC: 20/03/021	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD / COMMITTEE** There were no items to bring to the attention of the Board / Committee.
AC: 20/03/022	**DATE OF THE NEXT MEETING OF THE COMMITTEE** Tuesday, 24 April 2020, 9.00am – 12.00pm Cefn Mably Room, Ground Floor, Woodland House, Heath, Cardiff CF14 4HH

Action Log
Following Audit & Assurance Committee Meeting
3 March 2020

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	|STATUS/COMMENTS
Completed Actions					
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	**COMPLETED.** 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 19/09/017	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	**COMPLETED** 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.
Actions in Progress					
AC: 20/03/008	Consultant Job Planning	For an update~~d~~ to be presented to the		9.02.21	Update to be provided at February

	Follow-up: Limited Assurance Report	Committee in February 2021.			2021 meeting.
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 19/12/015	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 19/05/007	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 *(Agenda item)*
Actions referred to other Committees/Board					

REPORT TITLE:	Internal Audit Progress Report								
MEETING:	Audit & Assurance Committee						**MEETING DATE:**	14.04.20	
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 April 2020

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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2. Assignments Remaining to be Delivered
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

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 REMAINING TO BE DELIVERED

2.1. During the current Covid-19 pandemic the Health Board is obviously fully focused on dealing with the outbreak and planning provision of additional capacity. This means that key Health Board staff are therefore unavailable to engage with Internal Audit which has unavoidably impacted on delivery of the remaining elements of the Internal Audit plan.

2.2. 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 table below details those assignments which are still anticipated to be completed but have not been finalised in time for the April meeting. Details of those assignments that will now not be completed due to Covid-19 is provided under section four below.

Audit	Current Position	Draft Rating	Comment
Infection Prevention & Control	Draft	Reasonable	
Rookwood Relocation	Draft	Reasonable	
Pre-Employment Checks	Draft	Reasonable	
Surgery CB – Enhanced Supervision	Draft	Reasonable	
Strategic Planning / IMTP	Draft	Reasonable	
UHW Neonatal Development	Draft	Reasonable	

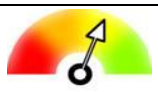
Management of Health Board Policies	Work in Progress		Small amount of fieldwork to complete. Anticipating positive assurance rating
Service Improvement Team	Work in Progress		Small amount of fieldwork to complete. Anticipating positive assurance rating

2.3. Whilst we are working to agree and finalise the current draft reports where possible, it is likely that a number of managers will not have the time or be in a position to facilitate this. The Audit Committee will therefore need to decide if it wishes to receive copies of any reports that remain in draft at the time of the May Audit Committee meeting.

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	
CD&T – Laboratory Turnaround Times (TAT)	Substantial	
UHB Core Financial Systems		
Risk Management	Reasonable	

4. DELIVERY OF THE 2019/20 INTERNAL AUDIT PLAN

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

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

4.2. The table below details the seven assignments that cannot now be completed due to the operational effects of the Covid-19 pandemic on the Health Board.

Audit	Comment
Health & Care Standards	Changes to Annual Reporting
Strategic Performance Reporting	Deputy Chief Operating Officer confirmed staff unavailable.

Data Quality Performance Reporting	Unable to undertake fieldwork within clinical areas.
IM&T Backlog	IM&T Management and staff unavailable.
Medicine Clinical Board QS&E Governance	Clinical Board Senior Nurses unavailable.
Medicine CB – Internal Medicine Follow-up	Directorate Management team unavailable.
Facilities / Estates Service Board Governance	Service Board Management team unavailable.

4.3. The number of assignments that have already been completed, combined with the current draft reports and work still planned to be finished, represents sufficient completion of the Internal Audit plan to allow for delivery of the annual Head of Internal Audit Opinion for the Health Board.

It is anticipated that thirty nine of the original fifty three assignments from the Internal Audit plan will now be delivered to at least draft report stage. These are sufficiently spread across the eight assurance domains to allow for an assurance rating to be determined for each domain and therefore feed into the overall year-end opinion. It is still forecast that the opinion will be a positive one.

The detail of the allocation of the completed audits across the assurance domains, along with those still to be undertaken and those deferred / not completed is recorded within Appendix B.

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

5. DEVELOPMENT OF THE 2020/21 INTERNAL AUDIT PLAN

5.1. A draft Internal Audit plan for 2020/21 has been developed following Meetings and correspondence with the Health Board's Executive Directors, Chief Executive, and Chairman and also with the Clinical Board Directors of Operations.

The draft plan was planned to be submitted to the Management Executive Team for comment. However due to the changes to the focus of the Management Executive Team in the current climate, the draft plan was issued to the Director of Governance for sharing with the Executive Directors where possible.

The draft Plan is being presented to the Audit Committee separately within the agenda for formal approval.

6. FINAL REPORT SUMMARIES

6.1. CD&T Laboratory Turnaround Times (TAT)

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.

Laboratory services for the processing of blood samples are subject to a strict and robust quality control environment that is monitored by the UK Accreditation Service.

The work we completed, focusing on an independent check of sample Turnaround Times, confirmed that the operation was in line with such standards and the recorded performance was accurate.

The Laboratory services have up to date and appropriate policies and procedures in place, in accordance with the requirements of ISO 1589 Quality Standards.

Effective processes are also in place for the request, collection and delivery of bloods and improvements are currently being rolled out in the form of electronic requesting.

Whilst we have raised no direct recommendations, a lean management approach would be the way to fully identify and evaluate the synergies and opportunities in the process as a whole.

6.2. UHB Core Financial Systems

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.

There is a general ledger financial control procedure (FCP) in place, which reflects the current processes. However, the procedure had not been reviewed in line with the review date detailed on the procedure.

Our review of the controls around the general ledger confirmed that reconciliations are undertaken on all areas and are appropriately documented and subject to review and approval.

Access to the Oracle system is password protected and where users have not logged on for 60 days, access is denied. However, our comparison of the Oracle User Access report against the UHB leavers report found that at least 53 leavers still had access to Oracle.

The UHB has guidance in place for uploading actual and budget journals onto the general ledger. Journal upload templates / spreadsheets are appropriately completed and retained.

There is a database in place for requesting and actioning amendments to the general ledger chart of accounts. Our review of two requests confirmed that the requests had been actioned and the correct adjustments had been made to the chart of accounts.

Our review of the controls around accounts receivable found that there is a current financial control procedure in place which sufficiently details the processes to be followed.

Our review of a sample accounts receivable invoices confirmed that they were raised accurately and promptly and receipts were accounted for properly, promptly and in full.

Robust processes are in place for pursuing outstanding debts. Debts are appropriately reported to the Losses and Special Payments panel before being approved for write off by the Audit Committee.

6.3. Risk Management

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 UHB has comprehensive structures in place to identify and manage risk. The health board's risk management model, which sets out the management of strategic and operational risks and the process for the

escalation of risks through the structure to the corporate level was revised in 2019 to introduce a Board Assurance Framework (BAF) and strengthen controls throughout the model.

The Risk Management framework includes comprehensive guidance to risk register owners on identification of risks and their subsequent management. Risk registers are in place at directorate, clinical board and corporate levels and are managed by local teams, and reviewed by Quality, Safety & Patient Experience (QSPE) groups/ committees.

The BAF is an integral part of the health board's system of internal control and captures the extreme potential risks (15 & above) which impact upon the delivery of the latter's Strategic Objectives. It also summarises the controls and assurances that are in place or the plans set out to mitigate them. The BAF aligns principal risks, key controls and assurances on controls alongside each of the Health Boards strategic objectives.

The audit, which focussed on the organisation's compliance with the rules of the framework relating to risk assessments, risk scoring, description and delivery of mitigating actions, escalation of risks to higher registers and the oversight activity of the QPSE groups/ committees identified a number of areas where compliance exceptions were observed or controls are not being applied consistently.

Findings and recommendations are recorded in the areas of training, risk identification and description and risk documentation, in particular that around the identification and capture of mitigating actions. Additionally, the audit has recommended the addition of some simple enhancements to the BAF documentation to improve clarity.

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 February 20	Reasonable	March
Medical Staff Study Leave	39		Workforce	Q3	Final – Issued February 20	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
Risk Management	**03**		**Governance**	**Q4**	**Final – Issued March 20**	**Reasonable**	**April**
CD&T CB – Laboratory Turnaround Times (TAT)	**33**		**COO**	**Q3**	**Final – Issued March 20**	**Substantial**	**April**
UHB Core Financial Systems	**13**		**Finance**	**Q3**	**Final – Issued March 20**	**Substantial**	**April**
Infection Prevention and Control	21		Nursing	Q2	Draft – Issued February 20	Reasonable	May
Rookwood Relocation Capital Project	SSU		Planning	Q4	Draft – Issued February 20	Reasonable	May
Pre-Employment Checks	40		Workforce	Q4	Draft – Issued March 20	Reasonable	May
Surgery CB – Enhanced Monitoring of Ward Patients	31		COO	Q2	Draft – Issued April 20	Reasonable	May
Strategic Planning / IMTP	08		Planning	Q3	Draft – Issued April 20	Reasonable	May
Neonatal and Obstetrics Capital Project	SSU		Planning	Q4	Draft – Issued April 20	Reasonable	May

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Management of Health Board Policies	04		Governance	Q4	Work in progress		May
Service Improvement Team	42		Planning	Q3	Work in Progress		May
Audits not completed due to Covid-19							
Medicine CB – QSE Governance	32		COO	Q2	Cannot be completed due to management / staff being unavailable		
Health & Care Standards	01		Nursing	Q4	Cannot be completed due to management / staff being unavailable		
Medicine CB – Internal Medicine Follow-up	38		COO	Q3	Cannot be completed due to management / staff being unavailable		
Strategic Performance Reporting	11		Transformation, Improvement & Informatics	Q3	Cannot be completed due to management / staff being unavailable		
Data Quality Performance Reporting	12		Transformation, Improvement & Informatics	Q4	Cannot be completed due to management / staff being unavailable		
Facilities / Estates Service Board Governance	46		Planning	Q4	Cannot be completed due to management / staff being unavailable		
IM&T Backlog	*SSU*		*Transformation, Improvement & Informatics*	*Q4*	Cannot be completed due to management / staff being unavailable		
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		

Planned output.	No	CRAF	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Engagement around Service Change	10		Planning	Q4	Deferred to 20/21. Agreed with Exec Dir of Planning. To be agreed by March AC		
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 ● Risk Management	● Standards of Behaviour Follow-up ● Claims	● Management of HB Policies	● H&CS
Financial Governance and Management	5					● Private & Overseas Patients ● Charitable Funds ● Core Financials	● Budgetary Control		● 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 ● PCIC CB – Child CHC Follow-up ● Brexit Planning ● *Strat Plan / IMTP (Draft)*			● Engagement Around Service Planning ● Strategic Performance Reporting ● Data Quality Performance Reporting

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			● GDPR Follow-up ● IT Service Management (ITIL) ● Cyber Security Follow-up ● IM&T Backlog
Operational Service and Functional Management	10					● MH CB – Sickness Management Follow-up ● Specialist CB – Rosterpro ● Surgery CB – Medical Staff Governance Follow-up ● PCIC CB – Business Continuity ● C&W CB – Consultant Leave ● *Surgery CB – Specialing of Ward Patients (Draft)*	● MH CB –Third Sector Contracts ● CD&T CB – Laboratory Turnaround Times (TAT)		● Medicine CB – QS&E Governance ● Medicine CB – Internal Medicine Follow-up
Workforce Management	3				● Consultant Job Planning Follow-up	● Medical Staff Study Leave ● *Pre-Employment Checks (Draft)*			

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 Fair Payment Charter Compliance			● Sustainability Reporting ● Maelfa Wellbeing Hub ● Control of Contractors ● *Rookwood Relocation (Draft)* ● *Neonatal & Obstetrics Project (Draft)*	● Carbon Reduction Commitment	● Service Improvement Team	● Commercial Outlets ● Facilities / Estates Service Board Governance

Audit and Assurance Services
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Cardiff
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Report Title:	**Declarations of Interest, Gifts, Hospitality & Sponsorship**								
Meeting:	**Audit & Assurance Committee**						**Meeting Date:**	**21st April 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.

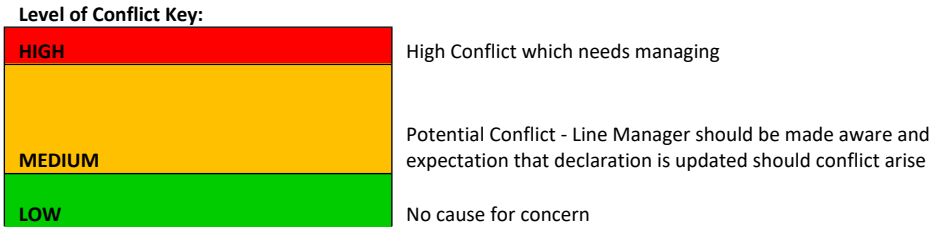
Corporate Governance have cleared the backlog of outstanding declarations, therefore, this report provides a fully up to date position.

Due to the ongoing COVID-19 situation, all planned Standards of Behaviour communication has been paused and will commence again when possible.

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 March 2020):

- 1,302 Declarations of Interests, Gifts, Hospitality & Sponsorship Forms
- 59% of staff banded 8a and above have returned their declaration forms, this is an increase of 19% 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:



- 79.5% of Declarations received are rated **Green**.
- 20% of Declarations received are rated **Orange**.

- 0.5% of Declarations are rated **Red**.

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

We have received regular updates on Declarations of Interests being launched on the ESR system, however, due to the ongoing COVID-19 situation, the original launch date of April 2020 will be delayed and we are currently waiting to receive a new proposed date. An update will be provided at the next Committee meeting.

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 Key:

HIGH	High Conflict which needs managing
MEDIUM	Potential Conflict - Line Manager should be made aware and expectation that declaration is updated should conflict arise
LOW	No cause for concern

Declarations of Interest
Interests Declared

Level of Conflict	Name	Position held in UHB	Directorate / Speciality	Band	Clinical Board / Corporate Dept	Date Form Returned	Interests to Declare (Yes/No)	Third Party Declaration eg Spouse/Partner (Yes/No)	a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies	Start - End Date	Financial / Other Benefits
	Craig Greenstock	Counter Fraud Manager	Finance		Executives	13/05/2019	Yes	Yes	N/A	N/A	N/A
	Aron White	Senior Nurse - Standards & Professional Regulation	Corporate Nursing		Corporate Nursing	13/05/2019	Yes	No	N/A	N/A	N/A
	Aled Roberts	Interim Clinical Board Director	Medicine		Medicine	16/05/2015	Yes	Yes	● Director of PLC - SAGE Roberts PLC. ● Wife is also a Director	Nov-18 - Ongoing	No Salary
	Richard Hurton	Head of Financial Accounting & Services	Finance		Corporate Department	12/05/2018	No	Yes	N/A	N/A	N/A
	Sridhar Kamath	Consultant Radiologist	Radiology			17/05/2019	Yes	No	● Director of Kamath Medical Services, Sanika Investments Limited ● Archana Kamath, Director of Kamath Medical	No Further Information Provided	No Further Information Provided
	Rhys Morris	Principal Clincal Scientis	RMPCE		CD&T	17/05/2019	Yes	No	N/A	N/A	N/A
	Eileen Brandeth	Independent Membembe of the Board	IMT & IG			03/01/2019	Yes	No	N/A	N/A	N/A
	John Michael Imperato	Independent Membembe of the Board				10/01/2019	Yes	Yes	● Director Association of Personal Injury Lawyers ● Director Bevan Foundation Charity ● Director Swansea Univerity Childrens Legal Centre	● May 2017 - No end date ● May 2016 - No end date ● Oct 2017 - No end date	N/A
	John Union	Independent Membembe of the Board	Finance		N/A	03/01/2019	Yes	No	● John Union Limited ● Swansea Building Society ● Cardiff Business Club Director	● 01/04/2016 - Onoging ● 01/11/2017 -Ongoing ●01/01/2019 - Ongoing	● Dividends ● Salary ● None
	Gary Baxtor	Independent Membembe of the Board	Bio-Medical and Life Sciences		Cardiff University	07/03/2019	Yes	No	N/A	N/A	N/A
	Nicola Foreman	Director of Corporate Governance				05/03/2019	Yes	No	Company Secretary of Husbands Business Safe Ventures (UK) LTD	March 2014 - Ongoing	N/A
	Lance Carver	Associate Member				05/03/2019	Yes	No	N/A	N/A	N/A
	Mandy Sara Collins	Interim Head of Governance	Corporate Governance		Corporate Governance	28/02/2019	Yes	Yes	N/A	N/A	N/A
	Sara Moseley	Independent Member of the Board - Third Sector				12/02/2019	Yes	No	● WCVA Elected Board Member ● Executive Director, MIND	No information provided	No information provided
	Richard Thomas	Chair of Strategic Reference Group	N/A		N/A	12/02/2019	No	No	● Care & Repair Home Improvement Services Ltd	28/12/2016 - Ongoing	N/A
	Sharon Hopkins	Director of Transformation, Improvement and Informatics / Dep CEO	Executive		Executive	31/12/2018	Yes	No	N/A	N/A	N/A
	Lee Davies	Operational Planning Director	Corporate		Chief Operating Officer	07/01/2019	No	Yes	N/A	N/A	N/A
	Maria Battle	Chair	HQ			09/01/2019	Yes	No	N/A	N/A	N/A
	Abigail Harris	Executive Director of Strategic Planning				03/01/2019	Yes	Yes	N/A	N/A	N/A
	Christopher Howrad Lewis	Deputy Director of Finance			Finance	28/01/2019	Yes	Yes	N/A	N/A	N/A
	Charles Janczewski	Vice Chair				02/01/2019	Yes	No	N/A	N/A	N/A
	Fiona Kinghorn	Executive Director of Public Health	Public Health		Public Health	24/01/2019	No	Yes	N/A	N/A	N/A
	Fiona Jenkins	Executive Director of Therapies and Health Science	Executive			03/01/2019	Yes	No	Director JJ Consulting Healthcare Ltd	01/04/2012 - Ongoing	Financial related publications and consultancy work
	Len Richards	Chief Executive			Executive Team	25/01/2019	Yes	No	Advisor to the Life Sciences Hub Board	2018 - ongoing	None
	Ruth Walker	Executive Nurse Director	Corporate		Corporate	02/01/2019	Yes	No	N/A	N/A	N/A
	CLLR Susan Elsmore	Independent Member of the Board - Local Authority				29/01/2019	Yes	No	N/A	N/A	N/A
	Paula Martyn	Chair of Stakeholder Ref Group (until Dec 2018)	N/A		N/A	12/03/2019	Yes	No	N/A	N/A	N/A
	Mary Lawrence	Associate Specialist in Psychiatry	Adult Mental Health		Mental Health	04/01/2019	Yes	No	N/A	N/A	N/A
	Julie Gittings	Counsellor	Psychology & Psychological Therapy		Mental Health	06/12/2018	Yes	No	N/A	N/A	N/A
	Rebecca Williamson	Counsellor	Psychology & Psychological Therapy		Mental Health	14/12/2018	Yes		N/A	N/A	N/A
	Jan Melichar	Counsultant in Substance Misuse Psychiatry (Long-Term Locum)	Psychiatry		Medicine	10/12/2018	Yes	No	100% Owner /Director of Limited Company used for any Private Work	March 2017 - Ongoing	Dividends
	Emily Harrington	Consultant Psychiatrist	Mental Health		Adult Mental Health	18/12/2018	Yes	No	N/A	N/A	N/A
	Hannah Brayford	Head of Programme Management Office	Transformation		Transformation	08/05/2019	Yes	Yes	● I'm a director of Longford Pugh Properties, a limited company ● Wife is also a Director of Longford Pugh Properties	● 2012 - Ongoing ● 2014 - Ongoing	● None ● None
	Ruth Jordan	Head of Continuous Service Improvement	Continuous Service Improvement	8C	Executives	08/05/2019	No	Yes	Spouse is Director of the Plaza Cardiff Bay (Phase 1) Management Company Limited	02/01/2008 - Ongoing	None
	Mark Thomas	Senior Service Improvement Programme Manager	Improvement and Transformation		Executive	23/05/2019	No	Yes	N/A	N/A	N/A
	Emma Cooke	Head of Physiotherapy	Therapy		CD&T	24/05/2019	Yes	Yes	N/A	N/A	N/A
	Claire Ganderton	Senior Appraisal Pharmacist	All Wales Theraputics and Toxicology Centre		CD&T	28/05/2019	Yes	Yes	Director and Spouse is Director too	12/09/2017 - Ongoing	Annual Dividend
	Nia Jones	Specialist Podiadrist	Therapies		CD&T	28/05/2019	Yes	No	N/A	N/A	N/A
	Rhodri Willment	Physiotherapist	Physiotherapy	6	Therapies	30/05/2019	Yes	No	N/A	N/A	N/A
	Joanne Moon	Dietitcian	Therapies		CD&T	29/05/2019	Yes	No	N/A	N/A	N/A
	Annie Gover	Weight Management CNS	Community Dietetics		CD&T	28/05/2019	Yes	No	N/A	N/A	N/A
	Alexandra Saunders	Physiotherapy Team Lead North and West Community Resource Team (Secondment)	Physiotherapy		PCIC	28/05/2019	Yes	Yes	N/A	N/A	N/A

	Claire Bruce	Community Physiotherapist CRT	Localities		PCIC	30/05/2019	Yes	No	N/A	N/A	N/A
	Lisa Small	Occupational Therapist	Therapies	7		30/05/2019	Yes	No	N/A	N/A	N/A
	Aisling Pigott - Jones	Lead Paediatric Diabetes Dietitian	Nutrition & Dietetics			15/05/2019	Yes	No	N/A	N/A	N/A
	Melanie Wilkey	Head of Outcomes Based Commissioning	Commissioning		Executives	28/05/2019	No	Yes	N/A	N/A	N/A
	Jamie Hayes	Director - Welsh Medicines Resource Centre & All Wales Therapeutics & Toxicology Centre	AWTTC		CD&T	03/06/2019	Yes	No	Director, JMH Collaborations LTD	March 2017 - Ongoing	Consultancy Fees
	Jane Maddison	Community Peadatric Physiotherapy Lead	Peadatric Physiotherapy	8a	Children & Women	05/06/2019	Yes	No	N/A	N/A	N/A
	Annette Mclean	Dietitcian	CD&T Dietetics		CD&T	03/06/2019	Yes	No	N/A	N/A	N/A
	Natalie Robertson	Principal Physiotherapist in Mental Health	Physiotherapy		CD&T	04/06/2019	Yes	Yes	N/A	N/A	N/A
	Robert Bleehen	Consultant Radiologist	Radiology		CD&T	05/06/2019	Yes	Yes	Both Directors of Cardiff Medical Consulting Ltd	No information provided	No information provided
	Sarah Congreve	Vale Assistant Locality Manager	Vale Locality Office		PCIC	08/05/2019	No	Yes	N/A	N/A	N/A
	Vanessa Adams	Cluster Pharmacist	Primary Care Cluster Pharmacist		Primary, Community & Intermediate Care	29/05/2019	Yes	No	N/A	N/A	N/A
	Farzana Mohammed	Cluster Pharmacist	PCIC		PCIC	16/05/2019	Yes	No	N/A	N/A	N/A
	Sarah Clements	Clinical Lead SLT	Therapies	8a	CD&T	05/06/2019	Yes	No	N/A	N/A	N/A
	Lorna Bennett	Consultant - Public Health	Public Health			23/05/2019	Yes	No	N/A	N/A	N/A
	Michelle Smalley	LATCH Clinical Phychologist			Acute Child Health / Child Phychology	07/06/2019	Yes	No	N/A	N/A	N/A
	Nicholas Grape	Occupational Therapist	Therapies	7	Therapies	11/06/2019	Yes	No	N/A	N/A	N/A
	Dr Kathrin Hammer	Consultant	Radiology			13/06/2019	Yes	No	Director MSK Radiology ltd	2014 - Ongoing	Honoraria
	Christopher Ronald Ellis	Contact Lens Specialist - Opthamology				18/05/2019	Yes	No	R. N. Roberts (North Road) Lrd	2008 - Ongoing	Salary & Dividens
	Deborah Keoghane	Lead Colorectal / Soma CNS	Colorectal Surgery		Surgery	06/06/2019	Yes	No	N/A	N/A	N/A
	Sharon Iving	Senior Nurse	ENT, Opthamology, Urology and Dental		Surgery	06/06/2019	Yes	No	N/A	N/A	N/A
	Andrew Jones	Lead Nurse	Surgery, Urology, Optjalmology, ENT		Surgery, Urology, Optjalmology, ENT	06/06/2019	Yes	No	N/A	N/A	N/A
	Roger Maggs	Laboratory Manager	Dental Technology		Surgery	06/06/2019	Yes	Yes	Directorship Wife also has Directorship	01/11/2014 - Ongoing 01/11/2014 - Ongoing	Salary Salary
	Catherine Marshall	Physio Clinical Lead	Therapies		CD&T	29/05/2019	No	Yes	Husband works in CMHT (Mental Health) Son working in Public Health (Dietetics)	No information provided	No information provided
	Denise Hayes Davies	Clinical Specialist Physiotherapist	Therapies	8a	CD&T	23/05/2019	Yes	No	N/A	N/A	N/A
	George Oliver	Performance and Service Improvement Lead, Outpatient Physiotherapy	Therapies		CD&T	20/05/2019	Yes	Yes	N/A	N/A	N/A
	Claire Butterworth	Clinical Specialist Physiotherapist	Therapies		CD&T	30/05/2019	Yes	No	N/A	N/A	N/A
	Jacqueline Sharp	Clinical Service Lead - Physiotherapy (Neurosciences)	Therapies		CD&T	04/06/2019	No	Yes	N/A	N/A	N/A
	Ruth Walford	Specialist Speech and Language Therapist	Therapies		CD&T	20/06/2019	Yes	No	N/A	N/A	N/A
	Emily Morris	Speciality Doctor	Community Child Health		Child Health	21/06/2019	Yes	No	N/A	N/A	N/A
	Ellen Long	Specialist Physiotherapist	Physiotherapy	6	Therapies	24/06/2019	Yes	No	N/A	N/A	N/A
	Alison Millard	Urology Clinic Sister	Urology	7	Surgery	24/06/2019	Yes	No	N/A	N/A	N/A
	Paul Rogers	Directorate Manager	ALAS		Specialist Services	15/05/2019	Yes	Yes	N/A	N/A	N/A
	Maurice Wentworth	Posture & Mobility Centre Business Manager	ALAS		Specialist Services	03/06/2019	Yes	No	N/A	N/A	N/A
	Shahad Latif	Specialist Information Pharmacist	Pharmacy	8a	Pharmacy	03/07/2019	Yes	No	N/A	N/A	N/A
	Andrew Sully	Principal Pharmacist Quality Control	Pharmacy	8c	CD&T	05/07/2019	No	No	N/A	N/A	N/A
		Pharmacist									
	Peter Meades	Manager	Psychology & Counselling	8a	Mental Health	11/07/2019	Yes	No	N/A	N/A	N/A
	Scott Gable	Cellular Pathology Service Manager	Laboratory Medicine		CD&T	29/04/2019	Yes	No	Executive Director - LabXcell Ltd	01/04/2019 - Ongoing	Retainer
	Ann Birch	Speech and Language Therapist - Cochlear Implant	Head and Neck Maxillo and Opthal	8a	Surgical Services	11/07/2019	Yes	No	N/A	N/A	N/A
	Richard Cuddihy	Consultant Clinical Psychologist/Head of Specialty/Lead Psychologist SpSCB	ALAS/Psychology & Psychological Therapies Directorate		Specialist Services	12/07/2019	Yes	No	N/A	N/A	N/A
	Lucy Wheeler	Pharmacist	Pharmacy	8a	CD&T	12/07/2019	No	Yes	N/A	N/A	N/A
	Aarti Sharma	Consultant	Gynaecology			19/06/2019	Yes	Yes	Yes Spouse - Ram Misra	April 2019 - Current	Nil
	Abigail Holmes	Consultant Midwife	Women & Children		Maternity	11/07/2019	Yes	No	N/A	N/A	N/A
	Annapurna Darbhamulla	Consultant	Obstetrics and Gynaecology		Women & Children	26/06/2019	Yes		Darbhamulla Consultancy Limited (10018781)	22/02/2016 - Ongoing	Yes
	Robert Bryan Beattie	Consultant	Obstetrics and Gynaecology		Women & Children	07/06/2019	Yes	No	Founding Director of Innermost Secrets Limited	15+ Years - Ongoing	Financial
	Preetkiron Bhal	Consultant	Womens / Gynaecology		Children & Women	11/06/2019	Yes	No	Director - Infiniti Healthcare Ltd Spouse - Nadia Bhal Director - Infiniti Healthcare Ltd	May 2013 - Ongoing	Director
	Richard Penketh	Consultant O & G				10/06/2019	Yes	Yes	Director - RPSF Ltd Spouse - Director, RPSF Ltd	01/05/2019 - Ongoing	This is a company for RPs private practice and thus might do business with the HB
	Marc Williams	Clinical Psychologist	Psychology and Counselling	8a	Gastroenterology	15/07/2019	Yes	No	N/A	N/A	N/A

	Ruth Cann	Senior Nurse	Medicine	8a	Medicine	15/07/2019	No	Yes	N/A	N/A	N/A
	Holly Davies	Clinical Psychologist	Psychology Department	8a	MHSOP	12/07/2019	Yes	No	N/A	N/A	N/A
	Aimee Stimpson	Clinical Psychologist	Welsh Inherited Bleeding Disorders / Severe and Brittle Asthma Service		Directorate of Psychology and Psychological Therapies / Internal Medicine	05/11/2018	Yes	No	N/A	N/A	N/A
	Bethan Phillips	Clinical Psychologist	Women & Children		Paediatric Psychology	23/10/2018	Yes	No	N/A	N/A	N/A
	Kerry-Ann Holder	Consultant Clinical Psychologist	Women & Children			23/10/2018	Yes	No	Bridgeman Psychological Consultancy - I am Director of this company, but all of my private practice is operated out of Talis Consulting Ltd	April 2017 - Ongoing	No information provided
	Kathryn Bond	Peadiatric Neuropsychologist	Paediatric Psychology			19/10/2018	Yes	No	N/A	N/A	N/A
	Andrew Vidgen	Consultant Psychologist	Mental Health	8c	Mental Health	15/04/2019	Yes	No	N/A	N/A	N/A
	Rona Aldridge	Clinical Psychologist	Integrated Autism Service, Psychology and Psychological Therapies	8b	Mental Health	15/04/2019	Yes	No	N/A	N/A	N/A
	Menna Myfanwy Jones	Clinical Lead	Service for High Risk Eating Disorders	8c	Mental Health	16/07/2019	Yes	No	N/A	N/A	N/A
	Shilbendra Datta	Consultant	Urology		Surgery	15/07/2019	Yes	No	Director of 'Urology Solution Cardiff Limited' Wife is Co - Director of 'Urology Solution Cardiff Limited'	N/A	Dividends
	Owen Hughes	Consultant	Urology		Surgery	15/07/2019	Yes	No	N/A	N/A	N/A
	Howard Kynaston	Consultant	Urology		Surgery	15/07/2019	Yes	Yes	Company Director - Bay Tree Wine Company Wife, Amanda Kynaston - Company Director Bay Tree Wine Company	May 2009 - Ongoing	No information provided
	Alun Rhys Bonello	Physiotherapist	Therapies		CD&T	04/06/2019	Yes	Yes	N/A	N/A	N/A
	James Smith	Advanced MSK Physiotherapist	Therapies		CD&T	04/06/2019	Yes	No	N/A	N/A	N/A
	Sarah Alexander	Physiotherapist	Therapies	6	Therapies	27/07/2019	Yes	No	N/A	N/A	N/A
	Hayley Dalls	Physiotherapist	Therapies	6	CD&T	22/07/2019	Yes	No	N/A	N/A	N/A
	Leanne Matthews	Physio Technician	Therapies		CD&T	25/07/2019	Yes	No	N/A	N/A	N/A
	Kath Singleton	Dietitcian	Nutrition & Dietetics	8a	CD&T	15/07/2019	Yes	No	N/A	N/A	N/A
	Elizabeth Wilding	Dietitcian	Therapies	7	CD&T	28/05/2019	Yes	No	N/A	N/A	N/A
	Gary Howell	Macmillan AHP Cancer Lead	Therapies		CD&T	24/05/2019	Yes	No	N/A	N/A	N/A
	Marzena Zygo	Dietetic Support Worker	Therapies		CD&T	28/05/2019	Yes	No	N/A	N/A	N/A
	Victoria Chapman	Dietetic Support Worker	Therapies		CD&T	17/07/2019	No	Yes	Father is Director of Nodor International	Over 10 Years - Ongoing	N/A
	Julia Lisa Williams	All Wales Nutrition Training Facilitator	Therapies		CD&T	28/05/2019	Yes	No	Director British Dieteic Association	Jul 2018 - Present	Department paid for time on BDA Business
	Gemma Purcell-Jones	Community Dietitian - Chronic Conditions Management Tea	Therapies		CD&T	10/07/2019	Yes	No	N/A	N/A	N/A
	Fiona Moore	Community Dietitian	Therapies		CD&T	27/05/2019	Yes	Yes	Director GRJM Consultancy Limited Spouse - Director GRJM Consultancy Limited	Jul 2018 - Present	No information provided
	Melanie Gray	Community Dietitian	Therapies	5	CD&T	28/05/2019	Yes	No	N/A	N/A	N/A
	Sally Shand	Counsellor	Therapies	6	CD&T	14/06/2019	Yes	No	N/A	N/A	N/A
	Conor Dunleavy	Physiotherapy	Physiotherapy	5	CD&T	28/06/2019	Yes	No	N/A	N/A	N/A
	Garwyn Bridges	Physiotherapy, Cystic Fibrosis	Therapies Physiotherapy	no details given	CD&T	02/09/2019	Yes	No	N/A	N/A	N/A
	Georgina Hooper	Physiotherapy Team Lead	Therapies Physiotherapy	no details given	CD&T	20/06/2019	Yes	No	N/A	N/A	N/A
	Ann Jones	Patient Safety Manager		8a	Corporate Nursing	12/11/2019	Yes	No	N/A	N/A	N/A
	Rachael Barlow	Clinical Lead		8c	Surgery	13/11/2019	Yes	No	N/A	N/A	N/A
	Pippa Mundy	Clinical Psychologist	Community Child Health	8c	Women & Children	12/11/2019	Yes	No	N/A	N/A	N/A
	Kathryn Lousie Allen	Community Pharmacy Advisor	PCIC	8a	PCIC	12/11/2019	Yes	No	Davies Homes Ltd	2010 - Ongoing	None
	Andy Jones	Lead Nurse: Surgery, urology, ophthalmology ent, dental wound healing and breast	Surgery	8b	Surgery	12/11/2019	Yes	No	N/A	N/A	N/A
	James Coulson	Honorary Consultant Physician, Clinical Pharmacologist & Toxicologist	Medicine / Clinical Pharamacology / CD&T	Consultant	Medicine & CD&T	12/11/2019	Yes	Yes	Both Director of Medical, Scientific & Toxicology Consultancy Ltd	April 2016 - Ongoing	Dividends
	Jessica Quirke	Consultant Clinical Neuropsychologist	Neurosciences	8c	Specialist Services	12/11/2019	Yes	No	N/A	N/A	N/A
	Christopher Howrad Lewis	Deputy Director of Finance	Finance	A4C 9	Executives	12/11/2019	Yes	Yes	N/A	N/A	N/A
	Christopher Anderson	Clinical Scientist	AWMGS	8a	All Wales Genomics Service	12/11/2019	No	Yes	N/A	N/A	N/A
	Louise Evans	Clinical Psychologist	Psychology and psychological therapies	8A	Mental Health	12/11/2019	Yes	No	N/A	N/A	N/A
	Miranda Barber	Consultant Clinical Psychologist	Adult Mental Health full time permanent post, Mental Health Services for Older People (1 day/week until end March 2020	8C	Mental Health	12/11/2019	No	No	Director Limited company (not traded on it since April 2018) - end client was not in the business of providing any form of health care	August 2015 - 2018	Tax free dividend amount only
	Rhys Morris	Clinical Scientist	Radiology, Medical Physics & Clinical Engineering	8C	CD&T	18/10/2019	Yes	No	N/A	N/A	N/A
	Helen Ludlow	CNS	Gastroenterology	8A	Medicince	01/11/2019	Yes	No	N/A	N/A	N/A
	Catherine Bryant	Consultant Clinical Scientist, Head of Non-Ionising Radiation	RMPCE	8D	CD&T	13/11/2019	Yes	No	N/A	N/A	N/A
	Clare Quinn	Consultant Clinical Psychologist	Clinical Psychology & MHSOP	8D	MHCB	13/11/2019	Yes	No	N/A	N/A	N/A
	Kim Atkinson	Strategic Lead Occupational Therapist	Therapies	8B	CD&T	13/11/2019	Yes	No	Director of the Royal College of Occupational Therapists	June 2018 - June 2021	None
	Julie Highfield	Consultant Clinical Psychologist Critical Care / Asscoaite Director Critical Care	Critical Care	8C	Specalist Services	13/11/2019	Yes	Yes	N/A	N/A	N/A
	Lee Davies	Operational Planning Director	Operations	9	Chief Operating Officer	13/11/2019	No	Yes	N/A	N/A	N/A
	Declan Coleman	Clinical Scientist	Radiology, Medical Physics and ClinicalEngineering	8B	CD&T	12/07/2019	Yes	No	N/A	N/A	N/A
	Emyr Stephens	Prescribing Advisor	PCIC	8A	PCIC	13/11/2019	Yes	no	N/A	N/A	N/A
	Judy Gaunt	Service Manager	RADIOLOGY,MEDICAL PHYSICS AND CLINICAL ENGINEERING	8A	CD&T	13/11/2019	No	Yes	N/A	N/A	N/A
	Gary Howell	Macmillan AHP Cancer Lead	Therapies		CD&T	13/11/2019	Yes	No	N/A	N/A	N/A
	Annette Mclean	Dietitcian	Dietetics	8A	CD&T	13/11/2019	Yes	No	N/A	N/A	N/A

	Peter O Callaghan	Clinical Director Cardiothoracic services	Consultant cardiologist		Consultant cardiologist	13/11/2019	Yes	No	N/A	N/A	N/A
	Melaine Wilkey	Head of Outcomes Based Commissioning	Commissioning	8C	Executives	13/11/2019	No	Yes	N/A	N/A	N/A
	Richard Attanoos	Doctor	Department of Cellular Pathology		Department of Cellular Pathology	13/11/2019	Yes	Yes	Managing Director Spouse is Company Secretary	2009 - Present	Financial
	Claire Louise Willson Osbourne	Consultant Clinical Neuropsychologist	Neurosciences/Neuropsychology	8C	Specialist Services	13/11/2019	Yes	No	N/A	N/A	N/A
	Farzana Mohammed	Cluster Pharmacist	PCIC		PCIC	16/05/2019	Yes	No	N/A	N/A	N/A
	Sarah Clements	Clinical Lead SLT	Therapies	8a	CD&T	05/06/2019	Yes	No	N/A	N/A	N/A
	Lorna Bennett	Consultant - Public Health	Public Health			23/05/2019	Yes	No	N/A	N/A	N/A
	Michelle Smalley	LATCH Clinical Phychologist			Acute Child Health / Child Phychology	07/06/2019	Yes	No	N/A	N/A	N/A
	Nicholas Grape	Occupational Therapist	Therapies	7	Therapies	11/06/2019	Yes	No	N/A	N/A	N/A
	Dr Kathrin Hammer	Consultant	Radiology			13/06/2019	Yes	No	Director MSK Radiology ltd	2014 - Ongoing	Honoraria
	Christopher Ronald Ellis	Contact Lens Specialist - Opthamology				18/05/2019	Yes	No	R. N. Roberts (North Road) Lrd	2008 - Ongoing	Salary & Dividens
	Deborah Keoghane	Lead Colorectal / Soma CNS	Colorectal Surgery		Surgery	06/06/2019	Yes	No	N/A	N/A	N/A
	Sharon Iving	Senior Nurse	ENT, Opthamology, Urology and Dental		Surgery	06/06/2019	Yes	No	N/A	N/A	N/A
	Andrew Jones	Lead Nurse	Surgery, Urology, Optjalmology, ENT		Surgery, Urology, Optjalmology, ENT	06/06/2019	Yes	No	N/A	N/A	N/A
	Roger Maggs	Laboratory Manager	Dental Technology		Surgery	06/06/2019	Yes	Yes	Directorship Wife also has Directorship	01/11/2014 - Ongoing 01/11/2014 - Ongoing	Salary Salary
	Catherine Marshall	Physio Clinical Lead	Therapies		CD&T	29/05/2019	No	Yes	Husband works in CMHT (Mental Health) Son working in Public Health (Dietetics)	No information provided	No information provided
	Denise Hayes Davies	Clinical Specialist Physiotherapist	Therapies	8a	CD&T	23/05/2019	Yes	No	N/A	N/A	N/A
	George Oliver	Performance and Service Improvement Lead, Outpatient Physiotherapy	Therapies		CD&T	20/05/2019	Yes	Yes	N/A	N/A	N/A
	Claire Butterworth	Clinical Specialist Physiotherapist	Therapies		CD&T	30/05/2019	Yes	No	N/A	N/A	N/A
	Jacqueline Sharp	Clinical Service Lead - Physiotherapy (Neurosciences)	Therapies		CD&T	04/06/2019	No	Yes	N/A	N/A	N/A
	Ruth Walford	Specialist Speech and Language Therapist	Therapies		CD&T	20/06/2019	Yes	No	N/A	N/A	N/A
	Emily Morris	Speciality Doctor	Community Child Health		Child Health	21/06/2019	Yes	No	N/A	N/A	N/A
	Paul Rogers	Directorate Manager	ALAS		Specialist Services	15/05/2019	Yes	Yes	N/A	N/A	N/A
	Maurice Wentworth	Posture & Mobility Centre Business Manager	ALAS		Specialist Services	03/06/2019	Yes	No	N/A	N/A	N/A
	Shahad Latif	Specialist Information Pharmacist	Pharmacy	8a	Pharmacy	03/07/2019	Yes	No	N/A	N/A	N/A
	Andrew Sully	Principal Pharmacist Quality Control	Pharmacy	8c	CD&T	05/07/2019	No	No	N/A	N/A	N/A
		Pharmacist									
	Peter Meades	Manager	Psychology & Counselling	8a	Mental Health	11/07/2019	Yes	No	N/A	N/A	N/A
	Scott Gable	Cellular Pathology Service Manager	Laboratory Medicine		CD&T	29/04/2019	Yes	No	Executive Director - LabXcell Ltd	01/04/2019 - Ongoing	Retainer
	Ann Birch	Speech and Language Therapist - Cochlear Implant	Head and Neck Maxillo and Opthal	8a	Surgical Services	11/07/2019	Yes	No	N/A	N/A	N/A
	Richard Cuddihy	Consultant Clinical Psychologist/Head of Specialty/Lead Psychologist SpSCB	ALAS/Psychology & Psychological Therapies Directorate		Specialist Services	12/07/2019	Yes	No	N/A	N/A	N/A
	Lucy Wheeler	Pharmacist	Pharmacy	8a	CD&T	12/07/2019	No	Yes	N/A	N/A	N/A
	Aarti Sharma	Consultant	Gynaecology			19/06/2019	Yes	Yes	Yes Spouse - Ram Misra	April 2019 - Current	Nil
	Abigail Holmes	Consultant Midwife	Women & Children		Maternity	11/07/2019	Yes	No	N/A	N/A	N/A
	Annapurna Darbhamulla	Consultant	Obstetrics and Gynaecology		Women & Children	26/06/2019	Yes		Darbhamulla Consultancy Limited (10018781)	22/02/2016 - Ongoing	Yes
	Robert Bryan Beattie	Consultant	Obstetrics and Gynaecology		Women & Children	07/06/2019	Yes	No	Founding Director of Innermost Secrets Limited	15+ Years - Ongoing	Financial
	Preetkiron Bhal	Consultant	Womens / Gynaecology		Children & Women	11/06/2019	Yes	No	Director - Infiniti Healthcare Ltd Spouse - Nadia Bhal Director - Infiniti Healthcare Ltd	May 2013 - Ongoing	Director
	Richard Penketh	Consultant O & G				10/06/2019	Yes	Yes	Director - RPSF Ltd Spouse - Director, RPSF Ltd	01/05/2019 - Ongoing	This is a company for RPs private practice and thus might do business with the HB
	Marc Williams	Clinical Psychologist	Psychology and Counselling	8a	Gastroenterology	15/07/2019	Yes	No	N/A	N/A	N/A
	Ruth Cann	Senior Nurse	Medicine	8a	Medicine	15/07/2019	No	Yes	N/A	N/A	N/A
	Holly Davies	Clinical Psychologist	Psychology Department	8a	MHSOP	12/07/2019	Yes	No	N/A	N/A	N/A
	Aimee Stimpson	Clinical Psychologist	Welsh Inherited Bleeding Disorders / Severe and Brittle Asthma Service		Directorate of Psychology and Psychological Therapies / Internal Medicine	05/11/2018	Yes	No	N/A	N/A	N/A
	Bethan Phillips	Clinical Psychologist	Women & Children		Paediatric Psychology	23/10/2018	Yes	No	N/A	N/A	N/A
	Kerry-Ann Holder	Consultant Clinical Psychologist	Women & Children			23/10/2018	Yes	No	Bridgeman Psychological Consultancy - I am Director of this company, but all of my private practice is operated out of Talis Consulting Ltd	April 2017 - Ongoing	No information provided
	Kathryn Bond	Peadiatric Neuropsychologist	Paediatric Psychology			19/10/2018	Yes	No	N/A	N/A	N/A
	Andrew Vidgen	Consultant Psychologist	Mental Health	8c	Mental Health	15/04/2019	Yes	No	N/A	N/A	N/A
	Rona Aldridge	Clinical Psychologist	Integrated Autism Service, Psychology and Psychological Therapies	8b	Mental Health	15/04/2019	Yes	No	N/A	N/A	N/A
	Menna Myfanwy Jones	Clinical Lead	Service for High Risk Eating Disorders	8c	Mental Health	16/07/2019	Yes	No	N/A	N/A	N/A

	Shilbendra Datta	Consultant	Urology		Surgery	15/07/2019	Yes	No	Director of 'Urology Solution Cardiff Limited' Wife is Co - Director of 'Urology Solution Cardiff Limited'	N/A	Dividends
	Owen Hughes	Consultant	Urology		Surgery	15/07/2019	Yes	No	N/A	N/A	N/A
	Howard Kynaston	Consultant	Urology		Surgery	15/07/2019	Yes	Yes	Company Director - Bay Tree Wine Company Wife, Amanda Kynaston - Company Director Bay Tree Wine Company	May 2009 - Ongoing	No information provided
	Alun Rhys Bonello	Physiotherapist	Therapies		CD&T	04/06/2019	Yes	Yes	N/A	N/A	N/A
	James Smith	Advanced MSK Physiotherapist	Therapies		CD&T	04/06/2019	Yes	No	N/A	N/A	N/A
	Sarah Alexander	Physiotherapist	Therapies	6	Therapies	27/07/2019	Yes	No	N/A	N/A	N/A
	Dennis Llewellyn Cochlin	Locum Consultant Radiologist	Radiology	Consultant	Therapies	22/01/2020	Yes	No	N/A	N/A	N/A
	Menna Jones	Clinical Lead, Service for High Risk Eating Disorders	Adult Mental Health	8c	Mental Health	18/12/2019	Yes	No	1. Director (Treasurer) of the Vegan Society which is a company by limited guarantee as well as a registered charity. 2. Director of the British Easting Disorders Charity	1.2013 - Ongoing 2. June 2017 - Ongoing	Reimbursments of expenses incurred
	Marion Moody	Counsellor	Psychology & Psychological Therapy	6	Mental Health	12/12/2019	Yes	No	N/A	N/A	N/A
	Gareth John Davies	Senior Clinical Biochemist	Weqas	8a	Weqas	27/12/2019	Yes	Yes	Pennstone Property Limited Spouse: Pennstone Property Limited	28/11/2018 - Ongoing	None
	Elizabeth (Libby) Erin	Clinical Psychologist	Child Psychology	8a	Women & Children	31/12/2019	Yes	No	N/A	N/A	N/A
	Sally Lynch	Radiographer	Radiology	7	CD&T	16/12/2019	Yes	No	N/A	N/A	N/A
	Robyn Ormond	Sonographer	Radiology	7	CD&T	18/11/2019	Yes	No	N/A	N/A	N/A
	Hannah Hughes	Sonographer	Radiology	7	CD&T	15/11/2019	Yes	No	N/A	N/A	N/A
	Victoria Kinsella	Sonographer / Radiographer	Radiology	7	CD&T	18.11.2019	Yes	Yes	N/A	N/A	N/A
	Kathryn Alison Hobbs	Counsellor	Psychology		Mental Health	17/12/2019	Yes	No	N/A	N/A	N/A
	Deborah Edmonds	Clinical Specialist Physiotherapist in Shoulder Rehabilitation	Therapies	8a	CD&T	17/12/2019	Yes	No	N/A	N/A	N/A
	Nerys Thomas	Superintendent Sonographer	Radiology	8A	CD&T	12/11/2019	Yes	No	N/A	N/A	N/A
	Emma Hatton	Sonographer	Radiology	7	CD&T	04/12/2019	Yes	No	N/A	N/A	N/A
	Andrea Louise Hunt	Counsellor	Psychiological Therapies		CD&T	11/12/2019	Yes	No	N/A	N/A	N/A
	Salema Rahman	Primary Care Counsellor	Psychology		Mental Health	10..12.2019	Yes	No	N/A	N/A	N/A
	Donna Giovannong King	Counsellor	Psychology		Mental Health	12/12/2019	Yes	No	N/A	N/A	N/A
	Lorraine Donovan	Senior Nurse	Neuroscience	8a	Specialist Services	21/11/2019	Yes	No	N/A	N/A	N/a
	Dean Marriott	Sonographer	Ultrasound	7	CD&T	16/12/2019	Yes	No	N/A	N/A	N/A
	Pat Penketh	Sonographer	Ultrasound	7	Radiology	19/11/2019	Yes	No	N/A	N/A	N/A
	Laurie Sherene Reardon-John	Sonographer	Radiology	7	Radiology	11/12/2019	Yes	No	N/A	N/A	N/A
	Tessa Abbas	Primary Care Counsellor	Psychology & Psychological Therapy		Mental Health	04.12.2019	Yes	No	N/A	N/A	N/A
	Bridget-Ann Kenny	Medical Writer		7		02/12/2019	No	Yes	N/A	N/A	N/A
	Nicola Watts	Primary Care Counsellor	Psychology & Psychological Therapy		Primary, Community & Intermediate Care	05/12/2019	Yes	No	N/A	N/A	N/A
	Caroline Kirwan	Principal Genetic Counsellor	All Wales Genomic Service	8a	All Wales Genomics Service	05/12/2019	Yes	No	N/A	N/A	N/A
	Adam Christian	Consultant Histopathologist	Cellular Pathology	Consultant	CD&T	27/02/2020	Yes	No	N/A	N/A	N/A
	Karen Visser	Professional UHB Lead SLT	Community Child Health	8C	Children & Women	27.11.2019	Yes	Yes	N/A	N/A	N/a
	David Hitt	CBT	Adult Mental Health	7	Mental Health	02.12.2019	Yes	No	N/A	N/A	N/A
	Julie Ann Loxton	Senior Nurse - Daytime Service	PCIC	8a	PCIC - Vale Locality	02/12/2019	Yes		N/A	N/A	N/A
	Ryan Shipp	Specialist Mental Health Practitioner	Psychological Therapies		Mental Health	03/12/2019	Yes	No	N/A	N/A	N/A
	David Mark Howells	Psychiatrist	Locum Consultant / Substansive Speciality Doctor		Mental Health	01/08/2019	Yes	No	N/A	N/A	N/A
	Sian Johnson	Clinical Specialist Physiotherapist	Neurosciences Directorate	8A	Specialist Services	13/11/2019	Yes	No	N/A	N/A	N/A
	Clare Clement	Locality Lead Pharmacist	Medicines Management		PCIC	25/11/2019	Yes	No	N/A	N/A	N/A
	Emlyn (George) Pritchard	Prescribing Advisor	Medicines Management	8A	PCIC	14/11/2019	Yes	No	N/A	N/A	N/A
	Paul Bracegirdle	Deputy Directorate Manager	Head & Neck & Dental Directorate	7	Surgery	14/11/2019	Yes	No	Non - Executive Director for Tre-Oda Court Management Private Ltd (Reg. 08945509)	5/10/2017-Present	No information provided
	Helen Jane Prangely	Rehab Coach	Neurosciences	3	Neurosciences	11/11/2019	Yes	No	N/A	N/A	N/A
	Suzanne Clifton	Locality Manager	PCIC	8A	PCIC	13/11/2019	Yes	No	N/A	N/A	N/A
	Nicole Parish	Clinical Psychologist	Child Health Psychology		Child Psychology	13/11/2019	Yes	Yes	N/A	N/A	N/A
	Satyajeet Bhatia	Consultant	Oral and Maxillofacial Surgery	Consultant	Surgery	13/11/2019	Yes	No	Facecon UK Ltd and Faceon Property Limited	2018 / 2019 - ongoing	No information provided
	Anurag Joshi	Consultant	CD&T Cellular Pathology	Consultant	CD&T	13/11/2019	Yes	No	N/A	N/A	N/A
	Jazz Callen-Davies	HI Psychological Therapist	MHSOP	6	Mental Health	14/11/2019	Yes	No	N/A	N/A	N/A
	Stephanie Lock	Rotational MSK Physio	Physiotherapy	6	CD&T	07/08/2019	Yes	No	N/A	N/A	N/A
	Victoria Collins	Physiotherapist	Therapies		CD&T	14/08/2019	Yes	No	N/A	N/A	N/A
	Joanne Pearle	Team Leader Physiotherapy	Therapies		CD&T	13/06/2019	Yes	no	N/A	N/A	N/A
	Katie Clubb	Physiotherapist	Frailty Team	7	CD&T	15/07/2019	Yes	No	N/A	N/A	N/A
	Rosalind Spooner	Physio Assistant	Phsyiotherapy	2	CD&T	28/06/2019	Yes	No	N/A	N/A	N/A
	Karen Long	Physiotherapist	Therapies		CD&T	15/07/2019	Yes	Ni	N/A	N/A	N/A
	Julian Mogg	Physiotherapist	Therapies	5	CD&T	01/05/2019	Yes	No	N/A	N/A	N/A
	Harry Green	Phsyiotherapist	Therapies	5	CD&T	12/08/2019	Yes	No	N/A	N/A	N/A
	Samuel Morgan	Physiotherapist	Therapies		CD&T	21/06/2019	Yes	No	N/A	N/A	N/A
	Hywel Pullen	Assistant Director of Finance	Finance	8D	Corporate	20/11/2019	Yes	Yes	N/A	N/A	N/A
	Lynda Jenkins	Nursing Informatics Officer	Corporate Nursing		Nursing	12/11/2019	Yes	No	N/A	N/A	N/A
	Carol Evans	Consultant Clinical Scientist	Lab Medicine Biochemistry	Consultant	CD&T	27/03/2020	Yes	Yes	Spouse, Director of Optect solutions. Distributor for Skyray	March 2020 - Ongoing	No information provided
	Hayley Pincott	Associate Pratitioner Healthcare Scientist	Head, Neck & Dental		Surgical Services	02/03/2020	Yes	No	N/A	N/A	N/A
	Ne-Ron Loh	Consultant	Child Health	Consultant	Children & Women	24/02/2020	Yes	No	N/A	N/A	N/A
	Elisa Smit	Consultant Neonatologist	Women & Children	Consultant	Women & Children	08/02/2020	Yes	No	N/A	N/A	N/A
	David Tuthill	consultant paediatrician	Children & Women	Consultant	Women & Children	08/02/2020	Yes	Yes	Director of Cardiff paediatrics Director of Cardiff paediatrics	2015 - ongoing	Salary & Shared Dividend

	PREETKIRON BHAL	Consultant	Womens Gynacology	Consultant	Women & Children	22/01/2020	Yes	No	INFINITI HEALTHCARE LTD Spouse: INFINITI HEALTHCARE LTD	May 2013 - Ongoing	No information provided
	Amy Joyce	Occupational Therapist	CD&T	6	CD&T	12/12/2019	Yes	No	N/A	N/A	N/A
	Amy Parfitt	Speech & Language Therapy Technician	CD&T	4	CD&T	28/11/2019	Yes	Yes	Director of The Bare Co. Trading Ltd Partner: Partner is Director of The Bare Co. Trading Ltd, and is Director of Advantage Accountancy	10/01/2019 - Ongoing 25/03/2019 - ongoing	No information provided
	Anna Burgess	Pharmacist Team Leader (Medicines Information)	Pharmacy & Medicines Management	8B	CD&T	19/11/2019	Yes	No	N/A	N/A	N/A
	Mari Lea-Davies	Lead Pharmacist - Respiratory	Pharmacy & Medicines Management	8A	CD&T	18/11/2019	Yes	No	N/A	N/A	N/A
	Declan Coleman	Clinical Scientist	Radiology	8B	CD&T	12/07/2019	Yes	No	N/A	N/A	N/A
	Karen Bradley	Operations Business Manager	Operations	8C	Operations	16/07/2019	Yes	No	N/A	N/A	N/A
	Emma Brereton	Occupational Therapist	Occupational Therapy	7	CD&T	15/07/2019	Yes	No	N/A	N/A	N/A
	Vinod Cherian Varghese	Consultant Clinical Geneticist	All Wales Genomic Service	Consultant	All Wales Genomics Service	19/07/2019	Yes	Yes	One of the directors of a Limited company - Apps4Medics limited. Not linked to NHS or Cardiff & Vale UHB.	2011 - to date	Shares
	Adam Christian	Consultant Pathologist	Cellular Pathology	Consultant	CD&T	15/11/2019	Yes	Yes	Director of PLC Spouse: Director of PLC	Nov 2019 - ongoing	Salary and Dividends
	Nia Evans	Consultant Pharmacist Advanced Therapies and Haematology	Pharmacy	Consultant	CD&T	10/10/2019	Yes	No	N/A	N/A	N/A

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	365	01/11/2018	01/10/2019	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	365	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 STANDARDS INSTITUTE												
	Planning	British Standards Institute	Capital, Estates & Facilities	ISO - 14001 Environmental	Abigail Harris	Health and Safety	Jon McGarrigle	185 (Twice Yearly)	01/07/2019	01/01/2020	Minor non conformances which will be addressed by next audit		
CARDIFF AND													
	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	365	17/06/2019	01/06/2020	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	365	27/06/2019	01/07/2020	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	365	09/07/2019	01/07/2020	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	365	10/09/2019	01/09/2020	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	365	19/09/2019	01/09/2020	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	365	19/09/2019	01/09/2020	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	365	30/09/2019	01/09/2020	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	365	21/01/2020	01/01/2021	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	365	21/01/2020	01/01/2021	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	365	27/01/2020	01/01/2021	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.		

REGULATORY BODY REVIEW TRACKER - September 2019

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												

	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	730	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	1460	4-5/02/2019	01/02/2023	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	365	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	365	30/04/2019		0	n/a	1
	Medical Physics	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	185 (Twice Yearly)	17/03/2017		4 non conformances, 3 recommendaitons	01/05/2017	1
	QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES												
Specialist Services	Immunology	Quality in Primary Immunodeficiency Services (QPIDS)	Immunology	Quality in Primary Immunodeficiency Services Standards	Stuart Walker	QSE Committee	Stephen Jolles/Richard Cousins	365		01/10/2019			
Specialist Services	Immunology	Quality in Primary Immunodeficiency Services (QPIDS)	Immunology	Quality in Primary Immunodeficiency Services Standards	Stuart Walker	QSE Committee			01/10/2019		Accreditation declined		
	RESEARCH AND DEVELOPMENT												
	Haematology	Research and Development			Stuart Walker	QSE Committee							
	UKAS												
CD&T	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)		01/01/2020	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	365	01/01/2019	01/09/2019	3 minors	01/01/2020	1
Surgical Services	Perioperative	SGS/UKAS	HSDU	ISO 13485:2017	Fiona Jenkins	QSE Committee	Mark Campbell	365	07/08/2019	01/08/2020	2 minors	07/08/2020	1

Specialist Services	Haematology	SGS/UKAS	Haematology/Blood Transfusion (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	Ffiona Jenkins	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	Health and Safety							
		WSAC											
	Audiology	WSAC	audiology - adults	audiology quality standards	Fiona Jenkins	QSE Committee	Lorraine Lewis	1095	01/06/2019	01/06/2022	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	730	01/06/2018	01/06/2020	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	730	01/06/2018	01/06/2020	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)	1095	01/10/2019	01/10/2022	In need of investment from WHSSC and ini stafff	01/12/2019	1

Report Title:	**Legislative and Regulatory Tracker Report**								
Meeting:	Audit and Assurance Committee							**Meeting Date:**	21st April 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. However, due to COVID 19 and the fact that regulatory inspections have ceased the tracker is currently not being updated with new information but will still be reviewed for inspections which may take place at a future date.

This in turn will provide further assurance to the Audit and Assurance 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 be updated, however these updates will be limited due to COVID 19.

Based on the information contained within the tracker there have been no inspections undertaken since the last report to the Audit Committee on 3rd March 2020.

Detailed below are inspections which were due to take place during the next quarter. As this would in many instances involved individuals coming onto site we do not believe that these inspections will take place.

1. The Fire and Rescue Service are due in July 2020 to undertake inspections under the Health and Safety at Work at in the Specialist Services, Medicine and Surgery Clinical Boards.

2. WSAC are due in June 2020 to be undertaking inspections in audiology services in relation to newborn hearing and paediatrics.

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 March 2020 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	x	6.	Have a planned care system where demand and capacity are in balance	x
2.	Deliver outcomes that matter to people	x	7.	Be a great place to work and learn	x
3.	All take responsibility for improving our health and wellbeing	x	8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4.	Offer services that deliver the population health our citizens are entitled to expect	x	9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

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

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

Report Title:	**Internal Audit Recommendation Tracker Report**								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	21st April 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 and Assurance 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 and Assurance 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 two 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 is 228. 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 and Assurance Committee.

It should also be noted that currently due to COVID 19 work is not proactively taking place on internal audit recommendation tracking by the Corporate Governance Department.

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

Although the Corporate Governance Department have not been proactively following up internal audit recommendations the tracker has been reviewed and some recommendations have been completed. In addition to this the audits undertaken during the financial period 2019/20, which have been through the Audit and Assurance Committee have also been added to the tracker.

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	2	14	3	19
Internal Audits 18/19	4	22	6	32
Internal Audits 19/20	5	12	2	19

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

As can be seen from the attached tables progress has still been made (despite COVID 19) 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 (April 2020 Update)

	Update April 2020				Update April 2020				Update April 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Complete	2	2										
Overdue under 3 months					1			1				
Overdue over 6 months under 12 months					5		1	4				
Overdue more than 12 months	6		2	4	15	1	4	10	7		2	5
Overdue more than 24 months	1		1		7	1	2	4	5		3	2
Superseded												
Total	**9**	**2**	**3**	**4**	**28**	**2**	**7**	**19**	**12**		**5**	**7**

Total number of recommendations outstanding as on 15th April 2020 for financial year 2017/18 is **49** compared to the position in March 2020 which was a total number of outstanding recommendations of **54**

INTERNAL AUDIT REPORT RECOMMENDATION FOR 2018/19

	Update April 2020				Update April 2020				Update April 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached	10		4	6	26		10	16				6
Complete												
Overdue under 3 months											1	
Overdue by over 3 months under 6 months												
Overdue over 6 months under 12 months	6			6	10		1	9			1	6
Overdue more than 12 months	5		4	1	16		4	12				7
Overdue more than 18 months					8		1	7				3
Total	**21**	**0**	**8**	**13**	**60**	**0**	**16**	**44**	**24**	**0**	**2**	**22**

Total number of recommendations outstanding as on 15th April 2020 for financial year 2018/19 is **105** compared to the position in March which was a total number of outstanding recommendations of **133**

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2019/20

	Update April 2020				Update April 2020				Update April 2020			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached												
Complete												
Overdue under 3 months	6			6	24			24	7			7
Overdue by over 3 months under 6 months	6			6	13			13	3			3
Overdue over 6 months under 12 months	2		1	1	9		4	5	3		2	1
Overdue more than 12 months					1			1				
Overdue more than 18 months												
Superseded												
Total	**14**		**1**	**13**	**47**		**4**	**43**	**13**		**2**	**11**

Total number of recommendations outstanding as on 15th April 2020 for financial year 2019/20 is **74** compared to the position in March which was a total number of outstanding recommendations of **25**

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 24-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 24-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 24-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 24-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 24-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 place. Work has already commenced in developing a SOP and it is envisaged will be completed within the next few weeks.	Chief Operating Officer		Overdue more than 24-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 aspects we keep going forward and how much these elements would cost. Action – Team therefore note the recommendation for any future projects.	Director of Planning		Overdue more than 24-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 24-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 Generation	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 24-months
IA 1718	01/04/2018	Wellbeing of Future Generation	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 24-months
IA 1718	01/04/2018	Wellbeing of Future Generation	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 24-months
IA 1718	01/04/2018	Wellbeing of Future Generation	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 24-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 24-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

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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 monitored at Monthly Executive Performance reviews and is reported into regular meetings with	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	01/09/2017	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		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 should reconcile between sickness documentation and	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
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	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	Not Provided	Director of Planning		Overdue more than 12-months

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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
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

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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	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	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 12 months
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 12 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 12 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 12 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 12 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 18 months under 24 months

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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 18 months under 24 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 18 months under 24 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 18 months under 24 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 18 months under 24 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 18 months under 24 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 18 months under 24 months
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 18 months under 24 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 18 months under 24 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 18 months under 24 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 18 months under 24 months

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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 18 months under 24 months
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 18 months under 24 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 by over 12 months under 18 months
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 12 months under 18 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 12 months under 18 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 12 months under 18 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 12 months under 18 months
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	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 12 months under 18 months
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 12 months under 18 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 12 months under 18 months

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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	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 12 months but under 18 months
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 12 months but under 18 months
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 12 months but under 18 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 12 months but under 18 months

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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 12 months but under 18 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 12 months but under 18 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 12 months but under 18 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 12 months but under 18 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 12 months but under 18 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 12 months but under 18 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 12 months but under 18 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
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 12 months but under 18 months

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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		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 6 months but under 12 months
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 over 6 months but under 12 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		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

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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 6 months under 12 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 12 months under 18 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 12 months under 18 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	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 12 months but under 18 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	tional Implementati	Overdue by over 12 months but under 18 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 over 12 months but under 18 months

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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		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 over 12 months but under 18 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 12 months but under 18 months
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 over 12 months but under 18 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 over 12 months but under 18 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 over 12 months but under 18 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	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

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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 6 months but under 12 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 6 months but under 12 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 6 months but under 12 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 6 months but under 12 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 6 months but under 12 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 6 months but under 12 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 over 6 months but under 12 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.			
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	
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 but under 12 months

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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 by over 6 months but under 12 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 by over 6 months but under 12 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.	Chief Operating Officer	01/09/2019	Overdue by over 6 months but under 12 months
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 by 6 months but under 12 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		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 6 months under 12 months
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	Overdue by 6 months under 12 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	Overdue by 6 months under 12 months
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	Overdue by 6 months under 12 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	Overdue by 6 months under 12 months
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	Overdue by 6 months under 12 months
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)			Over 3 months under 6 months
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	Over 3 months under 6 months

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IA 1920	25/11/2019	Claims Reimbursement	Executive Nurse Director	Sustainable	0					Executive Medical Director	01/11/2019	Over 3 months under 6 months
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	Over 3 months under 6 months
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	Over 3 months under 6 months
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	Over 3 months 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	Over 3 months 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	Over 3 months 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.			Over 3 months under 6 months
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.			Over 3 months under 6 months
IA 1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited	4	R1/4	H					Over 3 months under 6 months
IA 1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited		R2/4	H					Over 3 months under 6 months
IA 1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited		R3/4	H					Over 3 months under 6 months
IA 1920	12/12/2019	Consultant Job Planning Follow-up	Executive Medical Director	Limited		R4/4	H					Over 3 months under 6 months
IA 1920	04/10/2019	Tentacle IT System	Director of Transformation	Limited	9	R1/9	H					Over 3 months under 6 months
IA 1920	04/10/2019	Tentacle IT System	Director of Transformation	Limited	9	R2/9	M					Over 3 months under 6 months
IA 1920	04/10/2019	Tentacle IT System	Director of Transformation	Limited	9	R3/9	M					Over 3 months under 6 months
IA 1920	04/10/2019	Tentacle IT System	Director of Transformation	Limited	9	R4/9	M					Over 3 months under 6 months
IA 1920	04/10/2019	Tentacle IT System	Director of Transformation	Limited	9	R5/9	M					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	04/10/2019	Tentacle IT System	Director of Transformation	Limited	9	R6/9	M					Over 3 months under 6 months
IA 1920	04/10/2019	Tentacle IT System	Director of Transformation	Limited	9	R7/9	M					Over 3 months under 6 months
IA 1920	04/10/2019	Tentacle IT System	Director of Transformation	Limited	9	R8/9	L					Over 3 months under 6 months
IA 1920	04/10/2019	Tentacle IT System	Director of Transformation	Limited	9	R9/9	L					Over 3 months under 6 months
IA 1920	17/02/2019	Budgetary Control	Director of Finance	Substantial	1	R1/1	M					Over 12 months under 18 months
IA 1920	24/02/2020	Brexit Planning	Director of Planning	Reasonable	4	R1/4	H					under 3 months
IA 1920	24/02/2020	Brexit Planning	Director of Planning	Reasonable	4	R2/4	M					under 3 months
IA 1920	24/02/2020	Brexit Planning	Director of Planning	Reasonable	4	R3/4	M					under 3 months
IA 1920	24/02/2020	Brexit Planning	Director of Planning	Reasonable	4	R4/4	L					under 3 months
IA 1920	18/02/2020	Safeguarding Adults and Children	Executive Nurse Director	Reasonable	4	R1/4	H					under 3 months
IA 1920	18/02/2020	Safeguarding Adults and Children	Executive Nurse Director	Reasonable	4	R2/4	H					under 3 months
IA 1920	18/02/2020	Safeguarding Adults and Children	Executive Nurse Director	Reasonable	4	R3/4	L					under 3 months
IA 1920	18/02/2020	Safeguarding Adults and Children	Executive Nurse Director	Reasonable	4	R4/4	L					under 3 months
IA 1920	24/01/2020	Freedom of Information	Director of Transformation	Reasonable	7	R1/7	H					under 3 months
IA 1920	24/01/2020	Freedom of Information	Director of Transformation	Reasonable	7	R2/7	H					under 3 months
IA 1920	24/01/2020	Freedom of Information	Director of Transformation	Reasonable	7	R3/7	M					under 3 months
IA 1920	24/01/2020	Freedom of Information	Director of Transformation	Reasonable	7	R4/7	M					under 3 months
IA 1920	24/01/2020	Freedom of Information	Director of Transformation	Reasonable	7	R5/7	M					under 3 months
IA 1920	24/01/2020	Freedom of Information	Director of Transformation	Reasonable	7	R6/7	L					under 3 months
IA 1920	24/01/2020	Freedom of Information	Director of Transformation	Reasonable	7	R7/7	L					under 3 months
IA 1920	21/02/2020	Consultant Annual Leave - CW CB	Chief Operating Officer	Reasonable	5	R1/5	M					under 3 months
IA 1920	21/02/2020	Consultant Annual Leave - CW CB	Chief Operating Officer	Reasonable	5	R2/5	M					under 3 months
IA 1920	21/02/2020	Consultant Annual Leave - CW CB	Chief Operating Officer	Reasonable	5	R3/5	M					under 3 months
IA 1920	21/02/2020	Consultant Annual Leave - CW CB	Chief Operating Officer	Reasonable	5	R4/5	M					under 3 months
IA 1920	21/02/2020	Consultant Annual Leave - CW CB	Chief Operating Officer	Reasonable	5	R5/5	M					under 3 months
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R1/6	M					under 3 months
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R2/6	M					under 3 months
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R3/6	M					under 3 months
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R4/6	M					under 3 months
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R5/6	M					under 3 months
IA 1920	21/02/2020	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	6	R6/6	M					under 3 months
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R1/11	M					under 3 months
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R2/11	L					under 3 months
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R3/11	M					under 3 months
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R4/11	M					under 3 months
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R5/11	M					under 3 months
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R6/11	M					under 3 months
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R7/11	H					under 3 months
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R8/11	L					under 3 months
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R9/11	M					under 3 months
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R10/11	M					under 3 months
IA 1920	24/02/2020	Control of Contractors	Director of Finance	Reasonable	11	R11/11	M					under 3 months

Report Title:	**External Audit Recommendation Tracking Report and Regulatory Tracker Report**								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	21st April 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 and Assurance 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 42 further actions have been completed since the last Audit Committee meeting in March 2020.

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

A review of all outstanding recommendations has been undertaken since March 2020 meeting. However, it should be noted that due to COVID 19 the Corporate Governance Department has not been proactively following up these actions with Corporate Departments or Clinical Boards.

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 15th April 2020.

Recommendation:

The Audit Committee Members are asked to:

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

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

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

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

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

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

External Audit	Complete	Not due	In progress	< 3 mths	> 3 mths	+6 mths	+ 1 year	18 mths =	Total
Structured Assessment 2018					9	2	3		14
Clinical Coding Follow Up		3							3
Discharge Planning							1		1
Review of Medical Equipment						1	6	1	8
Audit of Financial Statements	1	1		6	1	1			10
Structured Assessment 2019	1		1						2
Implementation of the Wellbeing of Future Generations Act			7	3					10
Total	**2**	**4**	**8**	**9**	**10**	**4**	**10**	**1**	**48**

In March 2020 there were 90 outstanding recommendation from WAO r as of the 15th April 2020 there are 48 outstanding recommendations.

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	Head of Corproate 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		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 Corporate 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 Corporate 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		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		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		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		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		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 12 months
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 12 months
WAO 6	345A2017	2016-17	Jan-17	Review of follow-up outpatients – assessment of progress	Chief Operating Officer			R1 Broaden the range of performance information regularly reported to the People, Planning and Performance Committee. This should ensure that it: • covers a broader range of specialities; and • clearly reports clinical risks associated with delayed follow-up appointments.		In our previous report, we found that the Board had not received information on the volume of delayed follow-up appointments. The People, Planning and Performance Committee (the PPP Committee) is responsible for the oversight of outpatient follow-up care. We found that the PPP Committee had received information about delayed ophthalmology appointments, and updates on the progress of outpatient follow-up waiting list improvement actions. However, the PPP Committee did not receive information about specialties beyond ophthalmology, nor receive adequate assurance on the clinical risks associated with delayed appointments. Since our review, the Board and the PPP Committee have received regular progress reports on the steps taken to validate the outpatient follow-up list and to modernise outpatient services. The PPP Committee has also monitored closely the progress of the Clinical Risk Assessment (see recommendation two). After our report, initially, the PPP Committee were provided with updates on progress with transforming outpatient care every meeting, although the committee members now feel that twice-yearly updates are more appropriate. Performance information reported to the PPP Committee includes the number of patients on the outpatient follow-up waiting list by month, the percentage of patients with a target date, and the percentage of patients experiencing a delay.			Jan-16	Strategy and Delivery		
WAO 6	345A2017	2016-17	Jan-17	Review of follow-up outpatients – assessment of progress	Chief Operating Officer			R2 Implemented					Jan-16	Strategy and Delivery		
WAO 6	345A2017	2016-17	Jan-17	Review of follow-up outpatients – assessment of progress	Chief Operating Officer			R3 Develop interventions to minimise the risk to patients with those conditions who are delayed beyond their target follow-up date.					Jan-16	Strategy and Delivery		
WAO 6	345A2017	2016-17	Jan-17	Review of follow-up outpatients – assessment of progress	Chief Operating Officer			R4 Develop an outpatient transformation programme to create sustainable, efficient and good-quality services that meet population demand in the long term, considering: • projected demand and capacity for outpatient services; • impacts of local service changes that may result from wider South Wales Programme regional change; • potential for integrated acute, community and primary-level services; • advances in medical practices and potential to utilise technology; and • creation of lean clinical condition pathways.					Nov-15	Strategy and Delivery		
WAO 6	345A2017	2016-17	Jan-17	Review of follow-up outpatients – assessment of progress	Chief Operating Officer			R5 Identify the change management arrangement needed to accelerate the pace of long-term outpatient transformation. The Health Board should consider: • the clinical resources, including medical, nursing and allied health practitioners, required; • the change capacity and skills required; • internal and external engagement with stakeholders; and • primary and community care capacity to support outpatient modernisation.						Strategy and Delivery		
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	Strategy and Delivery		overdue by over 18 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	Strategy and Delivery		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		R3/8	R3 Review medical equipment risk management throughout the organisation, ensuring alignment between the corporate and operational approach.		Ensure CBs capture medical equipment risks as part of their risk management processes. These will be monitored via MEG, and escalated through relevant strategic committees, eg Strategy and Resources/Capital Management/QSE/Management Executive as required.	Director of Therapies & Health Science	Deputy Director of Therapies & Health Science	Apr-19	Strategy and Delivery		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		R4/8	R4 The Health Board should determine how it can develop an effective medical equipment inventory with available resources.		The MEG will review the WHO good practice guidance and determine what is feasible to introduce, with resources available, to improve medical equipment inventory.	Director of Therapies & Health Science		Apr-19	Strategy and Delivery		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		R5/8	R5 The Medical Equipment Group should assure itself that clinical boards operate effective systems and processes for the monitoring, purchase and replacement of medical equipment below £5,000.		Ensure MSDOs include key under £5,000 items on their risk log and escalate replacement needs within the CB. Ensure medical devices procurement officer scrutinises under £5,000 items to identify opportunities for standardisation and efficiency	Director of Therapies & Health Science	MSDOs Medical devices procurement officer	Jan-19	Strategy and Delivery		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	Strategy and Delivery		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	Strategy and Delivery		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		R8/8	R8 Evaluate the medical equipment arrangements in place within Pathology Services (Laboratory Medicine).		Agree Pathology MDSO role with CD&T with same CB functions at a directorate level reporting through to CB MDSO.	Director of Therapies & Health Science	Director of Therapies & Health Science	Nov-18	Strategy and Delivery		overdue by over 12 months
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	Strategy and Delivery		Partially 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.						Digital Health Information		

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.						Digital Health Information		
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.						Digital Health Information		
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	Audit and Assurance		
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	Audit and Assurance		
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	Audit and Assurance		
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	Audit and Assurance		
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	Audit and Assurance		
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	Audit and Assurance		

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	Audit and Assurance		
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	Audit and Assurance		
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	Audit and Assurance		
WAO 18	1391A2019-20	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R9	**A Senior Officer has been underpaid** The Health Board should ensure that the officer's salaray is corrected and paid accordingly. The Health Board should also review, and if necessary strengthen, its process for the appointment of new or promoted staff to pay scales.		The correction has been processed accordinly. The situation arose to to a mis-communication between NHS organisations. The processes in place are sufficient and this is not deemed a systemic issue.			COMPLETE	Audit and Assurance		
WAO 19	1604A2019-20	2019-20	Nov-19	Structured Assessment	Chief Executive Officer	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	Audit and Assurance		
WAO 19	1604A2019-20	2019-20	Nov-19	Structured Assessment	Chief Executive Officer	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	Audit and Assurane		
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	Strategy and Delivery		
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	Strategy and Delivery		
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	Strategy and Delivery		
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	Strategy and Delivery		

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	Strategy and Delivery		
WAO 20	1509A2019-20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Planning	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 Planning		Nov-21	Strategy and Delivery		
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	Strategy and Delivery		
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	Strategy and Delivery		
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	Strategy and Delivery		
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	Strategy and Delivery		

REPORT TITLE:	**Internal Audit Plan 2020/21**								
MEETING:	**Audit Committee**						**MEETING DATE:**	**21st April 2020**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
LEAD EXECUTIVE:	**Director of Governance**								
REPORT AUTHOR (TITLE):	**Head of Internal Audit**								

PURPOSE OF REPORT:

SITUATION:

Following an extensive planning process and in accordance with the requirements of the Public Sector Internal Audit Standards, the Internal Audit Plan has been prepared which sets out our risk based plan of work for the year 2020/21.

In addition the Plan also includes the Internal Audit Charter which has been prepared as at April 2020.

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.

It is a requirement of the Public Sector Internal Audit Standards that an Internal Audit Plan and Charter is prepared on an annual basis and presented to the Audit Committee for approval.

The work undertaken by Internal Audit will be in accordance with the Plan, which has been prepared following a detailed planning process and is subject to Audit Committee approval. The plan sets out the programme of work for the year ahead, covering a broad range of organisational risks. The full document also describes how we deliver that work in accordance with professional standards. The plan has been prepared following consultation with the Executive Directors.

The Internal Audit Charter has been updated as at April 2020 and sets out the purpose, authority and responsibility of the Internal Audit service along with the relationships with the Health Board, its officers and other assurance providers.

ASSESSMENT:

The Internal Audit Plan and Charter provide the Audit Committee with a level of assurance that the work of the Internal Audit department will be based around the key risks faced by the Health Board and will be sufficient to allow for delivery of the annual Internal Audit report and Head of Internal Audit Opinion.

RECOMMENDATION:

The Audit Committee is asked to:

- **APPROVE** the Internal Audit Plan for 2020/21
- **APPROVE** the Internal Audit Charter April 2020.

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 Value UHB Internal Audit Plan 2020/21 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
(1) Corporate governance, risk and regulatory compliance					
Annual Governance Statement		To provide an opinion and undertake specific areas of review to support the completion of the Statement.	Transformation, & Informatics	Q4	Feed into annual report
Risk, Governance & Assurance		On-going overview of general governance and risk management arrangements. Undertake specific areas of review to support annual opinion.	Corporate Governance	Q1-4	Feed into annual report
Governance, Leadership & Accountability Assessment		To review the process that has been adopted and evidence supporting the self-assessment.	Corporate Governance	Q4	Feed into annual report
IM&T Control & Risk Assessment	BAF PR6	Review and assess the control environment for the management of IM&T within the organisation.	Corporate Governance	Q1	Feed into annual report
Risk Management	BAF PR4	Review the on-going development and implementation of the Risk Management Strategy and Procedure. Focus on risk assessment and management processes within Clinical Boards	Corporate Governance	Q4	Feb
Health and Care Standards		Review utilisation of standards within the Health Board and processes for assessing performance against them.	Nursing	Q4	Apr
Claims Reimbursement		Review compliance with Welsh Risk Pool Standard requirements for claims reimbursement.	Nursing	Q3	Feb
Whistle Blowing Policy	BAF PR4	Review processes for UHB staff to raise concerns and on-going management.	Corporate Governance	Q3	Feb

Cardiff and Value UHB Internal Audit Plan 2020/21 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
(2) Strategic planning performance management and reporting					
Engagement Around Service Change	BAF PR5	Review processes for consulting with key stakeholders around service change. (Deferred from 19/20 plan)	Strategic Planning	Q2	Dec
Regional Partnership Boards	BAF PR3	Review UHBs arrangements for engaging with RPBs. Focus on governance arrangements around funding flows.	Strategic Planning	Q3	Feb
Commissioning	BAF PR3	Scope to be agreed with Commissioning Lead.	Strategic Planning	Q3	Feb
Strategic Performance Reporting		Review processes for production, presentation and utilisation of strategic performance data. Including accessibility of information & dashboards. (Deferred from 19/20 plan)	Transformation, & Informatics	Q3	Feb
Data Quality Performance Reporting		Review the accuracy and quality of data recording for a sample key Health Board performance target. (Deferred from 19/20 plan)	Transformation, & Informatics	Q4	April
Public Health Audit 1	BAF PR5	Details of potential scope to be agreed once feedback is received from the Exec Lead.	Transformation, improvement & Informatics	Q2	Dec
Public Health Audit 2	BAF PR5	Details of potential scope to be agreed once feedback is received from the Exec Lead.	Transformation, improvement & Informatics	Q3	Feb

Cardiff and Value UHB Internal Audit Plan 2020/21 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
(3) Financial Governance and management					
UHB Core Financial Systems	BAF PR2	Review a selection of controls in place to manage key risk areas across the range of the main financial systems.	Finance	Q3	Feb
Charitable Funds		Focus on progress with dormant funds management and implementation of revised governance arrangements.	Finance	Q2	Dec
Directorate Level Financial Control	BAF PR2	Review effectiveness of management of devolved budgets within Directorates.	Finance	Q2	Dec
(4) Clinical governance quality and safety					
Annual Quality Statement		Check if the AQS is developed in accordance with Welsh Government guidance and check the accuracy, completeness and consistency of information.	Nursing	Q1	Sept
Nursing Staffing Levels Act	BAF PR1	Review of processes in place at ward level to ensure compliance with calculated nurse staffing levels	Medical	Q1	Sept
Concerns / Serious Incidents	BAF PR4	Review the processes and controls in place for managing concerns. Focus on closure of Serious Incidents and lessons learnt.	Nursing	Q2	Dec
Clinical Board's QS&E Governance		Review the arrangements in place within the Clinical Boards for Quality, Safety and Experience Governance.	Nursing	Q3	Feb

Cardiff and Value UHB Internal Audit Plan 2020/21 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
Integrated Health Pathways	BAF PR3	Review of processes for the development, implementation and utilisation of pathways tool. Establish if benefits are being realised. (Deferred from 19/20 Plan).	Transformation & Informatics	Q2	Dec
(5) Information Governance and Security					
IT Service Management (ITIL)	BAF PR6	Review processes in place for the management of IT Service delivery to ensure they are aligned with best practice and meet the needs of the organisation.	Transformation & Informatics	Q1	Sept
IT Strategy	BAF PR6	Review processes in place for the development and delivery of the IT strategy to ensure it meets the needs of the UHB.	Transformation & Informatics	Q2	Dec
Infrastructure / Network Management	BAF PR6	Review processes in place for the management of the risks associated with the network and IT infrastructure.	Transformation & Informatics	Q3	Feb
Implementation of New IT Systems		Review processes for the implementation of new systems and releases to ensure a secure and stable system is provided.	Transformation & Informatics	Q2	Dec
Departmental IT System		Review controls in place to manage a local IT system. System to be agreed with management.	COO	Q3	Dec
Tentacle IT System Follow-up		Follow-up of 19/20 Limited Assurance report.	Transformation & Informatics	Q3	Feb
Cyber Security / GDPR Follow-up		Follow-up of 18/19 Limited Assurance reports - Dependent on outcome of ICO audit.	Transformation & Informatics	Q4	April

Cardiff and Value UHB Internal Audit Plan 2020/21 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
(6) Operational service and functional management					
Specialist CB - Stock Management in ALAS		Review of stack management arrangements focusing on processes from patient assessment through to placing the order using BEST, linkages through to Oracle and non-catalogue spend.	COO	Q2	Dec
Surgery - Sickness Absence Management		Review processes for reporting, recording and managing sickness absence. Assess compliance with the All Wales Managing Attendance Policy.	COO	Q2	Dec
Medicine CB - Bank & Agency Nurses Scrutiny Process		Review processes in place for the scrutiny, monitoring and management of bank and agency nurse usage.	COO	Q3	Feb
MH CB - Monitoring of Outpatient Clinic Cancellations		Review controls and processes in place for the management of Outpatient clinic cancellations.	COO	Q3	Feb
PCIC CB - GP Access		Detail of scope to be agreed with Clinical Board.	COO	Q3	Feb
US Governance		Detail of scope to be agreed with Clinical Board.	COO	Q4	April
C&W CB - Rostering In Community Children's Nursing		Review the controls and processes in place for the planning and management of Community Children's nursing rosters.	COO	Q4	April
(7) Workforce management					
Recruitment and Retention of Staff	BAF PR1	Review the effectiveness of international medical / nursing recruitment strategies.	Workforce	Q2	Dec

Cardiff and Value UHB Internal Audit Plan 2020/21 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
Management of staff Sickness Absence	BAF PR1	Review compliance with the All Wales Managing Attendance Policy. Focus on poor performing areas.	Workforce	Q3	Feb
Consultant Job Planning Follow-up		Second follow-up of Limited assurance report.	Medical	Q4	April
(8) Capital and Estates 5					
Sustainability Reporting	BAF PR4	To establish if the Health Board has robust systems in place to record and report minimum sustainability reporting requirements as required by the Welsh Government.	Finance	Q1	Sept
Fire Safety	BAF PR4	Assess compliance against the processes and procedures put in place by management to operate the estate and compliance with statutory regulations in relation to fire precautions.	Planning	Q2	Dec
Asbestos Management	BAF PR4	Assessment of the controls and practices in place within the UHB to ensure that the key asbestos regulatory requirements are adequately addressed and appropriate management arrangements are embedded within the organisation.	Planning	Q2	Feb
Major Capital Scheme - UHW II	BAF PR6	The programme business case is currently being developed and the programme team/governance arrangements are to be established during 2020. Noting the same a small provision of time is	Planning	Q1-4	April

Cardiff and Value UHB Internal Audit Plan 2020/21 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
		included to provide proactive input/overview of the progression through the period.			
Major Capital Scheme - UHW New Academic Avenue	BAF PR6	An SCP has been appointed by the UHB to progress the initial phase of the programme i.e. the Vascular Hybrid and MTC theatres, with the OBC targeted for submission to Welsh Government in June 2020 and FBC submission in February 2021. An SCP has been appointed by the UHB to progress the initial phase of the programme i.e. the Vascular Hybrid and MTC theatres, with the OBC targeted for submission to Welsh Government in June 2020 and FBC submission in February 2021. It is therefore proposed that the initial review of this element of the programme may focus on:- • the management of key risks; • project governance; • project management arrangements,; • appointment of contractors and advisers, • design development, • development of the target cost.	Planning	Q3	April
Shaping Future Wellbeing in the Community Scheme	BAF PR6	An annual provision is provided and will be allocated to one of the following schemes during the year (subject to separate risk assessment).	Planning	Q4	April
Capital Systems Management	BAF PR6	A review of the systems, policies and procedures in place to manage those projects not specifically identified within the audit plan.	Planning	Q2	Feb
Development of Integrated Audit Plans	BAF	A small provision of time is included within the annual audit plan for the development of Integrated	Planning	Q1-4	April

Cardiff and Value UHB Internal Audit Plan 2020/21 - Planned output.	BAF/ Risk Reg	Outline Scope	Lead Executive Director	Proposed Timing	Audit Committee meeting
	PR6	Audit Plans for inclusion within the respective business case submissions for those major projects/ programmes highlighted above.			
Audit Management and Reporting					
Contingency & Assurance and Advisory		This element of the plan allows the flexibility to respond to management requests in order to meet specific Health Board needs throughout the course of the financial year.	Corporate Governance / Finance		
Follow-up		We will conduct follow-up reviews throughout the year to provide the Audit Committee with assurance regarding management's implementation of agreed actions.	Corporate Governance / Finance		
Planning, Management and Audit Committee		An allocation of time is required for the management of the service to the Health Board:- • Planning, liaison and management – Incorporating preparation and attendance at Audit Committee; completion of risk assessment and planning; liaison with key contacts and organisation of the audit reviews; • Reporting and meetings – Key reports will be provided to support this, including preparation of the annual plan and progress reports to the Audit Committee; and • Liaison with External Audit and other stakeholders.	Corporate Governance / Finance		
Head of Internal Audit Annual Report and Opinion		Mandatory requirement to comply with the Public Sector Internal Audit Standards and Annual Governance Statement.	Corporate Governance / Finance	Q4	May

CD&T Clinical Board – Laboratory Turnaround Times

Final Internal Audit Report

Cardiff and Vale University Health Board

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- 33
Report status:	Final Internal Audit Report
Fieldwork commencement:	18th December 2020
Fieldwork completion:	10th March 2020
Draft report issued:	23rd March 2020
Management response received:	29th March 2020
Final report issued:	30th March 2020
Auditor/s:	Ian Virgill – Head of Internal Audit Adam Davies – Principal Auditor
Executive sign off:	Steve Curry - Chief Operating Officer
Distribution:	Matt Temby - CD&T Director of Operations Alun Roderick - Service Manager – Haematology, Blood Transfusion & Phlebotomy Nigel Roiberts - Laboratory Service Manager.
Committee:	Audit Committee

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

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

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the 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 Laboratory Services blood sample Turn Around Times (TATs) was completed in line with the 2019/20 Internal Audit plan for Cardiff and Vale University Health Board (the UHB).

Laboratory Services form part of the Medical Biochemistry, Immunology and Toxicology Department that is incorporated into the Clinical Diagnostic and Therapeutic Clinical Board (CD&T). A key aim of the service is provide 'tests required for the immediate management of patients'. Up to 4,000 samples may be processed daily. The main tests carried out by Biochemistry are for Full Blood Count (FBC) and Alinity's, mainly Urate & Electrolytes (U&E) for Haematology.

The services are underpinned by a range of quality processes, the main one of which is ISO 15189.

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

2. Scope and Objectives

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place in relation to the blood sample TAT service. The review seeks to provide assurance to the Audit and Assurance Committee that risks material to the system's objectives were being managed appropriately.

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

- Appropriate and up to date Health Board policy and / or procedures are in place for the management of bloods;
- Arrangements for the request, collection and delivery of bloods to the Laboratories are streamline and comprehensive;
- Bloods are processed by the Laboratories in an accurate and timely manner in accordance with established TATS, especially for any critical results;
- Reported blood results are accessed by users in a timely manner for use in the treatment process; and
- Effective monitoring arrangements are in place to ensure that the service is properly managed and developed.

As part of the audit, review and testing of blood collection process was undertaken from the Emergency Unit – Ambulatory Care and Ward A1.

3. Associated Risks

The potential risks considered in this review are as follows:

- Failure to comply with specified reporting standards could compromise patient care; and

- Working practices are not streamline leading to delays in the process that adversely impact on patient care.

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 CD&T Clinical Board for Laboratory Turnaround Times is **Substantial Assurance.**

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

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.

Laboratory services for the processing of blood samples are subject to a strict and robust quality control environment that is monitored by the UK Accreditation Service.

The work we completed, focusing on an independent check of sample Turnaround Times, confirmed that the operation was in line with such standards and the recorded performance was accurate.

The Laboratory services have up to date and appropriate policies and procedures in place, in accordance with the requirements of ISO 1589 Quality Standards.

Effective processes are also in place for the request, collection and delivery of bloods and improvements are currently being rolled out in the form of electronic requesting.

Whilst we have raised no direct recommendations, a lean management approach would be the way to fully identify and evaluate the synergies and opportunities in the process as a whole.

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 Health Board policy and / or procedures are in place for the management of bloods				✓
2	Arrangements for the request, collection and delivery of bloods to the Laboratories are streamline and comprehensive				✓
3	Bloods are processed by the Laboratories in an accurate and timely manner in accordance with established TATS, especially for any critical results				✓
4	Reported blood results are accessed by users in a timely manner for use in the treatment process	Not reported on – see narrative comment			
5	Effective monitoring arrangements are in place to ensure that the service is properly managed and developed				✓

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

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the system control/design for the Laboratory TAT service processes reviewed.

Operation of System/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the operation of the designed system/control for the Laboratory TAT service processes reviewed.

6. Summary of Audit Findings

In this section, we highlight the findings and areas of good practice that were identified during our review. No issues requiring recommendations were identified during the course of our work.

Objective 1 - **Appropriate and up to date Health Board policy and / or procedures are in place for the management of bloods.**

We noted the following areas of good practice:

- Laboratories work to ISO 15189 quality standards that require policies and procedures to be documented and applied.
- UKAS (UK Accreditation Service) carry out a schedule of visits across the year, to look at various aspects of laboratory arrangements, as part of the accreditation requirements.
- Management of bloods forms part of the clinical training for all staff grades.
- The Emergency Unit is now operating a Rapid Assessment Zone (RAZ). A clinician is in charge of all assessments including the taking of bloods, so ensuring compliance with blood policies and procedures.

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

Objective 2 - Arrangements for the request, collection and delivery of bloods to the Laboratories are streamline and comprehensive.

We note the following areas of good practice:

- Electronic requesting for bloods is being rolled out across the hospital via a transformation initiative. At present approximately 30% of requests are electronic. Such requests reduce the processing time in the laboratories as details are more accurate, so lessoning the rejection rates. Most of the clinical wards already have the facility but use varies depending on pressures on the clinicians. Introduction of electronic requesting to the Emergency Unit is now part of a Clinical Board initiative and a trial is being arranged.
- The Emergency Unit is trialling a RAZ approach in ambulatory care. The approach relies on a clinician overseeing the initial patient assessment, instead of nursing staff. Accordingly it is anticipated that the number of bloods requested from this are will reduce.
- A Pod system is in place to transport blood requests to the laboratories from around the hospital, especially from the Emergency Unit. Historically, the system has been administered by the laboratory service though currently there are on-going discussions to transfer the management of the system to Estates. As the Pod system represents a hospital infra-structure, we consider ownership to lie more obviously with Estates. Accordingly no recommendation has been raised.

- Phlebotomists undertake daily rounds of the wards to collect bloods and deliver to the laboratories. Wards may also use the Pod delivery system as and when required.

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

Objective 3 - Bloods are processed by the Laboratories in an accurate and timely manner in accordance with established TATS, especially for any critical results.

We note the following areas of good practice:

- Laboratory arrangements in Reception are to be reviewed within the quality control processes with the aim of streamlining arrangements. Accordingly we have not raised a recommendation.
- All samples from the Emergency Unit are processed via an 'Accelerated Samples Bench'. If necessary such samples can also be fast tracked during the processing operation.
- TATS are produced by the processing machines at collective blood test and individual levels. The processing machines have in-built system controls over a number of activities.
- Critical results are identified as part of the processing activity. Results are phoned through to the relevant contact if possible and flagged as urgent on the patient record.
- The Laboratories target for processing both the FBC (Full Blood Count) and the U&E (Urate & Electrolytes) samples is set at 80% within 60 minutes. Testing a sample of 20 bloods from the Emergency Unit (EU) and Ward A1 the percentage of our sample processed in under 60 minutes was 76% for FBC and 79% for U&E. Given the relatively small sample involved this is considered within tolerance.
- The testing also identified that TATs processing averaged 40 minutes for FBC and 49 minutes for U&E. These results are in line with those reported by the laboratories for January 2020 of 38 minutes FBC and 46 minutes for U&E.

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

Objective 4 - Reported blood results are accessed by users in a timely manner for use in the treatment process

Test results are reported on various clinical systems through an interface with Crystal Reports which is part of the Laboratory Information System. The key systems are the All Wales Clinical Portal and the CAV Clinical Portal. Whilst it is possible to identify the end processing time, it is not feasible to identify when the results are accessed and used by clinical staff.

Accordingly we have not given an opinion for this objective. Arrangements in the use of blood sample test results would lend themselves to a lean review.

Objective 5 - Effective monitoring arrangements are in place to ensure that the service is properly managed and developed

We note the following areas of good practice:-

- TATs are embedded in the processing system and reported at blood sample type and individual levels.
- All 'non-conformaties' are investigated as part of the quality control system.
- TAT samples are taken weekly and checked for accuracy against targets.
- TAT results are reported at weekly meetings.
- Sample testing TATs are in line with the laboratory TATs.

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

7. Summary of Recommendations

We are pleased to report that no audit issues were identified for recommendation purposes.

Appendix C - 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.

Core Financial Systems

Final Internal Audit Report

Cardiff and Vale University Health Board

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-1920-13
Report status:	Final Internal Audit Report
Fieldwork commencement:	23rd October 2020
Fieldwork completion:	3rd March 2020
Draft report issued:	5th March 2019
Management response received:	31st March 2019
Final report issued:	31st March 2019
Auditor/s:	Ian Virgill Johanna Butt
Executive sign off:	Bob Chadwick, Executive Director of Finance
Distribution:	Chris Lewis, Deputy Director of Finance Richard Hurton, Assistant Finance Director Paul Emmerson, Finance Manager Resource Management Alun Williams, Financial Services Manager
Committee:	Audit Committee

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

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

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1. Introduction and Background

A review of the Cardiff and Vale University Health Board (the UHB or the 'Health Board') Core Financial Systems was completed in line with the 2019/2020 Internal Audit Plan.

Given the high level of assurance that has been provided for the Core Financial Systems reviews in previous years, the individual areas are now covered on a cyclical basis. Last year's review covered Asset Register and General Ledger Approval Hierarchy systems and therefore this year's review focused on the General Ledger and Accounts Receivable systems.

The relevant lead Executive Director for this review is the Executive Director of Finance.

2. Scope and Objectives

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

The purpose of the review is to establish if the Health Board has appropriate processes in place to ensure the effective management of the General Ledger and Accounts Receivable systems.

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

General Ledger

- The Financial Control Procedure is appropriate and up to date;
- Access to the financial system is appropriately administered;
- Relevant monthly reconciliations are appropriately completed and reviewed;
- Journals posted to the general ledger are appropriately authorised and supported with appropriate evidence; and
- Changes to the coding structure of the general ledger are appropriately administered.

Accounts Receivable

- The Financial Control Procedure is appropriate and up to date;
- There are appropriate regular reconciliations between the general ledger and the debtor system;
- Income due is appropriately identified and invoices are accurately and promptly raised;
- Receipts are accounted for properly, promptly and in full;
- Outstanding debt is appropriately monitored and followed up; and

- Debt write-off is managed appropriately.

3. Associated Risks

- Incorrect data may be held on the general ledger; and
- Income due to the Health Board may not be received or properly accounted for.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

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

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

There is a general ledger financial control procedure (FCP) in place, which reflects the current processes. However, the procedure had not been reviewed in line with the review date detailed on the procedure.

Our review of the controls around the general ledger confirmed that reconciliations are undertaken on all areas and are appropriately documented and subject to review and approval.

Access to the Oracle system is password protected and where users have not logged on for 60 days, access is denied. However, our comparison of the Oracle User Access report against the UHB leavers report found that at least 53 leavers still had access to Oracle.

The UHB has guidance in place for uploading actual and budget journals onto the general ledger. Journal upload templates / spreadsheets are appropriately completed and retained.

There is a database in place for requesting and actioning amendments to the general ledger chart of accounts. Our review of two requests confirmed that the requests had been actioned and the correct adjustments had been made to the chart of accounts.

Our review of the controls around accounts receivable found that there is a current financial control procedure in place which sufficiently details the processes to be followed.

Our review of a sample accounts receivable invoices confirmed that they were raised accurately and promptly and receipts were accounted for properly, promptly and in full.

Robust processes are in place for pursuing outstanding debts. Debts are appropriately reported to the Losses and Special Payments panel before being approved for write off by the Audit Committee.

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	General Ledger FCP				✓
2	Access to the Financial System			✓	
3	Reconciliations				✓
4	Journals				✓
5	Changes to coding structure				✓
6	Accounts Receivable FCP				✓
7	Debtors reconciliation				✓
8	Raising invoices				✓
9	Receipts				✓

Assurance Summary					
10	Outstanding Debts				✓
11	Debt writ-off				✓

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

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the system control/design for UHB Core Financial Systems.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for UHB Core Financial Systems.

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).

General Ledger:

Objective 1: The Financial Control Procedure is appropriate and up to date.

We identified the following finding:

- The University Health Board (UHB) has a Financial Control Procedure (FCP) for the general ledger systems, namely, 'General Ledger Controls' FCP which reflects the current controls around the general ledger. This procedure was due to be reviewed in September 2018 but this review was not undertaken.

Objective 2: Access to the financial system is appropriately administered.

We note the following areas of good practice:

- The NWSSP E-enablement team are responsible for the control of the Oracle system security and set-up. As such, if the user has access to Oracle they have followed the necessary procedure in order for NWSSP E-enablement team to set-up a user account.

- The NWSSP E-enablement team are responsible for reviewing continued access rights with Quarterly audit reports run.
- Access to Oracle is user-name and password sensitive for all users. Passwords must contain both numbers and letters for increased security and all passwords are required to be updated on a regular basis.
- Users who have not logged in for 60 days or more are end dated (excluding requisition approvers, Dataload accounts and Report writer accounts).

We identified the following finding:

- We compared the current UHB Oracle User Access report against the UHB leavers (since 1 April 2019). This highlighted a total of 53 leavers whose user account was still open on Oracle.

  Additionally, for 30/53 of these we compared the leaver's termination date against the last user login as detailed on the Oracle report. This indicated that for 5/30 of these, the Oracle user account had been accessed after the individual had terminated employment with the UHB.

Objective 3: Relevant monthly reconciliations are appropriately completed and reviewed.

We note the following areas of good practice:

- We reviewed the front sheets for the monthly reconciliations from 1 April 2019 to October 2019. This confirmed that all monthly reconciliations were appropriately signed and dated as being completed. The schedules were also appropriately signed and dated as being reviewed and approved.
- Backing documentation is retained on file for all reconciliations included in the month-end process.

We did not identify any findings under this objective.

Objective 4: Journals posted to the general ledger are appropriately authorised and supported with appropriate evidence.

We note the following areas of good practice:

- The UHB has produced a procedure / guidance notes for uploading both Actual Journals and Budget Journals onto Oracle.
- A journal template / spreadsheet has been developed which includes automated controls to ensure journals balance and coding is reasonable.
- A sample of 20 journals was selected from the Actual and Budget journal listings to include 10 from each month. The completed journal template / spreadsheet was available for all journals selected.

- A journals database is maintained which details individuals authorised to upload journals onto Oracle. For our sample of 20 journals all had been prepared by individuals listed on the journals database.
- We selected seven items from the 20 journals selected, which confirmed that supporting documentation was available for the journals items selected.

We did not identify any findings under this objective.

Objective 5: Changes to the coding structure of the general ledger are appropriately administered.

We note the following areas of good practice:

- A database (FQA) has been set up with automated e-mails generated when changes to the Chart of Accounts is required and actioned.
- We selected a sample of four requests. Review of the FQA confirmed that it had been appropriately updated with the four requests and these were recorded as being actioned.
- We compared the two requests for amendments on the FQA to the Chart of Accounts. This confirmed that the Chart of Accounts had been appropriately updated with the 124 updates required as detailed in the e-mail requests.

We did not identify any findings under this objective.

Accounts Receivable:

Objective 6: The Financial Control Procedure is appropriate and up to date.

We note the following area of good practice:

- There is an Accounts Receivable financial control procedure which is available on the shared drive. We reviewed the procedure which confirms that it sufficiently details the procedures for Accounts Receivable and was produced in 2017.

We did not identify any findings under this objective.

Objective 7: There are appropriate regular reconciliations between the general ledger and the debtor system.

We note the following areas of good practice:

- Our review of the monthly reconciliation lead schedules confirms that this includes a reconciliation of accounts receivables and all its associated areas, including the Debtors Control Account; NHS Debtors; Non NHS Debtors; Bad Debt Provision and Prepayments.
- A sample of two months were selected, being Month 2 and Month 5. The backing papers were reviewed which confirmed that backing

documentation was included for Debtors Control Account; NHS Debtors; Non NHS Debtors; Bad Debt Provision and Prepayments.

We did not identify any findings under this objective.

Objective 8: Income due is appropriately identified and invoices are accurately and promptly raised.

We note the following areas of good practice:

- We selected a sample of 20 auto-invoices for a sample of two months, being June 2019 and September 2019 – 10 from each month. Our review of the invoice and remittance advice confirmed that, for the sample selected, invoices were correctly classified on the general ledger; invoices were raised in a timely manner and receipts in respect of the invoices confirmed that these were processed promptly.
- We selected a sample of 10 manual invoices for the period 1 April 2019 to the date of the audit. Where manual request forms were completed these had been appropriately authorised and actioned. Where the form had not been completed, valid reasons were provided.

We did not identify any findings under this objective.

Objective 9: Receipts are accounted for properly, promptly and in full.

We note the following areas of good practice:

- For the sample of 30 invoices, 20 auto-invoices and 10 manual invoices, where these were paid the receipt of income was applied / matched to the invoice accurately and promptly.

We did not identify any findings under this objective.

Objective 10: Outstanding debt is appropriately monitored and followed up.

We note the following areas of good practice:

- 1st and 2nd dunning letters are automatically generated from the Oracle system at the appropriate intervals.
- Our testing of a sample of aged debts confirmed that the 1st and 2nd letters, where applicable, had been issued. Where the debt was still outstanding following the second letter, the debts were assigned to individuals and a valid reason / explanation was provided for not referring the debt to CCI.

We did not identify any findings under this objective.

Objective 11: Debt write-off is managed appropriately.

We note the following areas of good practice:

- Debt write-off reports are presented to the Losses and Special Payments panel before write-offs are taken to the Audit Committee.
- We reviewed the minutes for the May 2019 panel meeting which confirmed that the proposed write-offs are presented to the panel. The minutes confirmed that the Panel recommended that the Audit and Assurance Committee approve the write-off. This confirms that there is adequate scrutiny before debts are written-off.

We did not identify any findings under this objective.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**1**	**1**	**2**

Finding 1 - Review of General Ledger Control FCP (Operating effectiveness)	Risk
The University Health Board (UHB) has a financial control procedure (FCP) in place, namely 'General Ledger Controls' FCP which "*sets out the responsibilities and controls that must be exercised when ensuring the integrity of information contained within the General Ledger*". The FCP had a next review date of September 2018. This review was not undertaken. However, it was confirmed that the FCP does reflect current procedures in respect of the general ledger. We understand that the FCP will be reviewed and updated to reflect any best practice identified from the All Wales Technical Accounting Group (TAG) review of FCP's across all NHS Wales health boards. However, we would consider it good practice / good housekeeping to continue to review the current procedure in line with the review date until any best practice is shared by the TAG.	Out of date procedures are followed which may affect the integrity of the general ledger.
Recommendation	**Priority level**
The FCP should be reviewed and updated to reflect it has been reviewed until any best practice arising from the TAG is identified.	**Low**
Management Response	**Responsible Officer/ Deadline**
The FCP will be reviewed and updated. Future reviews will reflect any best practice arising from the TAG.	Paul Emmerson / June 2020

Finding 2 - Leavers Oracle User Access (Operating effectiveness)	Risk
The health board's 'General Ledger Controls' Financial Control Procedure (FCP) details that the NWSSP E-enablement team are responsible for the control of the Oracle system security and are also responsible for reviewing continued access rights. The FCP details that "*Heads of department are required to complete an "Oracle Leavers" form for all users who leave the Health Board. In addition Heads of department are required to complete a change of responsibility form for all users who change job roles*". It also details "*In compliance with the Health Board's IT Security policy no users are permitted to share their login details*". We undertook a comparison of the health board's current Oracle Users against the leavers report (for the period 1 April 2020 to the date of the audit). We identified a total of 53 employees who have left the Health Board but their Oracle User access was still active. We selected a sample of 30 of these to compare the last user log-in against the employees leaving date. This identified five instances where Oracle had been accessed after the user had left the health board.	The integrity of the Oracle is compromised. Users have inappropriate access to the Oracle system.

User	User Leaving date	User last log-in	No. of days
1	25/07/2019	21/11/2019	116
2	28/04/2019	07/05/2019	9
3	31/07/2019	17/10/2019	77

4	31/10/2019	25/11/2019	25
5	30/08/2019	13/09/2019	13

Recommendation	**Priority level**
Although responsibility for removing Oracle user access is the responsibility of NWSSP. We recommend that the Health Board undertakes a periodic comparison of its current Oracle Users against its leavers report to ensure that access does not remain open after the employee has left the Health Board or is accessed after the leave date. Managers should be reminded of their responsibility to update the NWSSP E-enablement team of any leavers or change in roles.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Health Board will undertake a periodic comparison of its current Oracle Users against its leavers report to ensure that access does not remain open after the employee has left the Health Board or is accessed after the leave date.	Paul Emmerson/ June 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

Risk Management

Final Internal Audit Report

2019/20

Private and Confidential

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-1920-03
Report status:	Final Internal Audit Report
Fieldwork commencement:	31st January 2020
Fieldwork completion:	28th February 2020
Draft report issued:	6th March 2020
Management response received:	27th March 2020
Final report issued:	30th March 2020
Auditors:	Chris Scott, Ian Virgill
Executive sign off:	Nicola Foreman, Director of Corporate Governance
Distribution:	Steve Curry, Chief Operating Officer Lisa Dunsford Director of Operations PCIC Clinical Board Matthew Temby, Director of Operations CD&T Clinical Board Mike Bond, Director of Operations SSCD Clinical Board Scott McLean, Director of Operations Childrens & Womens Clinical Board; Aaron Fowler, Head of Corporate Governance
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 Risk Management was completed in line with the 2019/20 Internal Audit Plan. The review sought to provide the Health Board with assurance that operational procedure is compliant with the key corporate policies within Cardiff and Vale University Health Board.

The Lead Executive Director for this review is the Director of Corporate Governance.

2. Scope and Objectives

The review sought to provide assurance that the Health Board's Risk Management Strategy and Framework is being appropriately applied, and that responsibilities for risk management are effectively being discharged. It assessed the extent to which the associated management controls are being applied, with a view to providing an audit assurance rating over the management of risk.

The 2019/20 audit sought to provide assurance over the following areas:

Risk management strategy, policy and procedures

- an up to date, comprehensive risk management strategy and policy is in place and has been appropriately communicated to all members of staff; and
- documented risk management procedures are in place to support the delivery of the risk management policy.

Risk identification

- Risk management across the Health Board is led and supported by Clinical Board and Directorate risk champions or leads;
- Staff and members receive appropriate training and guidance on risk management;
- Clearly defined procedures are in place to both identify and assess new risks;
- Risk registers are maintained by the different Corporate departments / Clinical Boards and Directorates throughout the health board; and
- Risks identified are 'real' risks posed to the Health Board.

Risk mitigation, monitoring and reporting

- Mitigating measures are identified to address risks and prompt action is taken to reduce threats identified;
- There are appropriate escalation procedures in place for risks that cannot be resolved at a local level;

- Significant risks are escalated from local registers through to Directorate, Clinical Board and corporate risk registers as appropriate;
- Responsibilities relating to clinical, operational and financial risk management have been delegated to appropriate sub-committees of the Health Board;
- Risk management is a standing item of the Committee(s) agenda(s) and subject to regular review;
- Regular risk review and monitoring takes place across the Health Board, with appropriate reporting right up through to Board level; and
- There is a clear link between the Corporate Risk Register and the Board Assurance Framework.

The audit examined the corporate risk management environment as well as Primary Community & Intermediate Care (PCIC), Clinical Diagnostics & Therapeutics (CD&T) and Specialist Services and Children's & Women's Clinical Boards.

3. Associated Risks

The risks considered in the review are as follows:

- lack of awareness of the Risk Management Strategy and supporting processes;
- risks are not being identified, assessed or included on appropriate risk registers;
- risks are not being actively addressed; and
- risks are not being escalated through the Health Board as appropriate.

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 Risk Management is **Reasonable assurance**.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

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

The UHB has comprehensive structures in place to identify and manage risk. The health board's risk management model, which sets out the management of strategic and operational risks and the process for the escalation of risks through the structure to the corporate level was revised in 2019 to introduce a Board Assurance Framework (BAF) and strengthen controls throughout the model.

The Risk Management framework includes comprehensive guidance to risk register owners on identification of risks and their subsequent management. Risk registers are in place at directorate, clinical board and corporate levels and are managed by local teams, and reviewed by Quality, Safety & Patient Experience (QSPE) groups/ committees.

The BAF is an integral part of the health board's system of internal control and captures the extreme potential risks (15 & above) which impact upon the delivery of the latter's Strategic Objectives. It also summarises the controls and assurances that are in place or the plans set out to mitigate them. The BAF aligns principal risks, key controls and assurances on controls alongside each of the Health Boards strategic objectives.

The audit, which focussed on the organisation's compliance with the rules of the framework relating to risk assessments, risk scoring, description and delivery of mitigating actions, escalation of risks to higher registers and the oversight activity of the QPSE groups/ committees identified a number of areas where compliance exceptions were observed or controls are not being applied consistently.

Findings and recommendations are recorded in the areas of training, risk identification and description and risk documentation, in particular that around the identification and capture of mitigating actions. Additionally, the audit has recommended the addition of some simple enhancements to the BAF documentation to improve clarity.

5. Assurance Summary

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

Assurance Summary					
1	risk strategy policy & procedures			✓	
2	supporting effective risk management through risk champions			✓	
3	risk training & guidance		✓		
4	risk identification procedures			✓	
5	risk register model			✓	
6	risk identification and description		✓		
7	mitigating actions		✓		
8	risk escalation			✓	
9	role of committees in risk review			✓	
10	risk management in the BAF			✓	

** 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 two issues that are classified as weaknesses in the system control/design for Risk Management.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for Risk Management.

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: Risk strategy policy & procedures.

The following areas of good practice were noted:

- the Risk Strategy policy and procedures are recorded in a comprehensive series of linked documents.

We did not identify any findings under this objective.

Objective 2: supporting effective risk management through risk champions.

The following areas of good practice were noted:

- the Risk Strategy policy and procedures document roles and responsibilities for health board staff in respect of risk identification and management;
- risk leads are nominated at directorate/ business unit and clinical board levels and are active in the regular risk identification and review cycle.

We did not identify any findings under this objective.

Objective 3: risk training & guidance

The following areas of good practice were noted:

- a comprehensive training plan is in place to reach across all levels of the Health Board through multiple channels.

The following significant findings were noted:

- risk register owners and other clinical board/ directorate staff had not yet received formal training in the use of the new risk management processes. **(Recommendation 1)**

Objective 4: risk identification.

The following areas of good practice were noted:

- standard Risk Assessment template forms are used to record and capture new risks in a consistent manner;

- risks identified and recorded on Risk Assessment forms are discussed at QSE group/ committee meetings where impact and likelihood scores are ratified.

The following significant findings were noted:

- a number of risks in the directorate risk sample were not supported by risk assessment forms. **(Recommendation 3)**

Objective 5: risk register model.

The following areas of good practice were noted:

- risk registers operate at multiple levels in the organisation's structure to capture and manage the risks identified;
- risks in the lower level registers feed into the higher level registers according to pre-defined risk score banding;
- registers are regularly reviewed and the risks in them reassessed.

We did not identify any findings under this objective.

Objective 6: Risk identification and description.

The following areas of good practice were noted:

- comprehensive procedure and guidance documents detail the process that should be adopted in identifying and recording risks.

The following significant findings were noted:

- the clarity of risk descriptions across registers varied significantly;
- several registers in the audit sample contained a significant number of entries that were not risks but rather existing issues i.e. operational/ funding/ resourcing/ compliance matters that are currently causing the directorates problems. **(Recommendation 2)**

Objective 7: mitigating actions.

The following areas of good practice were noted:

- the new risk management model risk register template clearly defines how, going forward, mitigating actions should record action description, action owner and target dates.

The following significant findings were noted:

- sample clinical board and directorate level risk registers were found to lack clarity in their recording of planned actions to mitigate risks and reduce risk scores. **(Recommendation 3)**

Objective 8: Risk escalation.

The following areas of good practice were noted:

- Risk policy documentation provides rules for risk escalation to higher level registers based on risk severity aligned to risk score rating.

We did not identify any significant findings under this objective but did note that not all risks in the sample of directorate level register entries scoring 12+ were represented in the respective clinical board level registers.

Objective 9: Role of committees in risk review.

The following areas of good practice were noted:

- risk registers of the clinical boards and directorates are regularly reviewed by respective Quality, Safety and Experience (QSE) groups/ committees.

We did not identify any findings under this objective.

Objective 10: risk management and the Board Assurance Framework (BAF).

The following areas of good practice were noted:

- The new risk model includes a Board Assurance Framework that identifies the assurance sources that secure the delivery of the health board's organisational objective.

The following significant findings were noted:

- The BAF risk list document does not cross-reference to either the corporate risk register entries or the health board's 10 strategic objectives. **(Recommendation 4)**

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

Finding 1 - Risk management training & guidance (Control design)	Risk
Whilst a range of Risk Management strategy, policy and procedure documents have been widely circulated across the health board and training channels have been identified, at the time of the audit, risk register owners and other clinical board/ directorate staff had not yet received formal training in the use of the new risk management processes. Audit testing indicated a need to clarify the required content of some of the risk register template fields to ensure consistency of use.	Poor or absent training risks a low level of knowledge and understanding of requirements across staff groups and could result in non-compliance with health board policy.
Recommendation	**Priority level**
We recommend that the risk management training framework is finalised and detailed training materials are developed for roll out across the health board.	**Medium**
Management Response	**Responsible Officer/ Deadline**
A detailed plan will be developed but due to activities which Clinical Boards are dealing with in relation to COVID 19 the roll out of that programme will be delayed.	Head of Risk and Regulation July 2020 – December 2020

Finding 2 - Risk identification and description (Operating effectiveness)	Risk
We noted the following in respect of the entries in the sample of risk registers examined: • clarity of the risk description across registers examined were seen to vary significantly and reviewing a sample of registers across the health board, it wasn't possible to determine for all register entries the context, cause or impact of the matter being described (we appreciate the new risk model risk identification and assessment guidance addresses this aspect); • several registers in the audit sample contained a significant number of entries that were not risks but rather existing issues i.e. operational/ funding/ resourcing/ compliance matters that are currently causing the directorates problems.	Time and effort can be wasted on assessing and reviewing ill-defined risks/ existing issues to the detriment of the sound management of true future threats.
Recommendation	**Priority level**
We recommend that training initiatives include the distinction between risks and issues and that the latter are addressed through an alternative allied management oversight activity.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed – this will be picked up through the detailed training programme referenced above.	July 2020 Head of Risk and Regulation

Finding 3 - Risk documentation (Operating effectiveness)	Risk
We noted generally in the risk registers we examined that risk entries do not document well what will be developed going forward to reduce risk scores and for a number of risks in the directorate risk sample we were not provided with supporting risk assessment forms. We appreciate the new risk management model is more prescriptive in its description of action planning and recording but the following recurring weaknesses/ exceptions were observed in the sample of risk entries examined in the audit of the existing registers and risk assessment forms: • clear, discernible, further actions were not always identifiable in narrative texts entered in the risk register action columns; • actions typically don't record the action owner (although a risk owner was in some cases assigned) or a target timescale; • several registers were seen to contain multiple blank cells in the further action columns giving an impression of incompleteness or being in progress; • registers poorly distinguish between actions that have already been delivered and actions that are yet to be; • not all risks examined record in the register the date of last or next review.	Inadequate mitigation could mean risks remain at original threat level and if crystallise, have significant impact on the organisation.
Recommendation	**Priority level**
We recommend that going forward the weaknesses observed in the recording of risk mitigating actions are addressed.	**Medium**

Management Response	Responsible Officer/ Deadline
Agree this will initially be addressed through the training programme and then there will be a continuous review and support to ensure the weaknesses do not reoccur.	Head of Risk and Regulation July 2020 and onwards

Finding 4 – Board Assurance Framework reporting (Control design)	Risk
We observed the following in the presentation of the Board Assurance Framework report: • The report, which groups the highest rated risks of the health board under 6 organisational priorities/ domains/ areas, records separately the health board's 10 strategic objectives but we note that in this document these are not mapped/ linked to one another; • The BAF and Corporate Risk Register both report on the health board's top rated risks but the BAF report does not include a cross-reference to the corresponding entries in the Corporate Risk Register.	Absent cross-referencing between key elements in the assurance framework could result in a lack of clarity and subsequent management decision error.
Recommendation	**Priority level**
We recommend that going forward the weaknesses observed and recorded in the Board Assurance Framework reporting are addressed.	**Low**

Management Response	Responsible Officer/ Deadline
Agree	Director of Corporate Governance September 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.

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Mr Len Richards
Chief Executive
Cardiff and Vale University Health Board
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CF14 4HH

Reference: 0403.mju.richards

Date issued: 3 April 2020

Dear Len,

Annual Audit Plan 2020 – Impact of COVID-19

The COVID-19 national emergency has had an unprecedented impact on the UK and will significantly impact on public bodies' preparation of the 2019-20 accounts and our audit work, both financial audit and performance audit.

Due to the UK Government's restrictions on movement and anticipated sickness absence levels, we understand that many public bodies will not be able to prepare accounts in line with the timetables set out.

Alongside the delivery of the Auditor General's statutory responsibilities, our priority is to ensure the health, safety and well-being of Audit Wales staff, their families and those of our partners elsewhere in the public service at this incredibly challenging time.

In response to the government advice and subsequent restrictions, we have ceased on all on site work at audited bodies and our own offices have closed. Audit Wales staff are working from home and we will continue to make whatever progress we can whilst working and engaging with you remotely.

We commit to ensuring that our audit work will not have a detrimental impact on you at a time when public bodies are stretched and focused on dealing with the COVID-19 national emergency.

Amendments to the audit plan presented to the Audit Committee 3rd March 2020

Timetable

In light of the situation, the audit plan issued to you on 21 February 2020 will need to be amended.

In respect of our financial audit work, we are aware that Welsh Government have revised draft accounts preparation and submission deadlines to 22 May and 30 June respectively, although these will continue to be under review. Achieving legislative deadlines for preparation of draft accounts (31 August 2020) and audit (some four months after draft submission) are not currently thought likely to be problematic.

We will need to discuss amended timetables for the audit of accounts with you but will continue to work as flexibly as we can.

Our annual audit plan also set out a programme of performance audit work at the Health Board. We will make as much progress as possible with these activities by working remotely. However, the cessation of on-site work will have an inevitable impact on the delivery of our performance audit work. We are keeping this under on-going review and will communicate further information on revised timings and performance audit outputs when more is known about the duration of the COVID-19 restrictions and the wider impact of the outbreak on the NHS.

Audit risks

As a result of the COVID-19 national emergency, we need to update our assessment of audit risks. The following schedule replaces Exhibit 2 in the 2020 audit plan.

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

Financial audit risks	Proposed audit response
	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.
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.

Financial audit risks	Proposed audit response
Impact of COVID-19 The COVID-19 national emergency may see a significant delay in the preparation and audit of accounts. There is a risk that the quality of the accounts and supporting working papers e.g. around estimates and valuations, may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and make arrangements to monitor the accounts preparation process. We will help to identify areas where there may be gaps in arrangements.
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.
New accounting standards IFRS 16 was scheduled to replace the current leases standard IAS 17 in 2020-21. In light of COVID-19, this has now been deferred by the Welsh Government to 2021-22, but the new standard may pose some implementation risks for the health board. 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.	My team will roll forward any knowledge gained through audit work already undertaken to assess the Health Board's preparedness for the introduction of the new standard to our 2021-22 audit planning.

We will provide further updates as and when necessary. In the meantime, if you have any questions, please contact one of our audit team.

Yours sincerely

MIKE USHER
Engagement Director

cc: Bob Chadwick, Executive Director of Finance
Nicola Foreman, Director of Corporate Governance

Professor Chris Jones
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer

Dirprwy Gyfarwyddwr Gofal Iechyd Poblogaeth
Deputy Director Population Healthcare Division

Llywodraeth Cymru
Welsh Government

Health Board Clinical Audit Leads
Medical Directors

19 March 2020

Dear Colleague,

National Clinical Audit Programme

In these unprecedented times there will be questions concerning the continuation of the national clinical audit programme and its surrounding procedures.

Welsh Government has been in contact with HQIP and NHS England and all parties have agreed that during the Covid-19 period, all clinical audit data collection should be suspended and analysis and preparation of current reports left to the discretion of the audit providers.

The Welsh Government are taking a pragmatic approach going forward. We shall not be requesting nor chasing proformas whilst health board priorities are elsewhere.

We shall keep you updated as things progress. Please contact wgclinicalaudit@gov.wales if you have any queries.

Yours sincerely

PROFESSOR CHRIS JONES

CC: Andrew Goodall

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